

**MIDDLEBURY COLLEGE
HEALTH AND WELFARE BENEFITS PLAN**

Summary Plan Description

Effective as of January 1, 2014

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

I. GENERAL INFORMATION

1.1 Plan Name and Effective Date. The full name of the Plan is the Middlebury College Health and Welfare Benefits Plan, effective as of January 1, 2011. This SPD reflects the terms of the Plan in effect as of January 1, 2014, unless otherwise noted. The Plan contains benefits provided by your Employer which previously had been treated as separate plans for reporting purposes.

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

1.3 Employer Information.

The President and Fellows of Middlebury College ("College")
Room 200, Service Building
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 College, or its designee, and may be contacted at the address and telephone number given above. The College 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 Treasurer's Office at the following address:

The President and Fellows of Middlebury College
Treasurer's Office
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 and to eligible Retired Employees (as described in Section 2.2) 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) and the employee and family assistance program benefits ("EFAP") described in 3.1(h). 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 College 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 College 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 College only upon receipt of the certification by the College that the plan document has been amended to incorporate the provisions herein. The College 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 College with respect to such information. The College will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans. The College 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 College 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 College 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 College 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 College will notify the Plan of any such request by the Secretary prior to making such practices, books and records available. The College 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 College 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 College 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 College 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 College, and administered pursuant to a contract the College has with Comprehensive Benefits Administrator, Inc. dba CBABlue (“CBABlue”). 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 College has with 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 College has with CBABlue. 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 College has with Mutual of Omaha. 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 College has with Vision Service Plan Insurance company (“VSP”). The cost of such coverage is shared between active participants and the College. Retirees pay the entire cost of coverage elected.

Abroad Assignment Benefits are provided pursuant to a contract the College 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.

II. ELIGIBILITY

2.1 Am I eligible to participate in the Plan?

(a) General requirements.

- (1) For Staff Employees of the College and Monterey Institute of International Studies, a graduate school of Middlebury College (“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:

College/MIIS Staff E-Group and Benefit Eligibility Chart						
Classification	Org	FTE	Hours Per Year	Appointment Duration	E-Group Code	Benefits Eligibility
Full-Time	College	.8 - 1	1664+	on-going	08	Yes
	MIIS	.85 - 1	1664+	on-going	08	Yes
Part-Time – BE	College	.48 -.79	1000-1663	on-going	21	Yes
	MIIS	.51 - .84	1000-1663	on-going	21	Yes
Time-Limited	College	.48+	1000+	9+ months (with end date)	32	Yes
	MIIS	.51+	1000+	9+ months (with end date)	32	Yes
Part-Time – NB	College	<.48	<1000	on-going	22	No
	MIIS	<.51	<1000	on-going	22	No
On-Call	College	n/a	n/a	on-going	31	No
	MIIS	n/a	n/a	on-going	31	No
Temporary/ Seasonal	College	n/a	n/a	<9 months w/ end date	33	No
	MIIS	n/a	n/a	<9 months w/ end date	33	No

- (2) **For Faculty Employees of the College and 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:¹

College/MIIS Faculty E-Group and Benefit Eligibility Chart						
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¹ The eligibility requirements set forth in the chart are effective as of July 1, 2012. Prior to July 1, 2012, eligibility for participation in the Plan also was determined based on the number of instructional units completed by an eligible faculty member.

Classification	Org	Appointment Duration	FTE	E-Group Code	Benefits Eligibility
Full-Time <i>(Includes Visiting Faculty)</i>	College	≥1AY	.8-1	01	Yes
	MIIS	≥1AY	.8-1	01	Yes
Part-Time - BE <i>(Includes Visiting Faculty)</i>	College	≥1AY	.5-.79	02	Yes
	MIIS	≥1AY	.5-.79	02	Yes
Part-Time - NB	College	Any	<.5	03	No
	MIIS	Any	<.5	03	No
Adjunct	College	Any	Any	34	No
	MIIS	Any	Any	34	No

- (3) You will also be eligible if you:
- (A) would have been eligible pursuant to the above charts, 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;
 - (B) are in a **“Grant Funded”** position with the College or MIIS and classified as a “benefits eligible” employee in the records of Human Resources;
 - (C) 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;

- (D) 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);
 - (E) are a participant in the College’s Phased Retirement Program, as described in Appendix N; or
 - (F) are otherwise classified as a “benefits eligible” employee in the records of Human Resources, and has been approved for eligibility for benefits by the applicable insurance carrier.
- (4) 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.
- (5) Notwithstanding any provision of the Plan to the contrary, 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 only scheduled to work one semester during an academic year.
- (6) 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.
- (7) 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.

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

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

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

Eligible Retirees may continue participation in the Plan upon retirement from the College **for medical, dental and vision insurance benefits only**. If you are an Eligible Retiree and you do not continue participation immediately after retirement, you will not be allowed to re-enroll in the Plan (even if there is a change in the facts that caused you to stop participating in the Plan), unless federal law requires.

- 2.3 Are my spouse (including my same-sex spouse), dependent(s), domestic partner (including same-sex partner) or individual with whom I have entered into a civil union eligible for benefits under the Plan?** Your same-sex or opposite-sex 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 (same-sex or opposite sex) 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 must be enrolled for coverage at the time you are first eligible for coverage under the Plan or 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.

- 2.4 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). Eligible Employees of the College who are classified as “Faculty Employees,” **are not** eligible for short-term disability insurance benefits; however they may be eligible for other short-term salary continuation benefits, as set forth in the Faculty Handbook, and should discuss the need for such benefits with the Provost.
- (c) For purposes of the EFAP benefits, you can participate immediately upon hire.

2.5 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).

2.6 When must I enroll for benefits?

- (a) **Eligible Employee.** 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.
- (b) **Eligible Retiree.** You must be enrolled for benefits under the Plan immediately prior to your retirement. You may continue participation in the Plan immediately upon retirement by submitting an election form to the Office of Human Resources. Effective January 1, 2014, you also may elect to enroll in the retiree benefits offered under the Plan even if you did not enroll in such benefits immediately following your retirement. However, in order to enroll at a later date, you must provide the College with acceptable evidence of other medical coverage during the period following your retirement from employment with the

College to the date of your enrollment (e.g., proof of coverage through your spouse's employer or Marketplace coverage).

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

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

2.7 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 or Eligible Retiree, (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.

2.8 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 How is the cost of medical, dental and vision Plan benefits paid for Eligible Retirees? Eligible Retirees are generally required to pay the entire cost of the coverage elected, unless eligible for participation in some other program sponsored by the Employer. In some instances, for some "grandparented" Eligible Retirees, the cost of

coverage selected may be shared between the Employer and the Eligible Retiree. The list of “grandparented” Eligible Retirees is maintained in the College’s Office of Human Resources. For those Eligible Retirees not currently paying 100% of the cost of coverage, such costs are expected to increase by the regular annual premium increase plus 6% each year, but in no event will increase greater than 25% per year. Notwithstanding the foregoing, all retirees pay the full cost of the vision insurance. Failure to pay the required premiums in a timely manner will result in termination of coverage.

- 3.4 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.
- 3.5 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, as described in the "Change In Family Status" section below (provided the change is also permitted by the Group Health Benefit). If you wish to make a change, be sure to ask Human Resources for the Plan's complete procedures that implement these IRS rules, if you have questions after reading the following summary. **You must make your new election in writing within 30 days of the occurrence that permits the change. As a Participant in this Plan you must notify Human Resources of any change in family**

status affecting your own, or a dependent's, eligibility for benefits. Failure to do so can result in serious consequences including, but not limited to, the requirement to maintain your current election for the remainder of the Period of Coverage, even if your coverage is reduced based on a change in family status (e.g., from family to single). 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.

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 date. 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 Eligible Retiree, 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 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 requirements 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 extension period explained below, if applicable). 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 and either: (i) the other plan does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary; or (ii) the exclusion or limitation in the other plan either doesn't apply to the Qualified Beneficiary or has been satisfied, based on applicable law;
 - (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 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 decision. The notification will state, in a manner calculated to be understood by the claimant:

- (i) The specific reason for the adverse determination;
- (ii) Reference to the specific Plan provisions on which the determination is based;
- (iii) information sufficient to identify the health claim (if applicable) involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- (iv) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (v) A description of the Plan’s review procedures (including both the available internal appeals and external appeals process) and time limits (including a statement of the claimant’s right to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review);

- (vi) a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes; and
- (vii) If the claim is an urgent care claim, a description of the expedited review process.

If an internal rule, guideline, protocol or other similar criterion (collectively, “Internal Rule”) was relied upon in making the adverse determination, the notification will contain the Internal Rule, or a statement that such an Internal Rule was relied upon in making the determination and that a copy of the Internal Rule may be obtained free of charge upon request. Further, if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification will contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such explanation will be provided free of charge upon request.

- (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, 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.

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.

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.

You may be entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under the medical insurance plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing

coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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.

APPENDIX A

AFFILIATED EMPLOYERS PARTICIPATING IN THE PLAN

There are no Affiliated Employers currently participating in the Plan.

APPENDIX B

BENEFITS & CONTRIBUTIONS

I. GROUP HEALTH BENEFITS

Each Eligible Employee and Eligible Retiree 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. Eligible Retirees are generally required to pay the entire cost of the coverage elected.²

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.

² In some instances, for some “grandparented” Eligible Retirees, the cost of coverage selected may be shared between the College and the Eligible Retiree. The list of “grandparented” Eligible Retirees is maintained in the College’s Office of Human Resources. For those Eligible Retirees not currently paying 100% of the cost of coverage, such costs are expected to increase by the regular annual premium increase plus 6% each year, but in no event will increase greater than 25% per year. Failure to pay the required premiums in a timely manner will result in termination of coverage.

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 and Eligible Retirees may elect Vision Benefits, in accordance with Appendix L. The cost of such coverage elected is shared between the Employer and the Eligible Employee. Eligible Retirees are generally required to pay the entire cost of the coverage elected.

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.

APPENDIX C

MEDICAL INSURANCE PLAN

INTRODUCTION

The College sponsors this self-funded ERISA welfare plan which provides medical insurance benefits for all Eligible Employees, Eligible Retirees and their Dependents enrolled for coverage. Stop loss reinsurance has been purchased to protect the Plan Sponsor from unpredictable claims experience.

Each covered person is entitled to the benefits outlined in this Appendix. To obtain benefits from the Plan, the Participant must submit a diagnostic bill to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 2365
South Burlington, VT 05407-2365
Customer Service & Pre-Certification: (888) 222-9206
<https://lin04.cbabluevt.com/middleburyindex.htm>

This claim submission is required for reimbursement to the Participant or direct payment to the service provider by the Middlebury College Health and Welfare Benefits Plan (“Plan”).

A clerical error will neither invalidate the Participant’s coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

Comprehensive Benefits Administrator, Inc. dba CBABlue, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any underwriting financial risk or obligation with respect to claims liability. To the extent CBABlue assumes any liability, it is only as may be required by the Contract Administrative Services Agreement between the College and CBABlue, or as required by law.

PLAN ENROLLMENT

Unless otherwise noted, coverage becomes effective the first of the month after (or coincident with) the employee’s or dependent’s entering eligible status.

Employee Coverage

Eligibility: Only Eligible Employees, as defined in Section 2.1, are eligible for coverage under this Plan.

Plan Enrollment: An Eligible Employee must enroll for coverage within thirty (30) days of their eligibility date. The Employee will be enrolled when a benefit enrollment form is completed, signed, and delivered to your Employer within the time limit. Should the enrollment occur more than thirty (30) days following the eligibility date, the Eligible Employee will be eligible to enroll during the annual Open Enrollment Period described below or may be eligible under the “Transfer of Coverage” provision as described herein.

Annual Open Enrollment Period: 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.

Disability Leave: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of the disability leave of the Eligible Employee until employment is terminated by the Employer or the Eligible Employee.

General Leave of Absence: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of an approved leave of absence for a period of one (1) year, or until employment is terminated by the Employer or the Eligible Employee.

Layoff: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of the Eligible Employee’s layoff until employment is terminated by the Employer or the Eligible Employee.

Retiree Coverage

Eligibility: Only Eligible Retirees, as defined in Section 2.2, are eligible for coverage under this Plan. Notwithstanding the foregoing, a former employee who otherwise satisfies the requirements to be an Eligible Retiree under the terms of the Plan, is not eligible for the medical coverage provided under this Plan if the retiree resides outside of the United States.

Plan Enrollment: Eligible Retirees may continue participation in the Plan upon retirement from the Employer. Effective January 1, 2014, an Eligible Retiree also may elect to enroll in the retiree benefits offered under the Plan even if the Eligible Retiree did not enroll in such benefits immediately following retirement. However, in order to enroll at a later date, an Eligible Retiree must provide the College with acceptable evidence of other medical coverage during the period following retirement from employment with the College to the date of enrollment (e.g., proof of coverage through a spouse’s employer or Marketplace coverage), unless federal law requires otherwise.

Annual Open Enrollment Period: 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.

Dependent Coverage

Eligibility: The Dependent (s) of an Eligible Employee or Eligible Retiree, as defined in this Appendix, will become eligible for coverage on the date of the Eligible Employee’s or Eligible

Retiree's eligibility for coverage and/or on the date which the Eligible Employee or Eligible Retiree acquires the Dependent.

If an Eligible Employee or Eligible Retiree and Spouse are both eligible for coverage under the Plan, only one will be eligible to enroll Dependent(s). Also, a Participant cannot be covered as an Eligible Employee or Eligible Retiree and at the same time as a Dependent.

Plan Enrollment: To obtain coverage, a Dependent (s) must be enrolled within thirty (30) days of the Dependent's eligibility date. A Dependent will be enrolled in the Plan when the Eligible Employee or Eligible Retiree has completed and signed a benefit enrollment form or notice of change form and it is delivered to the Plan Sponsor. Dependents who are not enrolled within thirty (30) days following the eligibility date will only be eligible to enroll during the annual Open Enrollment Period described below or under the "Transfer of Coverage" section as described herein.

If an Eligible Employee or Eligible Retiree acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, then the Dependent(s) may be enrolled in the Plan, provided enrollment occurs within thirty (30) days of one of the above life events. If the new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, and the Eligible Employee or Eligible Retiree has not previously enrolled in the Plan, the Eligible Employee or Eligible Retiree may enroll in the Plan at this time, provided the enrollment occurs within thirty (30) days of one of the above life events. Coverage will begin on the first day of the month following the month in which the new Dependent was acquired. In the case of a birth, coverage begins on the day of birth; in the case of adoption, coverage begins on the day custody is awarded.

If an Eligible Employee is required to provide benefits for his Dependent (s) under the direction of a court order and the Eligible Employee is not enrolled in the Plan, the Eligible Employee may enroll himself and his Dependent(s) provided enrollment occurs within thirty (30) days of issuance of the court order. The Plan's Open Enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the Eligible Employee has not yet satisfied the Plan's waiting period, coverage will become effective after satisfaction of such waiting period.

If a Dependent who is enrolled as a full-time student in an accredited secondary school or college (including graduate school) takes a leave of absence from full-time student status due to an illness or injury, he or she will continue to be covered under the Plan as an eligible Dependent for a period of up to twelve (12) months from the date of the leave of absence, provided the medical necessity of the leave of absence has been certified by the Dependent's attending physician and written documentation of the illness or injury and medical necessity of the leave of absence has been provided to the College. In no event will a Dependent be covered beyond the age at which coverage of a Dependent who is enrolled as a full-time student terminates under the Plan.

Annual Open Enrollment Period: 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.

TRANSFER OF COVERAGE

Eligible Employees who lose medical coverage being provided by their Spouse may enroll for coverage under this Plan provided such Eligible Employee enrolls in the Plan, within 30 days of the loss of other coverage, and provides evidence that they were covered and that coverage has been terminated.

All eligible Spouses and Dependents of Middlebury College Eligible Employees who were enrolled in other group medical coverage, who lose their group medical coverage may enroll for coverage under the Plan provided such Spouse and/or Dependents enroll in the Plan within thirty (30) days of the Spouse's termination of employment or loss of insurance and provides evidence that they were covered and that coverage has been terminated.

SCHEDULE OF BENEFITS

Employee Deductible:

<i>Individual</i>	<i>\$300 per calendar year</i>
<i>Two Person</i>	<i>\$600 per calendar year</i>
<i>Family (True Family Aggregate)</i>	<i>\$900 per calendar year</i>

Employee Coinsurance:

<i>Individual</i>	<i>20%</i>
<i>Two Person</i>	<i>20%</i>
<i>Family</i>	<i>20%</i>

Plan Coinsurance:

<i>Individual</i>	<i>80%</i>
<i>Two Person</i>	<i>80%</i>
<i>Family</i>	<i>80%</i>

Employee Out-of-Pocket Maximum:

<i>Individual</i>	<i>\$1,100 per calendar year</i>
<i>Two Person</i>	<i>\$2,200 per calendar year</i>
<i>Family (True Family Aggregate)</i>	<i>\$3,300 per calendar year</i>

Physician's Office Visits:

<i>Employee Pays</i>	<i>20% (deductible waived)</i>
<i>Plan Pays</i>	<i>80% (deductible waived)</i>

Recommended Preventive Services:¹

<i>Employee Pays</i>	<i>0% (deductible waived)</i>
<i>Plan Pays</i>	<i>100%</i>

Physical Therapy:

<i>Employee Pays</i>	<i>Deductible; then 20%</i>
<i>Plan Pays</i>	<i>80% after deductible</i>

Chiropractic Care:¹

<i>Employee Pays</i>	<i>Deductible; then 20%</i>
<i>Plan Pays</i>	<i>80% after deductible</i>

Therapeutic Massage:²

<i>Employee Pays</i>	<i>Deductible; then 20%</i>
<i>Plan Pays</i>	<i>80% after deductible</i>

¹ See page C-39 of this Appendix for a description of the Plan services that are considered Recommended Preventive Services.

² Treatment Plan and/or Proof of Medical Necessity may be required.

**Diagnostic, X-ray & Labs
(except for services related
to a physician’s office visit or
well care as defined in the Plan
Details section):**

Employee Pays
Plan Pays

*Deductible; then 20%
80% after deductible*

Infertility Treatment

Employee Pays

*Deductible; then 20% (any
surgical corrective
procedure must be medically
necessary)*

Plan Pays

80% after deductible;
maximum prescription drug
benefit of \$2,000 annually;
maximum medical benefit of
\$15,000 per lifetime

Routine Vision Examinations:³

Employee Pays

*Deductible; then 20% to a
maximum of 1 exam every 2
calendar years*

Plan Pays

80% after deductible to a
maximum of 1 exam every 2
calendar years

Hearing Exams/Aids:

Employee Pays

*Deductible; then 20% to a
maximum of \$2,500 per
lifetime*

Plan Pays

80% after deductible to a
maximum of \$2,500 per
lifetime

³ If you are enrolled in the Vision Benefits Plan described in Section 4.1(h) of the Plan (or other vision coverage not obtained through the Employer (“Other Vision Coverage”)), the Vision Benefits Plan or Other Vision Coverage will be the primary coverage for eligible vision expenses. Accordingly, individuals who are covered under the Vision Benefits Plan or Other Vision Coverage should submit claims for routine vision examinations under the Vision Benefits Plan or Other Vision Coverage first. The Medical Plan will only cover expenses incurred for eligible routine medical examinations to the extent such expenses have first been submitted under the Vision Benefits Plan or Other Vision Coverage and are determined to not be a covered expense under such plan.

Emergency Room Services:⁴	
Employee Pays	20%
Plan Pays	80%
Non-emergency use of ER:	
Employee Pays	\$25 penalty per occurrence; then deductible and 20%
Plan Pays	80% after deductible and \$25 penalty
Inpatient Pre-Admission Certification Penalty:	
Employee Pays	None
Inpatient Mental Health/Substance Abuse:	
Employee Pays	Deductible; then 20%
Plan Pays	80% after deductible
Outpatient Mental Health:	
Employee Pays	20% (deductible waived)
Plan Pays	80% (deductible waived)
Outpatient Substance Abuse:	
Employee Pays	20% (deductible waived)
Plan Pays	80% (deductible waived)
Convalescent/Rehabilitation Hospital/Extended Care Facility:	
Employee Pays	Deductible; then 20% to a maximum of 120 days per lifetime
Plan Pays	80% after deductible to a maximum of 120 days per lifetime

⁴ Deductible waived provided services are diagnosed as a medical emergency and emergency services begin within 72 hours of an accidental injury or within 12 hours of the first symptoms of an illness.

Prescription Drug Plan (Retail – 30 day supply):⁵
Employee Pays (copayment)

\$10 generic
\$25 preferred brand
\$40 non-preferred brand

Out-of-Pocket Maximum:
\$500 Individual
\$800 Two Person
\$1,200 Family

Plan Pays

100% after copayment for generic, preferred brand; and non-preferred brand and 100% after out-of-pocket maximum

Prescription Drug Plan (Mail Order – 90 day supply):
Employee Pays (copayment)

\$20 generic
\$50 preferred brand
\$80 non-preferred brand

Out-of-Pocket Maximum:
\$500 Individual
\$800 Two Person
\$1,200 Family

Plan Pays

100% after copayment for generic, preferred brand; and non-preferred brand and 100% after out-of-pocket maximum

Individual Annual Maximum For Essential Health Benefits

Plan Pays

No limit.

⁵ See item 21 in the Section titled Medical Covered Expenses (p. C-18) for information regarding contraceptive coverage that is paid at 100% by the Plan.

NOTE:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. The preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.
3. See the “Plan Details” and “Medical Covered Expenses” sections for additional information.
4. The retail and mail order calendar year prescription out-of-pocket maximum is a combined maximum for both retail and mail order prescriptions.

TERMINATION OF BENEFITS

An Eligible Employee’s, Eligible Retiree’s and/or a Dependent’s coverage under the Plan will terminate:

1. on the date the Plan terminates; or
2. on the last day of the month in which an Eligible Employee or Eligible Retiree withdraws from the Plan; or
3. on the last day of the calendar month in which an Eligible Employee is terminated, unless continuation of coverage, as provided herein, is elected; or
4. on the date a Dependent withdraws from the Plan or a Dependent ceases to meet the definition of a Dependent as defined herein or Dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or
5. on the date an Eligible Employee or Dependent enters the military, naval, or air force of any country or international organization on a full-time, active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or
6. on the last date of the period for which contribution has been made if the Eligible Employee or Eligible Retiree fails to make any required contribution; or
7. the first day following the failure of an Eligible Employee to return from an Approved Leave of Absence.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered Eligible Employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered Eligible Employees and their Dependents must be offered the right to continue coverage for up to eighteen (18) months. Your Employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the Eligible Employee completes his active duty and returns to employment, the Eligible Employee and his eligible Dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the Eligible Employee's or Dependent's coverage which were in affect before the active military duty leave will continue to apply.

SICK LEAVE CONVERSION AT RETIREMENT

Retirees eligible for retiree medical 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 your Employer will pay 100% of the premium to continue the medical benefits for the enrolled Eligible Employee and enrolled eligible Dependents, until the end of the month in which the last SLR day is used. If an Eligible Employee or Dependent is over sixty-five (65), your Employer will pay the cost of the retiree medical for the number of insured days. At the end of the insured days the Eligible Employee and their Dependents will be eligible to continue the retiree medical insurance at their own expense.

Example: If the number of SLR days was thirty (30) and the Eligible Employee retires on 7/1/08, the converted sick leave would run out on 8/12/08. Therefore, the insurance would continue until 8/30/08.

Retiring part-time employees have the option of converting combined time off ("CTO") hours to insurance days at a conversion rate of 7.75 hours per day.

Faculty (who do not have CTO or SLR days) will be given a week of insurance continuation for each academic year in which a full course load was carried. (The Vice President for Academic Affairs and the Director of Human Resources will resolve any conflicts).

There is no cash conversion of SLR. Conversion of SLR to insurance days is only available as outlined in the sections on Sick Leave Conversion at Retirement and Sick Leave Survivor's Conversion.

SURVIVOR’S BENEFIT

Employees enrolled for the Middlebury College medical insurance have a survivor’s benefit. If an Eligible Employee dies while in an Active Status, then the enrolled survivors will be given survivor’s benefits for medical insurance. Medical benefits will be continued:

1. For sixty (60) days following the date of death with all premiums paid by your 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 Plan Administrator will pay 100% of the premium to continue the medical insurance coverage.
3. If survivors pay on a monthly basis 75% of the full internal premium, for the balance of one year following the sixty (60) days and Sick Leave Reserve.
4. If survivors pay on a monthly basis 100% of the full internal premium, until eligibility ends. For surviving children the eligibility will be the same as in the active plan. For surviving Spouses, eligibility will end when the person becomes eligible for another plan or becomes eligible for Medicare. However, a surviving Spouse’s eligibility will not end at Medicare eligibility if the Eligible Employee could have qualified as a retiree at the time of death. In such instance, the surviving Spouse will be given sixty (60) days to enroll for Medicare Parts A and B, and will be transferred from the “active” coverage under the Plan to the “retiree” coverage.

Timeframe	% of full internal premium paid by Middlebury College	% of full internal premium paid by survivor
1st 60 days following death of Eligible Employee, then	100	0
Sick Leave Conversion to Insurance days, then	100	0
Balance of one year from date of death of Eligible Employee, then	25	75
From end of 1st year to end of eligibility	0	100

PLAN DETAILS

Preferred Provider Network Program: The Plan includes access to Blue Cross Blue Shield of Vermont’s preferred provider network and the BlueCard Program in order to obtain discounts from participating providers for covered medical care. The Plan identification card identifies the selected preferred provider network and a current list of the participating providers is available through the CBABlue link on the Middlebury College website. Use of the network is

voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

Inaccessible In-Network Provider: Should a covered participant request services from a non-network provider because no in-network provider exists for that area of specialty within a fifty (50) mile radius of the covered person's place of residence, then benefits for covered services may be considered for payment at the in-network benefit level. In order for the Plan to approve reimbursement at the in-network benefit level, the Contract Administrator's Utilization Review Department must review and make an authorization determination for the requested medical services. To request this exception, members must contact the Utilization Review Department by calling 888-222-9206 or sending a letter to CBA Blue, P.O. Box 2365 South Burlington, VT 05407-2365. All requests must include at least the following information: patient name and ID number, diagnosis, requested service and explanation of medical necessity, distance from home to the nearest in-network provider able to provide the requested service, provider's name, and the request to have services paid at the in-network benefit level because there is no available in-network provider. This provision is effective as of November 1, 2011.

The BlueCard Program: When you receive health care services through BlueCard outside the geographic area covered by Blue Cross Blue Shield of Vermont's preferred provider network, claims processing is coordinated with the out-of-area Blue Cross Blue Shield plans through the BlueCard Program. The amount you pay for covered services is calculated on the lower of:

- The actual billed charges for your covered service; or
- The negotiated price that the local Blue Cross Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The negotiated price may also be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price. Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Contract Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Medical Deductible Carry-Over Provision: If, after September 30th of any year, a covered person incurs services for which any or all of the medical deductible amount must be paid, then that portion of the medical deductible paid by the covered person after September 30th will be deemed to have been paid toward the next year's medical deductible as well.

Inpatient Pre-Admission Certification Penalty: The Plan requires that all non-emergency hospital admissions be pre-certified and authorized by the Contract Administrator. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the Participant be admitted to a hospital, **it is the Participant's responsibility** to notify the Plan and to obtain pre-certification and authorization of the hospital admission, by calling the Customer Service number on your ID card. **It is the Participant's responsibility** to be sure that in the event of an **emergency admission**, the Contract Administrator is notified within **forty-eight (48)** hours or on the next workday following the emergency admission. If the Contract Administrator is closed due to a weekend or holiday, the emergency admission must be reported on the next workday.

In order for the Plan to approve the inpatient stay, the attending physician must certify to the Contract Administrator that, in the physician's professional opinion, the stay is necessary for the condition. The Plan reserves the right to request an independent medical opinion by a physician of the Plan's choice.

Should the Contract Administrator determine that the hospital admission is not necessary for the condition, the Participant, the physician, and the hospital will be notified so that discharge procedures may begin. Should the covered person not be discharged within seventy-two (72) hours of the notification and there is no new medical evidence to support confinement, the covered person will be responsible for hospital cost incurred after the seventy-two (72) hours have elapsed.

PRESCRIPTION DRUG BENEFITS

Retail Prescription Drug Plan: The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty (30) day supply (only one thirty-day supply may be filled at a time; no refill will be allowed before the expiration of thirty days). Individual prescriptions are subject to the copayments listed below. The balance of the covered prescription expense will be paid at 100% to a maximum out-of-pocket of \$500 per individual/\$800 per 2-person/\$1,200 per family.

<u>Generic Copayment</u>	<u>Preferred Brand Copayment</u>	<u>Non-Preferred Brand</u>
\$10	\$25	\$40

A list of participating pharmacies can be obtained by visiting:

<https://lin04.cbabluevt.com/middleburyindex.htm>.

Prescriptions purchased at non-participating pharmacies will not be covered expenses, unless purchased outside the United States.

Step Therapy Program: In order for the Plan to manage the quickly rising prescription drug costs, RESTAT has instituted a Step Therapy Program to ensure that covered persons are receiving appropriate, yet cost-effective drug therapies. If a covered person is taking certain drugs, such as Proton Pump Inhibitors-PPI and Non-sedating Antihistamines it will be necessary for the physician, pharmacist and RESTAT to work together to ensure that the prescription is covered under the prescription benefit. Please visit RESTAT’s website at www.restat.com for the most current version of the Step Therapy guidelines.

Mail Order Maintenance Prescription Drug Program: Maintenance drugs to treat chronic illnesses should be purchased through the mail order program. These illnesses include: diabetes, epilepsy, anemia, constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply. Mail order prescriptions are subject to the copayments listed below. The balance of the covered expense will be paid at 100% to a maximum out-of-pocket of \$500 per individual/\$800 per 2-person/\$1,200 per family.

<u>Generic Copayment</u>	<u>Preferred Brand Copayment</u>	<u>Non-Preferred Brand</u>
<u>Copayment</u>		
\$20	\$50	\$80

The calendar year prescription out-of-pocket maximum is a combined maximum for both retail and mail order prescriptions.

When filling a prescription, the doctor or the covered person may request the brand name drug over the generic. The covered person will pay the brand name copayment.

Split Incentive Program: New England Mail Order Pharmacy’s (“NEMOP”) Split Incentive Program offers a way to reduce the price and copayments for prescription medications. Since expensive drugs are often available in many strengths, and the difference in cost between the strengths is often insignificant, savings occur when tablets equal to twice the dose are dispensed and one-half of the tablet is taken. Patients get the correct dose of medication, while overall cost of prescriptions are reduced. NEMOP provides tablet splitters and instructions when the covered person fills their first prescription. The Split Incentive Program cannot be used for every prescription. Some tablets should not be broken, some medicines only come in capsule form and others may not be available in the dosage needed to participate. NEMOP pharmacists will automatically use the Split Incentive Program when appropriate. Mail order prescriptions are subject to the copayments listed below and are limited to one (1) copayment per ninety (90) day supply.

<u>Generic Copayment</u>	<u>Preferred Brand Copayment</u>	<u>Non-Preferred Brand</u>
<u>Copayment</u>		
\$10	\$25	\$40

MEDICAL COVERED EXPENSES

Expenses incurred for the following medical, health care services, and supplies will be considered a covered expense, provided the expenses are (i) medically necessary to treat an illness or injury, (ii) prescribed by an attending physician, and (iii) are incurred during a period that coverage was in effect in accordance with the applicable provisions of the Plan. Payment of such expenses will be subject to all applicable deductible, coinsurance limits, the maximum individual limit, and all other limitations described herein.

1. Inpatient hospital charges for room and board, operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, anesthesia, laboratory expenses, intensive care unit, and other necessary services and supplies during any one (1) period of hospital confinement, as shown below. Should the facility have no semi-private rooms or less expensive accommodations available, or the patient's condition requires the Participant or the Dependent to be isolated for their own health or the health of others, the private room rate will be allowed.

Room and Board:

semi-private room allowance.....semi-private room rate
private room allowance.....semi-private room rate
intensive care allowance.....actual charge (not to exceed MAB allowance)

2. Outpatient hospital or Ambulatory Surgical Center charges provided on an outpatient basis for surgery, but only for those charges incurred on the same day surgery is performed.
3. Charges for inpatient physician visits while the Participant or their Dependents are hospital confined as a result of an illness or an accidental injury. No benefits will be paid for more than one (1) visit per day by any one (1) physician or for the treatment received in connection with, on, or after the date of an operation for which a surgical expense benefit is payable under the Plan if such treatment is given by the physician who performed the operation.
4. Charges of a professional anesthesiologist, radiologist, or pathologist.
5. Charges for pre-admission testing, exams, x-ray and laboratory examinations on an outpatient basis made within fourteen (14) days of scheduled hospital admission and related to a condition previously diagnosed.

6. Charges for the transportation of a covered person in a ground or air ambulance that is regularly used for professional ambulance service, to and from the nearest hospital that can provide the necessary care.
7. **Emergency Room Services:** Emergency room charges for treatment of an illness or an accidental injury. Charges for emergency room services are covered expenses provided treatment is sought within twelve (12) hours of the first symptoms of illness. Charges may include facility fees, physician fees, x-rays, laboratory tests, and other necessary services and supplies, unless otherwise specified herein. Benefits will be payable at 80% provided services are diagnosed as a medical emergency and emergency services begin within seventy-two (72) hours of such accidental injury or treatment is rendered within twelve (12) hours of the first symptoms of an illness for a medical emergency.

Non-Emergency Use of the Emergency Room: Non-emergency use of an emergency room, as determined by the Contract Administrator, will not result in a rejection of the claim. However, a penalty of **\$25** per occurrence for a non-emergency use of an emergency room will be applied.

Patient Protection Act Requirements: Emergency Room Services provided under the Plan shall be provided in accordance with implementing regulations under Section 2719A of the Public Health Service Act. Pursuant to these requirements, the Plan will provide emergency room services: (a) without the need for any prior authorized determination (even if the emergency services are provided on an out-of-network basis); (b) without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; (c) if the emergency services are provided out of network, without imposing any administrative requirements or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; (d) if the emergency services are provided out-of-network, by imposing the same coinsurance rate as applies to in-network benefits (provided, however, that the Plan may require the participant to pay such additional amounts based on the difference between the in-network and out-of-network charge for the service as permitted by implementing regulations under Section 2719A of the Public Health Service Act); and (e) without regard to any other term or condition of the coverage other than the exclusion or coordination of benefits and an affiliation or waiting period as permitted under applicable federal law.

8. Diagnostic x-rays and laboratory charges for expenses incurred as a result of an illness or injury.
9. Charges for routine vision examinations. Benefits are subject to the calendar year deductible and coinsurance provisions. Maximum of one exam per covered person every two calendar years.
10. Charges for treatment by a qualified physiotherapist, occupational therapist, or speech therapist, except for the treatment of a learning disability as diagnosed by a physician.

11. Charges for physical therapy.
12. Charges for therapeutic massage as a replacement for physical therapy will be covered when prescribed by a doctor in the same manner as physical therapy provided treatment is for a medical condition.
13. Charges for dental services rendered by a physician, dentist, or oral surgeon for the treatment of a fractured jaw and dislocations of the jaw, and for cutting procedures in the oral cavity other than for the care of teeth and gums and for extractions, including treatment of cysts or tumors, or injury to sound natural teeth incurred as a result of an accident.
14. Charges for medically necessary private duty nursing care rendered on an outpatient basis by a registered nurse (RN) or, if none is available as certified by the attending physician for services of a licensed practical nurse (LPN), but only for nursing duties and excluding custodial care.
15. Charges for x-ray, laboratory, and radium expenses excluding dental x-rays, unless rendered for the treatment for a fractured jaw, cysts, tumors, or injury to sound natural teeth as a result of an accident will be considered covered expenses.
16. **Physician's Office Visits:** Charges for physician's office visits by a licensed physician when the Participant or his Dependent (s) incur expenses as a result of an illness or accidental injury are covered expenses. Benefits are payable at 80%. The calendar year deductible will be waived. The provision applies to any additional services provided at the time of the visit. If there are services provided in the physician's office, but there is not an office visit charge, the services will still be payable at 80%. Any services or tests performed outside of the physician's office are subject to the calendar year deductible and coinsurance provisions
17. Charges for physician's home and office visits when the Participant or his Dependent incur expenses as a result of an illness or accidental injury.
18. Charges for services of a surgeon and an assistant surgeon if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field involving multiple incisions, the maximum eligible expense for all procedures combined shall be limited to the amount payable for the procedure having the greater benefit plus fifty (50%) of the amount payable for the procedure(s) having the lesser benefit. Benefits are payable for the professional services of a legally qualified physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an inpatient basis (benefits will not exceed twenty-five (25%) of the reasonable and customary allowance for the procedure performed). However, no benefits are payable for surgical assistance rendered in a hospital where it is routinely available as a service provided by a hospital intern, resident, or house officer.
19. If a Recommended Preventive Service is provided in connection with a physician's office visit, and the Recommended Preventive Service is billed separately, the Plan's

normal cost-sharing provisions for the office visit will apply with respect to the office visit charge. If a Recommended Preventive Service is provided in connection with a physician's office visit and the Recommended Preventive Service is not billed separately, the Plan may impose the normal cost-sharing charge for the office visit, provided the primary purpose of the office visit is not the delivery of a Recommended Preventive Service (if the primary purpose of the visit is the delivery of a Recommended Preventive Service such cost-sharing charges shall not be applicable). The requirements of this paragraph are subject to any changes made pursuant to final regulations issued under Section 2713 of the Public Health Service Act.

20. **Prescription Drugs:** Charges for medically necessary dressings and medicines, fluoride and child, adult and prenatal vitamins for which a physician's prescription is required and dispensed by a licensed pharmacy. Supplements prescribed by a naturopathic provider are not covered expenses. For prescription drugs to be covered expenses, in-network providers must be used, unless the providers are outside of the United States.
21. All prescribed Food and Drug Administration (FDA) approved contraceptive methods for women, and patient education and counseling for all women with reproductive capacity are covered at 100% at the in-network benefit level or when received from a participating pharmacy. All prescribed brand oral contraceptives will be covered at 100% when received from a participating pharmacy only if medically necessary or a generic equivalent is not available.
22. Charges for diabetic supplies such as: insulin, accustrips, lancets, and syringes necessary for the administration of prescription drugs and professional instructions, not including printed material for their use. Insulin dispensers and blood testing machines with a letter of medical necessity.
23. Charges for artificial limbs or eyes, casts, splints, surgical dressings, trusses, crutches, braces (except dental), orthotics or prescribed corrective appliances inside shoes, oxygen and the rental of equipment for its use, rental of a wheelchair or hospital type bed and the rental of durable medical equipment which has no personal use in the absence of the condition for which it was prescribed (rental charges will not exceed the retail purchase price of such equipment), rental of an iron lung or other mechanical equipment required for treatment of respiratory paralysis, or radium or radioactive isotopes for diagnosis or therapy. If the purchase of any medical equipment is more cost effective than renting such equipment at the discretion of the Contract Administrator, the Plan will cover the purchase price. The Plan will also cover repair costs to the rented or purchased equipment.
24. Charges for elective abortions or for routine and reverse sterilizations.
25. Charges for x-rays, radium or radioactive isotopes for diagnosis or therapy; blood or blood plasma; and anesthesia and fluids needed for surgery.

26. Charges for maternity care including prenatal, delivery, postpartum care, and services performed by a Certified Nurse Midwife, as well as charges arising from complications that may occur during maternity and delivery. Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and costs for renting breastfeeding equipment are payable at 100% of the in-network benefit level.
27. Charges for treatment in a Convalescent or Rehabilitation Hospital/Extended Care Facility/Skilled Nursing Facility if within fourteen (14) days of discharge from a Hospital period of confinement, for a medically necessary illness or injury, a covered person is, pursuant to a written certification by a supervising Physician, requested to be confined in a Convalescent or Rehabilitation Hospital/Extended Care Facility/Skilled Nursing Facility. Confinement in the Convalescent or Rehabilitation Hospital/Extended Care Facility/Skilled Nursing Facility must be for the same or related condition which necessitated the Hospital confinement, up to a maximum of one hundred twenty (120) days of confinement per lifetime.
28. Newborn care charges are a covered expense for an Employee's newborn dependents. Charges for care of newborn children to include hospital charges for nursery room and board and miscellaneous expenses, charges by a pediatrician for attendance at a cesarean section, physician examination for a newborn while hospital confined and circumcision.
29. **Chiropractic Care:** Charges for home, office, and nursing home visits as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered expenses, unless such charges are for maintenance care purposes. Any care associated with any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs is not a covered expense.
30. Organ transplant benefits to include charges for organ transplants and peripheral stem cell transplants for the treatment of cancer are considered a covered expense when the transplant procedure is not considered experimental/investigative and the covered person is considered an eligible recipient. Donor charges are considered a covered expense provided the charges are not covered under any insurance policy the donor may hold. Donor charges are limited to:
 - a. evaluating the organ or tissue;
 - b. removing the organ or tissue from the donor; and
 - c. transporting the organ or tissue from within the United States and Canada to the transplant site.
31. Hospice care charges, as defined herein. Benefits include counseling and support services, for a maximum duration of six (6) months of care.
32. **Recommended Preventive Services:** As defined in this Appendix (See page C-39). Covered expenses can include routine physical examinations, well-female care,

medically necessary well child care up to age thirteen (13), examinations (including breast and pelvic), immunizations, consultations, laboratory tests, pap smears (including laboratory fees), x-rays, mammograms, and EKG's. Recommended Preventive Services are payable at 100%, including sterilizations for women when rendered by an in-network provider. The calendar year deductible will be waived.

33. **Mental Health Care and Substance Abuse:** Charges resulting from inpatient mental health care and alcohol and/or drug addiction in a hospital, public, or licensed mental hospital, or drug/alcohol abuse treatment facility, or outpatient mental health services provided by a board certified physician, a licensed psychologist, clinical or certified social worker, pastoral counselor or certified alcohol counselor (CAC) will be considered covered expenses.
34. **Home Health Care:** Charges for the following services or supplies furnished to the employee and their dependents at home:
 - a. Part-time intermittent nursing care by or under the supervision of a registered professional nurse (RN); and/or visits by persons who have completed a home health aide training course under the supervision of registered nurse for the purpose of giving personal care to the patient.
 - b. Physician's home and office visits, physical therapy, occupational therapy, and speech therapy.
 - c. Medical supplies, laboratory services, drugs, and equipment prescribed by a physician to the extent such items would have been covered if you or your dependent had been hospitalized.
 - d. **Exclusions and Limitations:** In no event will home health care expenses include charges for loss resulting from services solely for custodial care, transportation services, any period during which the Participant or Dependent are not under the continuing care of a physician, injury, or sickness arising out of or in the course of employment, declared or undeclared war or act of war.
35. Any taxes and/or surcharges applied to a covered expense are considered eligible expenses when the tax or surcharge is mandated by state or federal government until such time that ERISA preemption is clearly established by law prohibiting the applicable tax and/or surcharge.
36. Any of the following services in connection with a mastectomy:
 - a. all stages of reconstruction of the breast on which the mastectomy is performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The Women's Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify a covered Participant or Dependent under this Plan of their rights related to benefits provided through the Plan in connection with a mastectomy. A covered Participant or Dependent under this Plan has rights for coverage to be provided in a manner determined in consultation with the attending physician for the above referenced services.

37. Charges for mastectomy bras are a covered expense to a maximum of two (2) bras per covered person per calendar year.
38. Charges for a wig or hairpiece are a covered expense if the covered person has been diagnosed with cancer, and the treatment for the condition has caused hair loss. Benefits will not exceed one (1) wig per covered person every five (5) calendar years.
39. Charges for a medically prescribed weight loss program in life threatening situations. The program must be prescribed by a physician and for a covered person who is at least fifty (50) pounds or more overweight.
40. Charges for an initial pair of lenses necessitated by a surgical procedure, limited to one (1) pair of lenses per surgery. Charges for eye examinations to prescribe or fit corrective lenses, or the actual cost of corrective lenses are not covered expenses.
41. Charges for hearing tests, hearing aids and repair subject to a maximum of **\$2,500** per covered person per lifetime.
42. Charges for diagnosis, treatment and surgery by a licensed Podiatrist.
43. Charges for dietary supplements and nutritional formulas limited to formulas for PKU, maple syrup disease, histidinemia and homocystinuria.
44. Charges for medically necessary (i) male impotence medications, including Viagra, and (ii) female libido enhancement drugs.
45. Charges for acupuncture.
46. Charges for immunizations to travel abroad.
47. Charges for immunizations such as tetanus, diphtheria, Gardasil, and shingles vaccine, provided they are medically necessary or recommended by a physician as preventive care.
48. Charges for prescribed smoking deterrents to a maximum of two (2) cycles per calendar year.

49. Charges for the treatment of temporomandibular joint syndrome (TMJ), including a splint or other prescribed appliance will be covered, up to a lifetime maximum of \$5,000.
50. **Autism Disorders:** Charges for services to diagnose and treat autism spectrum disorders for a child beginning at 18 months of age and continuing until the child reaches age 6 or enters first grade, whichever comes first. This may include, but is not limited to a physician, a psychologist, or a covered provider who is an autism services provider. This coverage includes:
- a. Assessments, evaluations (including neuropsychological evaluations), genetic testing, and/or other tests to determine if a covered person has an autism spectrum disorder.
 - b. Habilitative and rehabilitative care. This is care to develop, maintain, and restore, to the maximum extent practicable, the functioning of the covered person. This care includes, but is not limited to, applied behavior analysis that is supervised by a board certified behavior analyst.
 - c. Psychiatric and psychological care that is furnished by a covered provider such as a physician who is a psychiatrist or a psychologist.
 - d. Therapeutic care that is furnished by a covered provider. This may include, but is not limited to, a speech, occupational or physical therapist, or a licensed independent clinical social worker. When physical therapy is furnished as part of the treatment of an autism spectrum disorder, the visit limit will not apply to these services.
 - e. Covered drugs and supplies that are furnished by a covered pharmacy.

No benefits are provided for services that are furnished by school personnel under an individual education program or services that are furnished or that are required by law to be furnished by a school or in a school-based setting.

The coverage for autism spectrum disorder described in this section is intended to be consistent with the autism spectrum disorder coverage required for insured plans under Vermont State Law. Unless the context indicates otherwise, terms used in this section shall have the same meaning as provided for in the Vermont autism statute.

51. **Infertility Treatment:** Charges for infertility treatment services are covered, as described below.
- a. Infertility means the inability to conceive after regular sexual relations without contraception. To be eligible for infertility benefits, the covered person and her spouse/partner:
 - i. must have at least a 2-year history of unexplained infertility; or

- ii. the infertility must be associated with at least one of the following: endometriosis; DES exposure; blocked or surgically removed fallopian tubes that are not the result of voluntary sterilization; abnormal male factors contributing to the infertility; or
 - iii. have been unable to sustain a successful pregnancy.
- b. Infertility treatment benefits will not be provided under the Plan unless the covered person has been unable to obtain successful pregnancy through any less costly infertility treatments covered by the Plan.
- c. Infertility treatment or procedures must to be performed at facilities that conform to the American Society of Reproductive Medicine and the Society of Reproductive Endocrinology and Infertility Guidelines.
- d. The following medically necessary surgical corrective procedures are covered and require pre-approval:
 - i. Artificial Insemination with donor sperm (AI)
 - ii. Intrauterine Insemination (IUI)
 - iii. Oocyte stimulation and retrieval
 - iv. Assisted Hatching
 - v. In Vitro Fertilization (IVF), including donor oocyte fertilization, up to four (4) cycles (the procedure must be done in accordance with American Society for Reproductive Medicine (ASRM) guidelines for number of embryos transferred)
 - vi. Intracytoplasmic sperm injection (ICSI)
 - vii. Pharmaceuticals associated with a covered service
 - viii. Preimplantation genetic diagnosis (PGD) for single cell disorders
 - ix. Oocyte and sperm storage
- e. The following procedures are not covered by the Plan:
 - i. GIFT (Gamete Intrafallopian Transfer)
 - ii. ZIFT (Zygote Intrafallopian Transfer)
- f. The lifetime maximum benefit under the Plan for infertility treatments is \$15,000.
- g. The maximum annual prescription drug benefit under the Plan for infertility treatments is \$2,000.

52. Charges for Approved Clinical Trials.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

- 1. Expenses for confinement, treatment, services, or supplies except to the extent herein provided which are:

- (a) not furnished or ordered by a recognized provider and not medically necessary to diagnose or treat a sickness or injury;
 - (b) experimental or investigational in nature.
- 2. Expenses for services for disease or injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.
- 3. Expenses for services for disease or injury sustained as a result of participation in a riot or civil disobedience, or while committing or attempting to commit an assault or a felony.
- 4. Expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.
- 5. Expenses incurred while on full-time active duty in armed forces of any country, combination of countries, or international authority.
- 6. Expenses for supplies, equipment, hair prosthesis for cosmetic use, improper use, loss or other non-medically necessary reasons.
- 7. Expenses for dental services, except to the extent herein provided.
- 8. Expenses for vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in treatment of strabismus.
- 9. Expenses incurred for or in connection with any corrective treatment or surgery to correct a refractive error (i.e. such as hyperopia, myopia, astigmatism, or radial keratotomy, etc.).
- 10. Expenses for eyeglasses or contact lenses, whether or not all or any portion of the expenses related to prescribing, fitting, or correcting lenses, except as specified herein.
- 11. Expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any government or agency thereof where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term "any government" includes the federal, veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a covered person who receives billable medical care at any of the above facilities.

12. Expenses for treatment, services, or supplies provided by the employee, spouse, parent, son, daughter, brother, or sister of a covered person or by a member of the covered person's household.
13. Expenses for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.
14. Expenses for services for which the covered person recovers the cost by legal action or settlement.
15. Expenses for transsexual surgery or related procedures.
16. Expenses for cosmetic or reconstructive surgery except for expenses:
 - (a) incurred within two (2) years after an accident, to repair or alleviate the damage from that accident; or
 - (b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or
 - (c) incurred as a result of a birth defect.
17. Expenses solely for custodial care, which is care designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel.
18. Expenses for routine foot care by a Podiatrist, to include treatment of corns, callouses, clavi, dystrophic nails, excrescences, helomas, hyperkeratosis, onychauxis, onychocryptosis, and tylomas, bunions (except capsular or bone surgery), flat feet, fallen arches, weak feet, or chronic foot strain, except where a systemic condition has resulted in severe circulatory impairment or desensitization in the feet as these conditions make it hazardous for the cutting of nails, corns, etc., to be performed by a nonprofessional person.
19. Expenses for telephone, radio, television, and beautification services or for the preparation of reports, evaluations and forms, phone consultations, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the physician or dentist or other health care professional in the course of rendering services.
20. Routine or elective expenses except as set forth herein. [i.e. shoe inserts, ankle pads, printed material, arch supports, elastic stockings, over the counter fluoride, over the counter prenatal, child and adult vitamins, nutritional or dietary counseling, food

supplements, and any “over the counter drug” which can be purchased with or without a prescription or when no injury or illness is involved].

21. Expenses for breast reduction surgery unless the covered person is within their normal weight range as determined by industry standards, has a chronic back problem, and a minimum of 500 grams of tissue per breast is being removed.
22. Expenses incurred prior to the covered person’s effective date of coverage or following the termination date of coverage.
23. Expenses in excess of the maximum allowed benefit in the locality where it is rendered or in excess of the lifetime maximum benefit stated herein.
24. Expenses for biofeedback training or equipment.
25. Expenses for massage therapy not medically necessary.
26. Expenses for rolfing.
27. Expenses for surrogacy.
28. Expenses for genetic screening and genetic screening procedures, except in women over thirty-five (35) and where a family history of genetically-linked disorders is present.
29. Expenses for equipment which has personal use in the absence of the condition for which is prescribed including, but not limited to, air conditioners, air purifiers, dehumidifiers, humidifiers, waterbeds and exercise equipment.
30. Expenses for learning disorders; educational, academic N.I.Q. testing.
31. Expenses for supplies, equipment, hair prosthesis for cosmetic use, improper use, loss or other non-medically necessary reasons.
32. Expenses for chiropractic care associated with any visceral condition arising from problems or dysfunctions of the abdominal or thoratic organs, and any chiropractic expenses related to maintenance care.
33. Expenses for marital counseling.

PATIENT PROTECTIONS

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan’s network and who is available to accept you or your family members. For information on how to select a primary care

provider, and for a list of the participating primary care providers, contact CBA Blue at the address below.

For children, you may designate a pediatrician as the primary care provider.

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, contact CBA Blue at the address below.

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 2365
South Burlington, VT 05407-2365
(888) 222-9206

CLAIM FILING PROCEDURES

Written notice of the Eligible Employee's, Eligible Retiree's or the Dependent's claim (proof of claim) must be received by the Contract Administrator within twelve (12) months after the occurrence or commencement of any loss covered by the Plan. Failure to furnish written proof of claim within the time required will invalidate the claim. It is the Participant's responsibility to inform his provider(s) of this claim submission time limit.

Filing a Prescription Drug Claim

In-Network: Normally, a Participant uses the prescription drug card, and benefits are received at the time of purchase. However, if a Participant pays full retail price rather than using a prescription drug card at an in-network pharmacy, reimbursement can be obtained by sending the claim to:

Restat Patient Reimbursement
P.O. Box 758
West Bend, WI 53095-0758

Out-of-Network: Prescription drugs from out-of-network providers are not covered except when purchased outside the United States. Claims for out-of-country prescription drugs should be sent to CBABlue at the address below.

Filing a Medical Claim

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the Participant's name, claimant's name, claimant's address, and Plan

number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process.

Mail all medical claims and out-of-country pharmacy claims to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 2365
South Burlington, VT 05407-2365
(888) 222-9206

Plan Administration:

Plan Administrator and Designated Decision Maker

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain fiduciary responsibility to ELAP Services, LLC (*the “Designated Decision Maker” or “DDM”*). The fiduciary responsibility allocated to the DDM is limited to discretionary authority and ultimate decision-making authority with respect to any final appeals of denied claims, which shall be referred to the DDM by the Plan Administrator (the “Referred Appeals”). The DDM shall have no authority, responsibility or liability other than with respect to the Referred Appeals.

The Plan Administrator shall establish the policies, practices and procedures of the Plan. The Plan Administrator and the Designated Decision Maker shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Designated Decision Maker shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a covered person’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or the Designated Decision Maker as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Designated Decision Maker decides, in its discretion, that the covered person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a covered person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reserve such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Duties of the Designated Decision Maker

The Designated Decision Maker shall have the following duties with respect to the Referred Appeals;

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a covered person's rights;
6. To review Referred Appeals and to uphold or reverse any denials; and
7. To keep and maintain records pertaining to the Referred Appeals.

The duties of the DDM shall be limited to those set forth above.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to

no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or

Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Plan Participant(s) fails to file a claim or pursue damages against:
 - a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) worker's compensation or other liability insurance company; or
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage; the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and

signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:
 - a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) worker's compensation or other liability insurance company; or
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

- b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
 3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and

reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Adverse Benefit Determination: Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage also shall be considered an adverse benefit determination.

Aggregate: The combined total of all family members.

Ambulatory Surgical Center: A facility which is not physically attached to a health care facility, which provides surgical treatment to patients not requiring hospitalization, and does not include the offices of private physicians or dentists whether in an individual or group practice.

Approved Clinical Trial: The Plan covers expenses for Approved Clinical Trials in accordance with the requirements of Section 2709 of the Public Health Service Act ("PHSA"), subject to the otherwise applicable limitations and under the Plan, to the extent permitted under Section 2709 of the PHSA. Pursuant to Section 2709 of the PHSA, the Plan may not: (1) deny a qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) discriminate against the individual on the basis

of the individual's participation in the trial. A qualified individual is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition and either (a) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or (b) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

An Approved Clinical Trial will be covered regardless of whether it is otherwise considered to be Experimental/Investigative under the terms of the Plan.

Birthing Center: A public or private facility, other than private offices or clinics of physicians, which meets the free standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in a area hospital; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

Coinsurance: Coinsurance percentages represent the portions of covered expenses paid by the covered person and by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the reasonable and customary charges. The covered person is responsible for all non-covered expenses and any amount which exceeds the reasonable and customary charge for covered expenses.

Co-pay or Copayment: Co-pay means a fixed dollar amount, which you must pay for covered services. You must pay the co-pay directly to the provider.

Contract Administrator: Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered Participant and/or providers;
2. remitting benefit payments for covered expenses under the Plan to covered Eligible Participant and/or providers;

3. reviewing all claims appeals.

Contributory Coverage: Plan benefits for which a Participant enrolls and agrees to make any required contributions toward the cost of coverage.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing treatment for individuals convalescing from injury or illness, including that part or unit of a hospital which is similarly constituted and operated, and:

1. has organized facilities for medical treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a physician or a registered nurse. Full-time supervision means a physician or a registered nurse is regularly on the premises at least forty (40) hours per week;
2. maintains daily clinical records concerning each patient and has a written agreement or arrangement with a physician to provide services and emergency care for its patients;
3. provides appropriate methods for dispensing and administering drugs and medicines;
4. has transfer agreements with one (1) or more hospitals, a utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) physician. A convalescent hospital/extended care facility will not include any institution which is a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism, or a nursing home.
5. qualifies as an “extended care facility” under the health insurance provided by Title XVIII of the Social Security Act, at the time.

Covered Person: A covered Eligible Employee, covered Eligible Retiree or a covered Dependent as determined under the applicable Plan provision.

Creditable Coverage: Coverage with a previous carrier that is credited toward the preexisting condition limitation provision of this Plan. Creditable Coverage includes Medicare, Medicaid, state health benefits risk pool coverage, group health plans, etc. Waiting periods are not considered breaks in coverage. Days in a waiting period are not creditable coverage.

Custodial Care: Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Custodial care includes services that could be performed by a relative or friend with minimal instruction or supervision.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

Day of Confinement: Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a Hospital.

Deductible: The amount of covered expenses the covered Participant must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that calendar year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

Dependent:

1. the lawful Spouse (including same-sex spouse) of an Eligible Employee or Eligible Retiree; or
2. the child of an Eligible Employee or Eligible Retiree who has not attained his or her twenty sixth (26th) birthday; or
3. an Eligible Employee's or Eligible Retiree's Domestic Partner or Civil Union Partner, as defined by your Employer's Office of Human Resources.

The term "child," as used above, includes an Eligible Employee's or Eligible Retiree's natural child, a legally adopted child (including a child in the custody of the Eligible Employee or Eligible Retiree under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild (including the child of a same-sex spouse, domestic partner or civil union partner), a foster child, or a child for whom legal guardianship (as evidenced by a court order) has been granted, but excludes a child who is eligible for Employee coverage under this Plan.

The mentally or physically handicapped child of an Eligible Employee or Eligible Retiree who is incapable of earning his or her own living and who is age 26 or older ("Disabled Adult Child") may be enrolled in the medical benefits under the Plan during the initial eligibility period of the Eligible Employee or Retiree, upon the occurrence of a qualifying change in family status (as defined by the Plan), or during open enrollment, provided that (a) the child is a Disabled Adult Child at the time that the Eligible Employee or Retiree initially enrolls in the

medical benefits under the Plan, and (b) the child was a Disabled Adult Child prior to attaining age 26. A Disabled Adult Child will continue to be considered a Dependent while such child remains disabled, subject to all of the terms of the Plan, provided the Eligible Employee or Retiree submits proof of the child's disability (as described above) at the time of enrollment and at such further times as the Plan Administrator or its designee may request. If the Eligible Employee's or Retiree's child is not considered a Disabled Adult Child at the time that the Eligible Employee initially enrolls in the medical benefits under the Plan, such child may not be later enrolled in the medical benefits under the Plan, even if the child is considered a Disabled Adult Child at a later date.

Additionally, should an Eligible Employee or Eligible Retiree have a child covered under the Plan who reaches age 26 and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a Dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the Eligible Employee or Eligible Retiree has, within thirty (30) days of the date on which the child attained such age, submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

Dependent Coverage: Plan benefits extended to the Dependent(s) of a covered Eligible Employee or Eligible Retiree.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Eligibility Date: The date an Eligible Employee, Eligible Retiree and/or their Dependent(s) become eligible to enroll in the Plan, as set forth in Article II of this SPD.

Eligible Employees: As defined in Section 2.1.

Eligible Retirees: As defined in Section 2.2. Eligible Retired Employees may remain in the active medical plan until obtaining age sixty-five (65). However, for Plan purposes they will be considered a retiree upon the date of retirement. They will begin being billed for retiree premiums at this time or at the end of the Sick Leave Reserve Conversion period.

Employee Coverage: Group medical benefits provided under the Plan on behalf of a covered Eligible Employee.

Essential Health Benefits: Essential Health Benefits are generally defined as those benefits that are described in Section 1302(b) of the Patient Protection and Affordable Care Act and implementing regulations. Essential health benefits include the following general categories and the items and services covered within the 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: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Experimental/Investigative: A drug, device, medical treatment or procedure is experimental or investigative:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. if reliable evidence shows that the drug, device, medical treatment, or procedures is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Health Care Professional: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Home Health Care Agency: A licensed and state approved home health care facility possessing a valid certificate of approval issued in accordance with Title XVIII of the Social

Security Act and licensed and approved by the appropriate state authorities which specializes in providing health care and therapeutic services to a person in such person's home.

Home Health Care Plan: A program for care and treatment of a covered person established and approved, in writing, by such covered person's attending physician, together with such physician's certification that the proper treatment of the injury or sickness would require confinement as a resident inpatient in a hospital or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, at the time, in the absence of services and supplies provided as part of the home health care plan.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual who has been diagnosed by a physician as having a life expectancy of six (6) months or less. Room and board may be provided. The agency must meet all of the following tests: (i) approved under any required state or governmental Certificate of Need; (ii) provides twenty-four (24) hour a day, seven (7) day a week service; (iii) it is under the full-time supervision of at least one (1) duly qualified physician; (iv) has a nurse coordinator who is a registered graduate nurse with at least four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients; (v) has a social service coordinator who is licensed in the area in which it is located; (vi) the main purpose of the agency is to provide hospice services; (vii) has a full-time administrator; (viii) maintains written records of services given to each patient; (ix) its employees are bonded; (x) it provides malpractice and malplacement insurance; (xi) is established and operated in accordance with any applicable state laws.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and treatment of sick or injured persons on an inpatient and/or outpatient basis, and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the reasonable and customary charges for the disability involved.

Hospital Confinement: Being registered as a bed-patient in a hospital upon the recommendation of a physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.

Illness: Sickness or disease which results in expenses for medical care, services, and supplies covered by the Plan. Such expense must be incurred while the covered person, whose illness is

the basis of the claim, is covered under the Plan. Medical expenses incurred by a covered person because of pregnancy will be covered to the same extent as any other illness.

Injury: Accidental bodily harm resulting from an accident.

Inpatient Basis: Hospital confinement including one (1) or more days of confinement for which a room and board charge is made by a hospital.

Intensive Care Unit: An accommodation in or part of a hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. is established by the hospital for the purpose of providing formal intensive care;
2. is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a physician and performed by a physician or by a specifically trained registered nurse; and
3. provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Maximum Allowable Benefit (MAB): An amount a provider is allowed for a particular service. If an out-of-network provider charges more than the maximum allowable benefit, the Plan will not cover more than the maximum allowable benefit and the Participant is responsible for the difference.

Medical Emergency: The sudden, unexpected onset of a medical condition with severe symptoms requiring urgent and immediate medical attention. Such conditions are considered hazardous to the patient's life, health, or physical well-being. Criteria used in determining the existence of a "medical emergency" condition and whether benefits will be paid are as follows:

1. the condition must be of such nature that failure to receive immediate care of treatment could reasonably result in deterioration to the point of placing the patient's life in jeopardy and/or cause serious impairment to bodily function;
2. a chronic condition for which symptoms have existed over a period of time would not qualify as a medical emergency. However, if symptoms become acute enough to require emergency medical assistance, it might, at that point, qualify; and
3. care must be received within twenty-four (24) hours of onset for the condition to qualify as a medical emergency. The non availability of a private physician or the fact that the physician may refer an eligible employee or dependent to the emergency room does not, in itself, constitute a "medical emergency."

Medical Intervention: Any medical treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or treatment will be considered medically necessary if:

1. there is a sickness or injury which requires treatment; or
2. the confinement, service, or supply used to treat the sickness or injury is:
 - required;
 - generally professionally accepted as usual, customary, and effective means of treating the sickness or injury in the United States; and
 - approved by regulatory authorities such as the Food & Drug Administration; and
3. diagnostic x-rays and laboratory tests when they are performed due to definite symptoms of sickness or injury, or they reveal the need for treatment.

Mental Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

1. is licensed to give medical treatment and is operated under the supervision of a physician;
2. offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical treatment;
3. is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Illness: Neuroses, psychoneuroses, psychoses, and other mental and emotional disorders falling within any of the diagnostic categories in the mental disorders section of the international classification of diseases.

Newborn Care Charges: Charges for care of newborn children as more specifically defined herein.

Out-of-Pocket Maximum: Under the terms of this Plan, the maximum amount any individual covered under the Plan would be required to pay toward the reasonable and customary (R&C) allowance on all covered expenses during a calendar year. The out-of-pocket maximum will be determined by adding the deductible and employee share of coinsurance amounts as set forth by this Plan.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited hospital, or community mental health center or other mental health clinic or day care center which furnished mental health services with the approval

of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or treatment of mental illness or emotional disorder.

Period of Confinement: Any period of Hospital confinement as a result of the same or related conditions separated by less than six (6) months will be considered the same period of confinement.

Physician: A duly licensed doctor of medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a medical doctor. This shall include a chiropractor, Christian Science practitioner, dentist, optometrist, Physician (including psychiatrist), Doctor of Osteopathy (D.O.), podiatrist, psychologist, massage therapist, naturopath or acupuncturist.

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Sponsor: Middlebury College

Recommended Preventive Services: In accordance with Section 2713 of the Public Health Service Act, and implementing regulations thereunder, the following services are considered Recommended Preventive Services: (a) 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 (Task Force) with respect to the individual involved (excluding those recommendations regarding breast cancer screening, mammography, and prevention issued on or around November of 2009); (b) immunizations for routine use in children, adolescents, and adults 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 individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention); (c) 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 ("HRSA"); and (d) with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise recommended by the recommendations of the Task Force). Effective for the Plan Year beginning January 1, 2013, those standards developed by HRSA on August 1, 2011 regarding women's preventive services, including preventive services with regard to contraceptive methods and counseling, shall be considered Recommended Preventive Services.

The Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a Recommended Preventive Service.

A current listing of the Recommended Preventive Services can be obtained at the following website maintained by the United States Department of Health and Human Services: <http://www.HealthCare.gov/center/regulations/prevention.html>.

In accordance with implementing regulations, the Plan is not required to provide Recommended Preventive Services for services provided by out-of-network providers, and to the extent such services are covered out-of-network, the Plan may impose the otherwise applicable cost-sharing requirements.

Rehabilitation Hospital: A facility which meets all requirements of a hospital (as defined herein) other than the “surgical facilities” requirements and, in addition, meets the following criteria:

1. it must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified hospital;
2. it must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies; and
3. it must maintain a utilization review committee.

Rehabilitative Care: Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) excluding custodial care or occupational training.

Residential Treatment Facility: A child care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Substance Abuse: Any use of alcohol or drugs which produces a state of psychological and/or physical dependence.

Substance Abuse Treatment Facility:

1. A public or private facility providing services especially for detoxification or rehabilitation of substance abusers and which is licensed to provide such services;
2. A comprehensive health service organization, community mental health clinic or day care center which furnishes mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of substance abusers and which is licensed to provide such services.

Surviving Spouse of a Retiree: In the event of the death of a retiree, the Eligible Retiree's Spouse can elect to continue his/her coverage and will be billed accordingly.

Termination Date: See "Termination of Benefits" section for details.

Totally Disabled: A covered person who, because of disease or injury, is unable to engage in any gainful occupation for profit or compensation for which the employee qualifies by reason of education, activities of a person of the same sex or age.

Waiting Period: The period of time between an Eligible Employee's date of employment and their effective date of coverage.

MEDICARE PROVISIONS

General Medicare Benefit Information: Most employees who are eligible for Medicare Part A benefits can receive such benefits at no cost because they or their Spouse paid Medicare taxes while working. Ineligible employees age sixty-five (65) and over, who are required to pay for Medicare Part A coverage, may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B and, effective January 1, 2006, Medicare Part D, is available to all employees age sixty-five (65) and over who make application **and pay the full cost of the coverage.**

Active Employees: All active Eligible Employees and their Dependents, age sixty-five (65) and over, who are eligible for coverage under the Plan, will be provided with coverage under this Plan on the same basis as available to covered Eligible Employees under the age of sixty-five (65). Due to the Eligible Employee's current employment status, the Plan will be the primary payer of benefits and Medicare, if the Eligible Employee is participating, 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 an Eligible Employee or Dependent, 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 CARVEOUT PLAN PROVISIONS

Medicare Carve-Out: Your Employer offers Eligible Retirees, Dependents and survivors a Medicare Carve Out Plan. Carve Out generally offers protection for medical expenses not paid by Medicare. Medicare Carve Out applies to all Eligible Retirees age sixty-five (65) or older, as well as Participants who are no longer actively employed due to disability (during the time they remain on the Plan). Medicare Carve Out is designed to provide protection against high medical bills. Carve out complements Medicare by providing payment for expenses not paid by Medicare. Payment is determined by the design of the medical insurance coverage.

Retired Employees: Eligible Retired Employees who are enrolled in the Plan upon obtaining age sixty-five (65) either as an Eligible Retiree or as an Eligible Employee are automatically eligible to continue in the Plan provided they have met the definition of Eligible Retiree and their legal residence is in the United States. Due to the fact such Eligible Retired Employees are no longer in active employment, Medicare will be the primary payer of benefits and Plan benefits will be integrated on a carve-out basis. The administration for retiree medical coverage under the Plan will be the same as for active Eligible Employees, regarding status changes and life style changes. Should a retiree opt out of the medical insurance plan and wish to re-enroll, they will only be allowed to re-enroll if required by Federal law.

Medicare Coordination: 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 Participant or Dependent who is eligible to enroll in Medicare must enroll in both Parts A and B of Medicare as soon as eligibility commences. If either the Participant or Dependent does not enroll in Parts A and B of Medicare as soon as eligibility for such coverage commences, such Participant or Dependent shall not be eligible for the benefits available under this Plan.** However, this section will not apply if your Employer is obligated by law to have this Plan pay its benefits before Medicare covers the health care services provided to the Participant or Dependent.

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

	MEDICARE	MEDICAL PLAN MEDICARE CARVE OUT PROVISIONS
IN-HOSPITAL EXPENSES:	<p>MEDICARE PART A is a Hospital Insurance Plan which provides payment for hospital inpatient services, such as semi-private room and board, normal hospital services, post-hospital care in a skilled nursing facility and post-hospital care in the home.</p> <p>PART A requires that a deductible be paid by the patient before Medicare Part A benefits are available.</p>	<p>CARVE OUT will pay the difference between what the Medical Insurance Plan would have paid and what Medicare Part A actually paid for covered expenses.</p>
DOCTORS AND OTHER MEDICAL EXPENSES:	<p>MEDICARE PART B is the Medical Insurance Plan which provides payment for reasonable charges for physician's services, home health care services, diagnostic services and medical services and supplies.</p> <p>PART B requires that a deductible be paid by the patient before Part B benefits are available. In addition, Medicare requires co-payment by the patient for all expenses up to an annual out-of-pocket maximum. When the maximum is reached Medicare will pay 100% of covered charges for the rest of the year.</p>	<p>CARVE OUT will pay the difference between what the Medical Insurance Plan would have paid, and what Medicare Part B actually paid for covered expenses.</p>
NURSING CHARGES:	<p>MEDICARE makes no payment for nursing charges.</p>	<p>After satisfaction of the plan deductible, CARVE OUT will pay for these charges up to the limits of the Medical Insurance Plan.</p>
OUT-PATIENT DRUGS:	<p>MEDICARE PARTS A and B make no payment for out-patient drugs.</p> <p>MEDICARE PART D provides coverage for out-patient prescription drugs for enrolled participants. Participants are required to pay the applicable premium.</p>	<p>CARVE OUT pays expenses for out-patient drugs on the same basis as for Active Eligible Employees.</p> <p>Given this out-patient drug coverage, participants will generally experience no advantage</p>

		<p>to enrolling for Medicare Part D coverage. If participants elect to purchase Medicare Part D coverage, this Plan will pay secondary to Medicare.</p>
<p>MEDICAL EXPENSES WHILE RESIDING OR TRAVELING OUTSIDE THE UNITED STATES:</p>	<p>MEDICARE generally makes no payment for medical expenses incurred while residing or traveling outside the United States.</p>	<p>CARVE OUT has no limit on medical expenses incurred while traveling outside the United States except for the maximum benefit of the Medical Insurance Plan. Retirees who legally reside outside of the United States and who are not eligible for Medicare due to their legal residence are not eligible for the medical benefits offered under the Plan.</p>

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An Independent Licensee of the Blue Cross and Blue Shield Association

APPENDIX D

DENTAL INSURANCE PLAN

INTRODUCTION

The College sponsors this self-funded ERISA welfare plan which provides dental benefits for all Eligible Employees, Eligible Retirees and their Dependents enrolled for coverage.

Each covered person is entitled to the benefits outlined in this Appendix. To obtain benefits from the Plan, you must submit a diagnostic bill from the provider to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
PO Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

This claim submission is required for reimbursement to the Participant or direct payment to the service provider by the Middlebury College Health and Welfare Benefits Plan (“Plan”).

A clerical error will neither invalidate the Participant’s coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

In the event you receive dental services from a dentist who participates in the CBABlue Program, you may receive certain “in-network” discounts. Please contact CBABlue or Human Resources for additional information.

PLAN ENROLLMENT

Unless otherwise noted, coverage becomes effective the first of the month after (or coincident with) the employee’s or dependent’s entering eligible status.

Employee Coverage

Eligibility: Only Eligible Employees, as defined in Section 2.1, are eligible for coverage under this Plan.

Plan Enrollment: An Eligible Employee must enroll for coverage within thirty (30) days of his eligibility date. The Eligible Employee will be enrolled when a benefit enrollment form is completed, signed, and delivered to your Employer within the time limit. Eligible Employees who are not enrolled within thirty (30) days following the eligibility date will only be eligible to enroll under the “Transfer of Coverage” provision as described herein or during the annual Open Enrollment Period.

Annual Open Enrollment Period: 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.

If an Eligible Employee enrolls during the annual Open Enrollment Period, then the Eligible Employee will be considered a Late Entrant and will be subject to the late entrant provisions as stated on the Schedule of Benefits. (The “late entrant” provisions will apply unless there is a simultaneous Transfer of Coverage.)

Disability Leave: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of the disability leave of the Eligible Employee until employment is terminated by the Employer or the Eligible Employee.

General Leave of Absence: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of an approved leave of absence for a period of one (1) year, or until employment is terminated by the Employer or the Eligible Employee.

Layoff: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of the Eligible Employee’s layoff until employment is terminated by the Employer or the Eligible Employee.

Retiree Coverage

Eligibility: Only Eligible Retirees, as defined in Section 2.2, who legally resided in the United States are eligible for coverage under this Plan.

Plan Enrollment: Eligible Retirees may continue participation in the Plan upon retirement from your Employer. In the event an Eligible Retiree does not continue participation immediately after retirement, he or she will not be allowed to re-enroll in the Plan (even if there is a change in the facts that caused the Eligible Retiree to cease participation in the Plan), unless federal law requires otherwise.

Annual Open Enrollment Period: 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.

Dependent Coverage

Eligibility: The Dependent (s) of an Eligible Employee or Eligible Retiree, as defined in this Appendix, will become eligible for coverage on the date of the Eligible Employee's or Eligible Retiree’s eligibility for coverage and/or on the date which the Eligible Employee or Eligible Retiree acquires the Dependent.

If an Eligible Employee or Eligible Retiree and Spouse are both eligible for coverage under the Plan, only one will be eligible to enroll Dependents. Also, a Participant cannot be covered as an Eligible Employee or Eligible Retiree and at the same time as a Dependent.

Plan Enrollment: To obtain coverage, a Dependent (s) must be enrolled within thirty (30) days of the Dependent's eligibility date. A Dependent will be enrolled in the Plan when the Eligible Employee or Eligible Retiree has completed and signed a benefit enrollment form or notice of change form and it is delivered to the Plan Sponsor. Dependents who are not enrolled within thirty (30) days following the eligibility date will only be eligible to enroll under the "Transfer of Coverage" provision as described herein or during the annual Open Enrollment Period.

If an Eligible Employee or Eligible Retiree acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption then the Dependent(s) may be enrolled in the Plan, provided enrollment occurs within thirty (30) days of one of the above life events. If the new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, and the Eligible Employee or Eligible Retiree has not previously enrolled in the Plan, the Eligible Employee or Eligible Retiree may enroll in the Plan at this time, provided the enrollment occurs within thirty (30) days of one of the above life events. Coverage will begin on the first day of the month following the month in which the new Dependent was acquired. In the case of a birth, coverage begins on the day of birth; in the case of adoption, coverage begins on the day custody is awarded.

If an Eligible Employee is required to provide benefits for his Dependent (s) under the direction of a court order and the Eligible Employee is not enrolled in the Plan, the Eligible Employee may enroll himself and his Dependent(s) provided enrollment occurs within thirty (30) days of issuance of the court order. The Plan's open enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the Eligible Employee has not yet satisfied the Plan's waiting period, coverage will become effective after satisfaction of such waiting period.

If a Dependent has continued coverage due to student status, withdraws from classes, then re-enrolls for classes, coverage begins on the date the Dependent resumes classes.

Annual Open Enrollment Period: 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.

If a Dependent enrolls during the Open Enrollment period the Dependent will be considered a Late Entrant and will be subject to the late entrant provisions as stated on the Schedule of Benefits. (The "late entrant" provisions will apply unless there is a simultaneous Transfer of Coverage.)

TRANSFER OF COVERAGE

All Eligible Employees, Spouses and Dependents who were enrolled in other group dental coverage, who lose their group dental coverage may enroll for coverage under the Plan provided they enroll in the Plan within thirty (30) days of the loss of insurance and provide evidence that they were covered and that coverage has been terminated.

The Late Entrant provisions will not apply if there is a Transfer of Coverage.

SCHEDULE OF DENTAL BENEFITS

Class 1 - Diagnostic/Preventive Care	100%
Class 2 - Basic Care	80%
Class 3 - Major Care	80%
Class 4 - Orthodontic Care	80%
Individual Calendar Year Deductible: (applies to classes 2,3&4)	\$25
Individual Calendar Year Maximum: (classes 1,2,&3)	\$2,000
Individual Lifetime Maximum: (class 4 only)	\$2,000

This Plan is participating with the Dental Blue® and Dental GRID preferred provider dental networks. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.

Note:

1. Please see the “Covered Dental Expenses” section for further details.
2. If two (2) or more alternate procedures, services, or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for reimbursement. Such determination will be made by the Contract Administrator based upon professionally endorsed standards of dental care.
3. No payment will be made for expenses incurred as a result of Class 3 services during the first twelve (12) months following the Eligible Employee’s, Eligible Dependent’s, or Eligible Retiree’s actual date of enrollment for Late Entrants.
4. No payment will be made for expenses incurred as a result of Class 4 services during the first twenty-four (24) months following the Eligible Employee’s, Eligible Dependent’s, or Eligible Retiree’s actual date of enrollment for Late Entrants.

5. Individuals added during the annual Open Enrollment Period who do not also qualify under the Transfer of Coverage provisions will be considered Late Entrants in the Plan.
6. This Plan is participating with the Dental Blue® preferred provider dental network. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
7. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.

TERMINATION OF BENEFITS

An Eligible Employee's, Eligible Retiree's and/or a Dependent's coverage under the Plan will terminate:

1. on the date the Plan terminates; or
2. on the last day of the month in which an Eligible Employee or Eligible Retiree withdraws from the Plan; or
3. on the last day of the calendar month in which an Eligible Employee is terminated, unless continuation of coverage, as provided herein, is elected; or
4. on the date a Dependent withdraws from the Plan or a Dependent ceases to meet the definition of a Dependent as defined herein or Dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or
5. on the date an Eligible Employee or Dependent enters the military, naval, or air force of any country or international organization on a full-time, active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or
6. on the last date of the period for which contribution has been made if the Eligible Employee or Eligible Retiree fails to make any required contribution; or
7. the first day following the failure of an Eligible Employee to return from an Approved Leave of Absence.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to Eligible Employees who otherwise lose health

insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected Eligible Employees and their Dependents must be offered the right to continue coverage for up to eighteen (18) months. Your Employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the Eligible Employee completes his active duty and returns to employment, the Eligible Employee and his eligible Dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the Eligible Employee's or Dependent's coverage which were in affect before the active military duty leave will continue to apply.

SICK LEAVE CONVERSION BENEFIT

Retirees eligible for retiree dental insurance are eligible for the retirement conversion of Sick Leave Reserve ("SLR").

At retirement accumulated SLR hours will convert to an insured day (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 your Employer will pay 100% of the premium to continue the dental benefits for the enrolled Eligible Employee and enrolled eligible Dependents, until the end of the month in which the last insurance day is used. If an Eligible Employee or Dependent is over sixty-five (65), your Employer will pay the cost of the retiree dental for the number of insured days. At the end of the insured days the Eligible Employee and their Dependents will be eligible to continue the retiree dental insurance at their own expense.

Example: If the number of SLR days was thirty (30) and the Eligible Employee retires on 7/1/08, the converted sick leave would run out on 8/12/08. Therefore, the insurance would continue until 8/30/08.

Retiring part-time employees have the option of converting combined time off ("CTO") hours to insurance days at a conversion rate of 7.75 hours per day.

Faculty (who do not have CTO or Sick Leave Reserve days) will be given a week of insurance continuation for each academic year in which a full course load was carried. (The Vice President for Academic Affairs and the Director of Human Resources will resolve any conflicts.)

There is no cash conversion of SLR. Conversion of SLR to insurance days is only available as outlined in the sections on Sick Leave Conversion and Sick Leave Survivor's Conversion.

SURVIVOR'S BENEFIT

Employees enrolled in the Middlebury College dental insurance plan have a survivor's benefit. If an Eligible Employee dies while in an Active Status, then the enrolled Dependents will be given survivor's benefits for dental insurance. These benefits will be continued:

1. For sixty (60) days following the date of death with all premiums paid by your Employer.
2. Following those sixty (60) days, accumulated SLR will be converted to insured days (weekends and holidays listed in the Employee Handbook will not count.) For each insured day the Plan Administrator will pay 100% of the premium to continue the dental insurance.
3. If survivors pay on a monthly basis 75% of the full internal premium for the balance of one year following the sixty (60) days and SLR.
4. If survivors pay on a monthly basis 100% of the full internal premium, until eligibility ends. For surviving children the eligibility will be the same as in the active plan. For surviving Spouses, eligibility will end when the person becomes eligible for another plan or becomes eligible for Medicare.

Timeframe	% of full internal premium paid by Middlebury College	% of full internal premium paid by survivor
1st 60 days following death of Eligible Employee, then	100	0
Sick Leave Conversion to Insurance days, then	100	0
Balance of one year from date of death of Eligible Employee, then	25	75
From end of 1st year to end of eligibility	0	100

INCREASES/DECREASES IN COVERAGE

Increases: Any amendment to the Plan providing an increase in the amount of the Participant's and Dependent's coverage will become effective as of the date of such amendment, provided that the Eligible Employee is in Active Service on that date and the Eligible Retiree and Eligible Employee's Dependent(s), meet the definition of Eligible Retiree and Dependent, respectively, on that date.

Decreases: Any amendment to the Plan providing a decrease in the amount of the Participant's and Dependent's coverage will become effective on the effective date of such amendment.

PLAN DETAILS

Pre-Determination of Dental Benefits

Pre-determination of benefits means a review by the Contract Administrator of a dentist's

description of planned treatment and expected charges including those for diagnostic x-rays.

It is recommended that a treatment plan be submitted to the Contract Administrator before a course of treatment begins for any course of treatment which can reasonably be expected to involve extensive dental work in excess of **\$300**. Pre-determination of benefits does not guarantee payment.

All pre-determinations should be mailed to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
PO Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

EXTENDED BENEFITS

Dental procedures, other than dentures or bridges, will be considered a covered dental service if such procedures relate to a particular multiple-appointment dental procedure which had commenced before coverage ceased, but only to the extent that such procedures are performed within thirty-one (31) days after termination of coverage.

Orthodontic services will be considered as covered dental services if, on or before the date of termination, payment of orthodontic benefits have commenced. However, benefits will be continued for no longer than the ninety (90) days immediately following the date of termination.

If a final impression for a denture has been taken, then charges for the construction and/or insertion of such denture or bridge will be considered as a covered dental charge only to the extent that such construction or insertion procedures are performed within thirty-one (31) days after termination of coverage.

COVERED DENTAL EXPENSES

Covered dental expense means the maximum allowable benefit charge made by a dentist for the performance of a dental service covered by the dental portion of the Plan, provided such a service is performed by or under the direction of a licensed dentist for necessary care of the teeth.

The total amount payable for covered dental expenses incurred by the Participant and each covered Dependent (s) in any one (1) calendar year for dental services will in no event exceed the maximums shown in the Schedule of Benefits.

CLASS 1: Diagnostic and Preventive Care

Oral Examinations (not more than two (2) exams in a calendar year)
includes routine and periodic exams

Cleanings (not more than two (2) cleanings in a calendar year)

Topical Application of Sealants (only for Dependent children under age nineteen (19), not more than one (1) treatment per permanent posterior tooth in any three (3) year period)

Topical Application of Fluoride (only for Dependent children under age nineteen (19), not more than one (1) treatment per calendar year)

CLASS 2: Basic Care

Palliative emergency treatment and emergency oral examinations

Amalgam, composite, plastic or acrylic filling and bonding

Extractions, including wisdom teeth (including soft tissue, partial and completely bony) and alveolectomy at the time of tooth extraction

Oral Surgery

General Anesthesia administered in connection with a covered Dental Service only if administered by an individual licensed to administer general anesthesia

Endodontics (root canal therapy)

Recementing of crowns, inlays and/or bridges

Denture adjustments and relining and/or rebasing

Apicoectomy

Hemisection

Injection of antibiotic drugs

Consultations with Dentist for case presentation when diagnostic procedures have been performed by a general dentist

Periodontics as follows:

- Occlusal equilibration, when no restoration is involved

- Gingivectomy and gingivoplasty

- Gingival curettage

- Scaling and root planing

- Osseous surgery (osteoplasty and ostectomy), including flap entry and closure

- Surgical periodontic examination

- Mucogingivoplastic surgery

- Management of acute periodontal infection and oral lesions

X-rays

- Bitewings (two (2) sets per calendar year)

Space Maintainers (effective as of January 1, 2007)

CLASS 3: Major Care

Dentures, full and partial, and fixed bridges. Removable bridges (unilateral)-one piece casting, chrome cobalt alloy clasp attachment (all types) per unit including pontics

Inlays, onlays, gold fillings, crowns (including precision attachment for dentures) provided, however, that gold or crown restorations are covered only when the tooth cannot be restored with a filling material or if the tooth is an abutment to a covered partial denture or fixed bridge

Crowns which are acrylic, acrylic with gold, acrylic with non-precious metal, porcelain with gold, porcelain with non-precious metal, gold or non-precious metal

Fixed bridgework (including inlays and crowns to form abutments) to replace one (1) or more natural teeth extracted while covered under these benefits

A denture or a fixed bridge involving replacement of a tooth or teeth missing since birth

Partial or full removable dentures to replace one (1) or more natural teeth extracted while covered under these benefits

Replacement of or addition of teeth to an existing removable denture (full or partial) or fixed bridgework as follows:

replacement or addition of teeth is made necessary by the extraction of natural teeth which occurred while covered under this Plan

replacement is necessary to correct temporomandibular joint disturbances caused by the existing denture or bridgework when the prosthesis cannot be economically modified to correct the condition

replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be economically modified to the final shape required

the existing denture or bridgework was installed at least five (5) years prior to this replacement and the existing denture or bridgework cannot be made serviceable

replacement is necessary as a result of an injury occurring while covered

Pontics (artificial teeth) which are cast gold, cast non-precious metal, porcelain fused to gold, porcelain fused to non-precious metal, plastic processed to gold, plastic processed to non-precious metal

Dental Implants

CLASS 4: Orthodontic Care

Installation of orthodontic appliances and all orthodontic treatments and conditions resulting from the malocclusion through correction of abnormally positioned teeth

Diagnostic services, including examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs

Appliances for tooth guidance, limited to one (1) appliance per covered person

Appliances to control harmful habits limited to one (1) application per covered person

Retention appliances limited to one (1) appliance per covered person

GENERAL DENTAL EXCLUSIONS AND LIMITATIONS

Following is a list of services/supplies that will not be paid by the Plan:

1. Any expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.
2. Any expenses for services for which a charge is not usually made, for a charge that would not be made if the individual had no dental coverage, or for services rendered by a person to his/her own family members.

3. Any expenses for services for cosmetic purposes unless made necessary by an accident occurring while covered (facings on molar crown or pontics are always considered cosmetic).
4. Any expenses for confinement in a hospital.
5. Any expenses which the Participant or their family members are not legally required to pay.
6. Any expenses in excess of what is the maximum allowable benefit, as determined by the Plan.
7. Any expenses for unnecessary care or treatment, including personalization of characterization of teeth or dentures.
8. Any expenses for replacement of a lost or stolen appliances or procedures for the purpose of splinting, or to alter vertical dimension or restore occlusion.
9. Any expenses for education or training in and supplies used for dietary or nutritional counseling, oral hygiene or dental plaque control.
10. Any service or supply which is not furnished by a dentist, except a service performed by a dental hygienist working under the supervision of a dentist and x-rays ordered by a dentist.
11. Any expenses for completion of claim forms or for failure to keep a scheduled dentist appointment.
12. Any expenses for appliances or restorations, other than full dentures, whose primary purpose is to alter vertical dimension, stabilize periodontally involved teeth or restore occlusion, or to splint or replace teeth structure lost as a result of abrasion or attrition.
13. Any expenses for an appliance, or modification of one, if an impression was made before the individual was covered; a crown, bridge or gold restoration for which the tooth was prepared before the individual was covered; root canal therapy if pulp chamber was opened before coverage began.
14. Any expenses for treatments or procedures which are experimental whether for diagnosis or treatment of any sickness or injury as determined by the American Dental Association or the appropriate dental specialty society or that do not meet common dental standards.
15. Any expenses for services that are deemed to be medical services.
16. Any expenses for prescription drugs or medications, except as provided herein.

17. Any expenses for over-the-counter home fluoride treatments (i.e. omni gel).
18. Any expenses for services which have not been completed.
19. Any expenses for a crown, gold restoration, denture, fixed bridge or addition of teeth to pre-existing bridge, if the work involves a replacement or modification to an existing appliance installed less than five (5) years before. For this purpose inlays, onlays and crowns on the same tooth are limited to once every five (5) years.
20. Any expenses for a crown made completely of porcelain.
21. Any expenses for orthodontic treatment for which an impression was made or an appliance installed before the covered person was enrolled in the Plan.
22. Any expenses for separate charges for adjustments to dentures within six (6) months of initial installation.
23. Any expenses for a denture or fixed bridge involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered, and the tooth was not an abutment for a denture or fixed bridge installed during the preceding five (5) years.
24. Incurred charges for a service or supply on the date the service is provided except:
 - a. Expenses for fixed bridgework, crowns, inlays or restorations on the first date of preparations of the tooth or teeth involved, provided the covered person remains continuously covered during the course of treatment.
 - b. Expenses for full or partial dentures on the date the final impression is taken, provided the covered person remains continuously covered during the course of treatment.
 - c. Expenses for relining or rebasing of an existing partial or complete denture on the first day of preparation of the reline or rebase of such denture, provided the covered person remains continuously covered during the course of treatment.
 - d. Expenses or charges for endodontic service on the date the specific root canal procedure commenced, provided the covered person remains continuously covered during the course of treatment.
 - e. Expenses or charges for orthodontic services on the date the initial active appliance was installed.
25. Any expenses for the diagnosis or treatment of temporomandibular joint (TMJ) dysfunction.

26. Any expenses for services furnished by or for the U.S. Government, or any other government unless payment is legally required, or to the extent provided under any government program or law under which the individual is, or could be covered.
27. Any expenses for services not included under the “Covered Dental Expenses” section.
28. Any expenses applied toward satisfaction of a deductible under the “Covered Dental Expenses” section.

CLAIM FILING PROCEDURES

Written notice of the Participant’s or their Dependent’s claim (proof of claim) must be received by the Contract Administrator as soon as is reasonably possible but within twelve (12) months after the occurrence or commencement of any loss covered by the Plan. Failure to furnish written proof of claim within the time required will invalidate the claim. It is the Participant’s responsibility to inform his or her provider(s) of this claim submission time limit.

Filing a Dental Claim:

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the Participant’s name, claimant’s name, claimant’s address and Plan number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process.

Mail all dental claims to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION

If the Participant, or anyone who receives benefits under this Plan becomes ill or is injured, and is entitled to receive money from any source, including but not limited to any party’s liability insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if the individual fully cooperates with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the Participant or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney’s fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. If the Participant

or covered person retains an attorney, then the Participant or covered person agrees to only retain one who will not assert the Common Fund or Made Whole Doctrines. Reimbursement will be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor trustee, guardian, parent, or other representative, will be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The Participant or covered person agrees to sign any documents requested by the Plan including, but not limited to, reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the Participant or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received will first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Participant or covered person and their attorney if applicable. The Participant or covered person agrees to take no action, which in any way prejudices the rights of the Plan.

If it becomes necessary for the Plan to enforce this provision by initiating any action against the Participant or covered person, then the Participant or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the Participant or covered person takes no action to recover money from any source, then the Participant or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Coinsurance: The percentage of charges for covered expenses that a covered person is required to pay under the Plan.

Contract Administrator: Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. Reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered Participant and/or providers;
2. Remitting benefit payments for covered expenses under the Plan to covered Participants and/or providers;
3. Reviewing all claim appeals.

Covered Person: A covered Participant or a covered Dependent as determined under the applicable Plan provisions.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

Deductible: The amount of covered expenses the covered Participant must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that calendar year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed Doctor of Dentistry and a Dental professional or practitioner, who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a Doctor of Dentistry, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a Doctor of Dentistry.

Dependent:

1. the lawful Spouse (including a same-sex spouse) of an Eligible Employee or Eligible Retiree; or
2. the child of an Eligible Employee or Eligible Retiree who has not attained his or her twenty-sixth (26th) birthday; or
3. an Eligible Employee's or Eligible Retiree's Domestic Partner or Civil Union Partner, as defined by your Employer's Office of Human Resources.

The term "child," as used above, includes an Eligible Employee's or Eligible Retiree's natural child, a legally adopted child (including a child in the custody of the Eligible Employee or Eligible Retiree under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild (including the child of a same-sex spouse, domestic partner or civil union partner), a foster child, or a child for whom legal guardianship (as evidenced by a court

order) has been granted, but excludes a child who is eligible for Employee coverage under this Plan.

The mentally or physically handicapped child of an Eligible Employee or Eligible Retiree who is incapable of earning his or her own living and who is age 26 or older (“Disabled Adult Child”) may be enrolled in the dental benefits under the Plan during the initial eligibility period of the Eligible Employee or Retiree, upon the occurrence of a qualifying change in family status (as defined by the Plan), or during open enrollment, provided that (a) the child is a Disabled Adult Child at the time that the Eligible Employee or Retiree initially enrolls in the dental benefits under the Plan, and (b) the child was a Disabled Adult Child prior to attaining age 26. A Disabled Adult Child will continue to be considered a Dependent while such child remains disabled, subject to all of the terms of the Plan, provided the Eligible Employee or Retiree submits proof of the child’s disability (as described above) at the time of enrollment and at such further times as the Plan Administrator or its designee may request. If the Eligible Employee’s or Retiree’s child is not considered a Disabled Adult Child at the time that the Eligible Employee initially enrolls in the dental benefits under the Plan, such child may not be later enrolled in the dental benefits under the Plan, even if the child is considered a Disabled Adult Child at a later date.

Additionally, Should an Eligible Employee or Eligible Retiree have a child covered under the Plan who reaches age 26 and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a Dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the Eligible Employee or Eligible Retiree has, within thirty (30) days of the date on which the child attained such age, submitted proof of the child’s incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child’s incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the “Termination of Benefits” section of this Plan except as modified herein.

Dependent Coverage: Group Plan benefits extended to the Dependent(s) of a covered Participant.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Eligibility Date: The date a Participant and/or his Dependent (s) become eligible to enroll in the Plan, as set forth in Article II of this SPD.

Eligible Employees: As defined in Section 2.1.

Eligible Retirees: As defined in Section 2.21. In order to be eligible, your legal residence must be the United States of America. They will begin being billed for retiree premiums at the time of retirement or at the end of the Sick Leave Reserve Conversion period, whichever is later.

Employee Coverage: Group dental benefits provided under the Plan on behalf of a covered Eligible Employee.

Expense: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Hospital: A duly licensed, if required, and legally constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care, and treatment of sick or injured persons on an inpatient and/or outpatient basis and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged.

Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the Maximum Allowable Benefit charges for the disability involved.

Illness: Sickness or disease which results in the incurrence, by a covered person, of expenses for dental care, services and supplies covered by the Plan. Such expense must be incurred while the covered person whose illness is the basis of claim is covered under the Plan. Pregnancy will be treated as any other illness.

Injury: Accidental bodily harm.

Inpatient Basis: Hospital confinement, including one (1) or more days of confinement for which a room and board charge is made by a Hospital.

Late Entrant: An individual who was not covered at the time he or she was originally eligible for coverage under the Plan, but who was later enrolled for coverage. Service restrictions apply (see "Schedule or Benefits,") except where there is a "Transfer of Coverage".

Maximum Allowable Benefit: An amount a provider is allowed for a particular service. If an out-of-network provider charges more than the maximum allowable benefit, the Plan will not cover more than the maximum allowable benefit and the person is responsible for the difference.

Maximum Calendar Year Benefits: The maximum benefit amount under this Plan for all covered dental expenses incurred by a covered person in one (1) calendar year. See amounts on the Schedule of Benefits.

Maximum Lifetime Benefits: The maximum benefit amount under this Plan for all covered dental expenses incurred by a covered person in a lifetime. See amounts on the Schedule of Benefits.

Non-Dependent/Dependent: A Participant covered under this Plan (non-dependent) who is also covered under another group dental insurance plan as a Dependent.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

Physician: A duly licensed Doctor of Medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a Doctor of Medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a Medical Doctor.

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Sponsor: Middlebury College

Prior Plan: The prior dental insurance plan offered by the Plan Sponsor.

Pronouns: Masculine pronouns used herein apply to both sexes.

Surviving Spouse of a Retiree: In the event of the death of an Eligible Retiree, the Eligible Retiree's Spouse can elect to continue his/her coverage in the Plan and will be billed accordingly.

Termination Date: See "Termination of Benefits" section for details.

Totally Disabled: A covered person who, because of illness or injury, is unable to engage in any gainful occupation for profit or compensation for which the covered person qualifies by reason of education, training, or experience. In the case of a dependent, the term "occupation" will include the normal activities of a person of the same age or sex.

Transfer of Coverage: All Eligible Employees, Spouses and Dependents who were enrolled in other group dental coverage, who lose their group dental coverage may enroll for coverage under the Plan provided they enroll in the Plan within thirty (30) days of the loss of insurance and provide evidence that they were covered and that coverage has been terminated. The Late Entrant provisions will not apply if there is a Transfer of Coverage.

Waiting Period: The period of time between an Eligible Employee's date of employment and their effective date of coverage.



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Dental Blue® Network Program

The Plan includes access to CBA Blue’s preferred dental provider network, Dental Blue®, in order to obtain discounts from participating providers for covered dental care. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

Dental GRID Network Program

The Plan includes access to the Dental GRID network which links participating Blue Cross and Blue Shield dental providers in several states into one overall national dental network with broad access to participating dentists. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

APPENDIX E

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

INTRODUCTION

Middlebury College sponsors the Health Care Flexible Spending Account (“Health FSA”) to help you pay for a range of medically related expenses on a pre-tax basis, through payroll deductions. Because money for your Health FSA is withheld in equal amounts each paycheck, participating in the account can make budgeting for uninsured medical and dental care expenses easier, and, because your contributions to the account are pre-tax, participation in the Plan lowers the amount of money you owe in taxes. Depending on your personal tax bracket you may save 30% or more on eligible health care expenses by using tax-free money via the Health FSA to pay for uninsured health related expenses for yourself or family members. Using this account can be a valuable tool for budgeting and for saving money on health care expenses!

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. However, employees may not file claims for expenses incurred prior to the date the enrollment form was signed.

Eligible Employees, as defined in Section 2.1, are allowed to participate in the Health 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.

PLAN DETAILS

Out-of-pocket expenses incurred by you, your Spouse, your children who have not attained age 26, and any Dependent that you would otherwise be able to claim on your federal income tax return are eligible for reimbursement through the Health FSA (for a listing of who may be considered a Dependent under the Health FSA, please go to <https://lin04.cbabluevt.com/middleburyindex.htm> or call CBABlue at 888-222-9206). This applies even if you and/or your Dependents are not insured through the Middlebury College medical or dental insurance plans.

If you elect to participate in the Health FSA, your Employer will establish a Health 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 Health FSA. As you incur eligible expenses, you will submit a claim form in order to be reimbursed from your account. Health FSA claims are paid out *up to the full annual election amount plus any carryover amount that you may have from the previous year (see subsection entitled “Carryover 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 (see orthodontia exception, below).

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.

Effective January 1, 2011, 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:

<https://lin04.cbabluevt.com/middleburyindex.htm> or call CBABlue at (888) 222-9206.

INELIGIBLE EXPENSES

Examples of expenses specifically disallowed from the Health FSA 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.

Effective January 1, 2011, 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.

ESTIMATING EXPENSES

Before deciding whether or not to participate in the Health FSA each year, Eligible Employees must first carefully estimate the health care expenses they anticipate will be incurred by themselves and their eligible dependents (if any) during the upcoming plan year. Resources are available to help you estimate your expenses. You can contact CBABlue at <https://lin04.cbabluevt.com/middleburyindex.htm> or call CBABlue at (888) 222-9206 for a worksheet. Reviewing your prior year’s health care expenses may also give you a good starting point for estimating your future expenses.

Important Note: You must calculate your annual Health FSA contribution wisely in order to maximize your tax savings and minimize the chance of forfeiting unused funds. The Health FSA is subject to what is commonly referred to as the “use-or-lose” rule, which prohibits you from using contributions made for one Plan Year to reimburse medical expenses incurred in a later Plan Year. Under the “use-or-lose- rule, unused contributions are forfeited. As more fully described in the Carryover Amount section in this Appendix E, beginning with contributions made during the 2014 Plan Year, you will be able to carryover up to \$500 of unused contributions from one Plan Year to the immediately following Plan Year. You should take into account the Carryover Amount when you are estimating your expenses.

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.

<u>Annual Amount You May Contribute</u>	<u>Minimum</u>	<u>Maximum</u>
Health Care Flexible Spending Account	\$130	\$2,500

After the 2013 Plan Year, the maximum dollar amount described above will be increased to the maximum extent permissible under Internal Revenue Code Section 125(i). The annual

maximum Health Care Flexible Spending Account 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 Health 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 Health FSA.

CARRYOVER AMOUNTS

Beginning with contributions made for the 2014 Plan Year, you will be able to carryover up to \$500 of any amount remaining unused in your Health FSA as of the end of the prior Plan Year. The carryover of up to \$500 may be used to pay or reimburse qualifying medical expenses under the Health FSA incurred during the entire Plan Year to which it is carried over. For this purpose, the amount remaining unused as of the end of the Plan Year is the amount unused after medical expenses have been reimbursed at the end of the claims runout period for the Plan Year. The carryover of up to \$500 does not count against or otherwise affect the maximum contribution amount described in this Appendix E.

The Plan will treat reimbursements of all claims for expenses that are incurred in the current Plan Year as reimbursed first from unused amounts credited for the current Plan Year, and, only after exhausting these current Plan Year amounts, as then reimbursed from unused amounts carried over from the preceding Plan Year.

Any unused amounts from the prior Plan Year that are used to reimburse a current year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run out period, (b) must be counted against the \$500 carryover amount, and (c) cannot exceed the permitted carryover amount.

CLAIM FILING PROCEDURES

Claim forms are available from Human Resources or go to :

<https://lin04.cbabluevt.com/middleburyindex.htm> or call CBABlue at (888) 222-9206.

To be reimbursed for eligible expenses, simply complete and sign a claim form and return it with supporting documentation to the address on the claim form. Upon receipt, review, and approval of your claim, you will be reimbursed from your Health FSA. Reimbursement for qualifying health care expenses will be made up to the total amount of your Plan Year election, less any previous reimbursements. There is no minimum claim reimbursement amount.

You may submit a claim at any time after the service was incurred, either during the period of coverage or during the claims runout period. Claims incurred during the claims runout period are not eligible for reimbursement under the prior year's Plan – all expenses must be incurred during the Plan Year.

For reimbursement of expenses partially covered under another health care plan:

- Submit expenses through your primary health care plan (i.e. insurance plan) for processing of covered expenses.
- If you also have coverage through a second health care plan, such as under a Spouse's plan, you must also submit claims to this source for processing.
- Once processed by all your health care plan carrier(s), complete the Health FSA Claim Form and attach a copy of the Explanation of Benefits ("EOB") form(s) from the insurer(s) showing the remaining amount of unpaid expenses.
- Send the completed claim form and documentation to CBABlue.

For reimbursement of expenses not covered under another health plan:

- Complete and sign the Health FSA claim form.
- Attach itemized bills for the medical expenses.
- Send the completed form and documentation to CBABlue.

Health FSA claims can be mailed to CBABlue at:

PO Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

Health FSA claims can be faxed to CBABlue at: (888) 291-0920.

You can check the status of your claim on-line at any time. See the "Contacting CBABlue" section below, for details.

Reimbursement checks will be sent to your home address, or if you prefer, can be direct deposited to your bank account (see Direct Deposit, below).

CBABlue will notify you if any required information is missing from your claim.

As required by the IRS you should keep original receipts of claims for your tax records.

Debit Cards:

As an alternative to utilizing a claim form, you may use a debit card for automatic payment of reimbursable claims at the point of service. You must produce documents supporting the reimbursement upon request. Accordingly, you should keep original receipts of claims.

SPECIAL CLAIMS FILING – LUMP SUM ORTHODONTIA PAYMENTS

Special claims filing rules apply to orthodontia claims when payment for services is made in a lump sum, rather than with periodic payments. Lump sum payments are fully reimbursable in the Plan Year in which they are paid UNLESS the documentation (bill, EOB, etc.) indicates that the services were incurred in the prior Plan Year or that the services will be incurred in a future Plan Year. For example, if a lump sum orthodontia claim were submitted in January 2008 and the orthodontist's bill and other documentation did not indicate a specific date (or dates) of service, full reimbursement could be made from your 2008 Health FSA. However, if the bill indicated that it was for services incurred during November and December 2007 (the prior Plan Year) then **NONE** of the bill would be reimbursable from your 2008 Health FSA.

DIRECT DEPOSIT

If you wish to have reimbursements from your Health FSA come via direct deposit to your bank account, please contact Human Resources for a CBABlue direct deposit form. Direct deposit instructions from you will remain in effect until you cancel the instructions, that is, direct deposit instructions will carryover from one Plan Year to the next, if you continue to elect to participate in the Health FSA plan, unless you revoke the instructions.

REIMBURSEMENT SCHEDULE

Claims that have been processed are paid weekly, on Mondays, except for holidays. Claims received will be processed if received by the Monday prior to the next scheduled claim reimbursement date.

CHANGE IN FAMILY STATUS

You may change your Health FSA election during the Plan Year only if you experience a qualifying change in family status, and if that change in family 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

You have until **March 15** 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 15). After this

deadline unused funds in your account will be forfeited, unless they may be carried over as described in the “Carryover Amounts” section in this Appendix E. Remember that funds contributed for one Plan Year cannot be used to reimburse you for expenses incurred in another Plan Year unless they qualify as a Carryover Amount.

FORFEITURES

IRS regulations require that *all Health FSA funds unused during the Plan Year must be forfeited unless they qualify as a Carryover Amount*. See Article IV for further information. Therefore, it is important to plan carefully. While worksheets are available from the CBABlue website to help you estimate your expenses, it is your responsibility to plan prudently.

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.

TERMINATION OF EMPLOYMENT AND HEALTH FSA BENEFITS

If you terminate employment, you will no longer be an active Participant in the Health 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. Upon termination of employment you may also be eligible for certain COBRA rights. See the COBRA section of this SPD (Article V), or contact Human Resources for further information.

AFFECT OF HEALTH FSA PARTICIPATION ON TAXES

If your eligible health care expenses exceed 7.5% of your adjusted gross income, you can deduct the expenses on your federal income tax return. However, 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.

The federal tax deduction is usually only available to people with extremely high medical costs that are not covered by health care plans. In general, the tax savings is higher with the Health FSA, but your situation may be different. You may want to consult your own tax advisor for advice specific to your own situation.

If you participate in the Health FSA, your savings will depend on how much you contribute and on your tax bracket. The following example illustrates possible savings:

Jane, who earns \$45,000 a year, covers herself and her two children under the Health FSA. She contributes \$2,500 to the Health FSA this Plan Year to cover her family’s health care costs. Here’s how Jane saves money this year:

	Without Health FSA	With Health FSA
Jane's Annual Income	\$45,000	\$45,000
Health FSA Contributions	0	2,500
Taxable Income	\$45,000	\$42,500
Estimated Federal Income Tax	- 2,850	- 2,475
Social Security Tax	- 3,443	- 3,251
Estimated State Tax	- 1,599	- 1,422
Family Medical & Dental Expenses	- 2,500	- 2,500
Reimbursement From Health FSA	0	+ 2,500
Annual Spendable Income	\$34,608	\$34,998

Tax Savings in One Year* **\$390**

*Assumes single head of household with two dependents, using 2013 tax rates. This is just one example; your specific tax saving may differ.

Note: Jane could have incurred the expenses in January and been reimbursed for the full amount, even though, at that time, she had only been contributing for 1/12 of the year.

SOCIAL SECURITY IMPACT

Health 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 Health FSA outweigh any possible reduction in future Social Security benefits. Again, consult your own tax advisor for specific advice.

W-2 REPORTING

The W-2 form you receive after year end, which shows your annual earnings, will **NOT** include the contributions you made to your Health 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 CBABLUE

Enrolled Participants have direct access to their accounts 24 hours a day through the CBABlue website: <https://lin04.cbabluevt.com/middleburyindex.htm>. The website shows account information such as claims status and account balances and has printable claim forms. First time users will be instructed to register and create an account. CBABlue can also be reached by telephone at (888) 222-9206 between 8:00 a.m. and 7:00 p.m. eastern time.



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APPENDIX F

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

INTRODUCTION

Middlebury College sponsors the Dependent Care Flexible Spending Account (“Dependent Care FSA”) to help you pay for dependent care expenses for one or more of your “qualifying dependents” on a pre-tax basis, through payroll deductions. Because money for your Dependent Care FSA is withheld in equal amounts each paycheck, participating in the account can make budgeting for dependent care expenses easier, and, because your contributions to the account are pre-tax, participation in the Plan lowers the amount of money you owe in taxes. Depending on your personal tax bracket you may save 30% or more on eligible dependent care expenses by using tax-free money via the Dependent Care FSA to pay for dependent care expenses for your qualifying dependents. Using this account can be a valuable tool for budgeting and for saving money on dependent care expenses!

PLAN ENROLLMENT

Unless otherwise noted, coverage becomes effective the first of the month after (or coincident with) the employee entering eligible status. However, employees may not file claims for expenses incurred prior to the date the enrollment form was signed.

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

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.

PLAN DETAILS

Dependent care expenses incurred by you, as well as related household services, 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. A "qualifying dependent" is either (i) your child under the age of 13, or (ii) your Spouse or other Dependent (including an older child) if that individual is physically or mentally unable to care for himself or herself.

Expenses **are not** reimbursable if the provider is your child under the age of 19 or another Dependent. Care outside your home for a Dependent who is age 13 or older is reimbursable only if that Dependent spends at least eight hours each day in your home.

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.
- The services may be provided inside or outside your home, but not by someone who is your minor child or Dependent for income tax purposes (for example, an older child).
- 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 your Spouse to be a full-time student.
- The amount reimbursed must not be greater than your income, or combined income of an Eligible Employee and 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 form in order to be reimbursed from your account. 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 care 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.

ESTIMATING EXPENSES

Before deciding whether or not to participate in the Dependent Care FSA each year, Eligible Employees must first carefully estimate the dependent care expenses they anticipate will be incurred during the upcoming Plan Year. Resources are available to help you estimate your expenses. You can contact Human Resources or CBABlue for a worksheet. Reviewing your

prior year's dependent care expenses may also give you a good starting point for estimating your future expenses.

Important Note: You must calculate your annual Dependent Care FSA contribution wisely in order to maximize your tax savings and minimize the chance of forfeiting unused funds.

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.)

<u>Annual Amount You May Contribute</u>	<u>Minimum</u>	<u>Maximum</u>
Dependent Care Flexible Spending Account	\$130	\$5,000

Under the IRS Code, the maximum amount of dependent care expenses that can be reimbursed on a nontaxable basis through the Dependent Care FSA for a Plan Year generally is the lesser of: (i) \$5,000 or your earned income, if you are unmarried; or (ii) \$5,000 or the earned income of yourself or your Spouse, whichever income is lower, if you are married. (Special rules may apply if your spouse is a full-time student or disabled.) The maximum dollar amount is \$2,500, not \$5,000, if you are a married taxpayer filing a separate tax return. "Earned income" is the compensation received from an employer, plus any net earnings received from self-employment. Please note that under the IRS Code, the maximum contributions allowed per year, per couple, is \$5,000 – this includes contributions under all employer plans you participated in during the year.

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 Dependent Care 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 Dependent Care FSA.

CLAIM FILING PROCEDURES

Claim forms are available from Human Resources or CBABlue.

To be reimbursed for eligible expenses, simply complete and sign a claim form and return it with supporting documentation to the address on the claim form. Upon receipt, review, and approval of your claim, you will be reimbursed from your Dependent Care FSA. Reimbursement for qualifying dependent care expenses will be made up to the total amount of Salary Reduction Contributions credited to your Dependent Care FSA to that point, less any previous reimbursements. There is no minimum claim reimbursement amount.

You may submit a claim at any time after the service was incurred, either during the period of coverage or during the claims runout period. Claims incurred during the claims runout period are not eligible for reimbursement under the prior year's Plan – all expenses must be incurred during the Plan Year.

For reimbursement of expenses not covered under another dependent care assistance plan:

- Complete and sign the Dependent Care FSA claim form.
- Attach itemized bills for the dependent care expenses **OR**, if you do not have itemized bills, have your provider sign the claim form.
- Send the completed form and any documentation to CBABlue.

Dependent Care FSA claims can be mailed to CBABlue at:

PO Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

Dependent Care FSA claims can be faxed to CBABlue at: (888) 291-0920.

You can check the status of your claim on-line at any time. See the “Contacting CBABlue” section below, for details.

Reimbursement checks will be sent to your home address, or if you prefer, can be direct deposited to your bank account (see Direct Deposit, below).

CBABlue will notify you if any required information is missing from your claim.

As required by the IRS you should keep original receipts of claims for your tax records.

DIRECT DEPOSIT

If you wish to have reimbursements from your Dependent Care FSA come via direct deposit to your bank account, please contact Human Resources for a CBABlue direct deposit form or go to: <https://lin04.cbabluevt.com/middleburyindex.htm> to print a form. Direct deposit instructions from you will remain in effect until you cancel the instructions, that is, direct deposit instructions will carryover from one Plan Year to the next, if you continue to elect to participate in the Dependent Care FSA, unless you revoke the instructions.

REIMBURSEMENT SCHEDULE

Claims that have been processed are paid weekly, on Mondays, except for holidays. Claims received will be processed if received by the Monday prior to the next scheduled claim reimbursement date.

CHANGE IN FAMILY STATUS

You may change your Dependent Care FSA election during the Plan Year only if you experience a qualifying change in family status, and if that change in family 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

You have until **March 15** 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 15). After this deadline unused funds in your account will be forfeited. Remember that funds contributed for one Plan Year cannot be used to reimburse you for expenses incurred in another Plan Year.

FORFEITURES

IRS regulations require that *all Dependent Care FSA funds unused during the Plan Year must be forfeited*. See Article IV for further information. Therefore, it is important to plan carefully. While worksheets are available from CBABlue to help you estimate your expenses, it is your responsibility to plan prudently.

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.

TERMINATION OF EMPLOYMENT AND DEPENDENT CARE FSA BENEFITS

If you terminate employment, you will no longer be an active Participant in the Dependent Care 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.

AFFECT OF DEPENDENT CARE FSA PARTICIPATION ON TAXES

Under the IRS Code, you are allowed a tax credit for certain amounts of dependent care expenses; namely a percentage of \$3,000, if you have one qualifying dependent, or \$6,000 if you have two or more qualifying dependents. The percentage depends upon your adjusted gross income. However, the \$3,000 or \$6,000 basis for the credit is reduced, dollar for dollar, by the amount of any expenses that are reimbursed under the Dependent Care FSA. Therefore, 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) before electing to participate in the Dependent Care FSA. IRS Publication 503 may also be helpful in making this determination.

If you elect to participate in the Dependent Care FSA, your savings will depend on how much you contribute and on your tax bracket. The following example illustrates possible savings:

Bill, an employee who earns \$45,000 a year, is married and has one child. He enrolls in the Dependent Care FSA for help with daycare expenses his family incurs while he and his spouse work. He contributes \$5,000 to the Dependent Care FSA this year to cover those daycare expenses. Here's how Bill saves money this year:

	Without FSA	With FSA
Bill's Annual Income	\$45,000	\$45,000
<u>Dependent Care FSA Contributions</u>	-0	-5,000
Taxable Income	\$45,000	\$40,000
Estimated Federal Income Tax	-1760	-1010
Social Security Tax	-3443	-3060
Estimated State Tax	-1599	-1422
Family Dependent Care Expenses	-5000	-5000
<u>Reimbursement from Dependent Care FSA</u>	+0	+5000
Spendable Income	\$33,198	\$34,508
 Tax Savings in One Year*		 \$1,310

*Assumes married status with two dependents, using 2013 tax rates. This is just one example; your specific tax saving may differ.

SOCIAL SECURITY IMPACT

Dependent Care 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 Dependent Care FSA outweigh any possible reduction in future Social Security benefits. Again, consult your own tax advisor for specific advice.

W-2 REPORTING

The IRS W-2 form you receive after year end, will **NOT** include the contributions you made to your Dependent Care FSA in the federal, state, or social security or Medicare income boxes - the 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 CBABLUE

Enrolled Participants have direct access to their accounts 24 hours a day through the CBABlue website: <https://lin04.cbabluevt.com/middleburyindex.htm>. The website shows account information such as claims status and account balances and has printable claim forms. First time users will be prompted to register and create an account. CBABlue can also be reached by telephone at (888) 222-9206 between 8:00 a.m. and 7:00 p.m. eastern time.



An Independent Licensee of the Blue Cross and Blue Shield Association

APPENDIX G

CORE LIFE INSURANCE PLAN

**YOUR GROUP LIFE AND
ACCIDENTAL DEATH AND
DISMEMBERMENT BENEFITS**

The President and Fellows of Middlebury College

Revised January 1, 2011

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

The President and Fellows of Middlebury College
Middlebury College
Service Building, 2nd Floor
Middlebury, VT 05753

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

When contacting the Company please have your policy number available. Your policy number is GLUG-ADY1.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

GROUP TERM LIFE AND AD&D INSURANCE SUMMARY OF COVERAGE



The President and Fellows of Middlebury College
GLUG-ADY1

Revised: January 1, 2011

All eligible full time and part time employees

This Summary of Coverage provides a brief description of some of the terms, conditions, exclusions and limitations of Your employer's Policy. Definitions of capitalized terms in this Summary of Coverage can be found in the Certificate. For a complete description of the terms, conditions, exclusions and limitations of Your employer's Policy, refer to the appropriate section of the Certificate. In the event of a discrepancy between this Summary of Coverage and the Certificate, the Certificate will control. For a copy of the Certificate, contact the group Policyholder or Benefits or Plan Administrator.

This Summary of Coverage is not a contract. You are not necessarily entitled to insurance under the Policy because You received this Summary of Coverage. You are only entitled to insurance if You are eligible in accordance with the terms of the Certificate.

BENEFITS	
Guarantee Issue Limit	For You: All Amounts Subject to any reductions, Guarantee Issue means the amount of insurance applied for which does not require Evidence of Good Health.
Life Insurance Benefit for You	An Amount of Life Insurance equal to 1.5 times Your Annual Salary up to \$600,000. Any Amount of Life Insurance not a multiple of \$1,000 will be changed to the next higher multiple of \$1,000. Annual Salary means Your gross Annual Stated Salary, in effect just prior to your date of loss, before taxes and any deductions made for pretax 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 or any other extra compensation, shift differential, or income received from sources other than your employer. Note: If you are on a leave of absence your annual earnings are your annual stated salary prior to beginning your leave. Note: In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living benefits previously paid under the Policy.

Reductions	<p>Your original Life Insurance Benefit will reduce to:</p> <ul style="list-style-type: none"> • 65% at age 70 • 50% at age 75 <p>If You are age 70 or older on the day You become insured under the Policy, the reduction will be made in accord with Your attained age.</p> <p>Life Insurance Benefits end on the date of Your retirement.</p>
Accidental Death and Dismemberment Benefit for You	<p>A Principal Sum equal to the amount of Your Life Insurance Benefit.</p> <p>If Your Life Insurance Benefit has been reduced by the Living Benefits Option, such reduction will not apply to this Accidental Death and Dismemberment Principal Sum.</p>
EMPLOYEE ELIGIBILITY	
Minimum Work Hours Required	<p>Staff Employees who are working 1,000 hours or more per year</p> <p>Faculty Employees who are Actively Working for the Policyholder teaching .5 FTE's (full time equivalents) or more per year</p> <p>Faculty employees who are appointed to an administrative assignment and are actively working for the Policyholder at least .5 FTE's (full time equivalents) or more per year</p>
Eligibility Waiting Period	None
When Employee Insurance Begins	<p>When the Policyholder pays 100% of the cost of the Employee's insurance under the Policy, the Employee will become insured on the later of the first day of the month which coincides with or follows the day:</p> <ul style="list-style-type: none"> • the Employee satisfies the Eligibility Waiting Period; or • We approve Evidence of Good Health, if required; <p>provided the Employee is Actively Employed on that date.</p>
Changes in the Amount of Your Insurance	<p>Decrease in the Amount of Your Insurance</p> <p>Regardless of whether or not You are Actively Employed at the time, any decrease in the amount of insurance will take effect on the day of the decrease.</p> <p>The amount of insurance cannot be decreased to an amount less than any plan minimums shown in the Schedule of the Certificate. Any reductions due to age as shown in the Schedule in the Certificate will apply.</p> <p>Increase in the Amount of Your Insurance</p> <p>You cannot request an increase to the amount of Your insurance unless You are Actively Employed on the day You submit such request.</p> <p>Any increase in the amount of Your insurance will take effect on the later of the day:</p> <ul style="list-style-type: none"> • of the change; or • the day We approve Your Evidence of Good Health, if required by Us.
When Employee Insurance Ends	<p>Insurance will end on the earliest of the day:</p> <ul style="list-style-type: none"> • the Policy terminates; • You are no longer Actively Employed; • You do not satisfy any other eligibility conditions described in the Certificate; • any applicable premium contribution is due and unpaid; or • You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less).

FEATURES

Living Benefits Option For You	50% of the amount of the Life Insurance Benefit is available to You if You incur a Terminal Condition, but not to exceed \$750,000. Terminal Condition means an Injury or Sickness expected to result in Your death within 12 months and from which there is no reasonable prospect of recovery as determined by Us.
Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence	<p>You may be able to continue life and accidental death and dismemberment insurance under this provision until the last day of the month following 60 days from the day in the event of a temporary layoff approved by the Policyholder.</p> <p>You may be able to continue life and accidental death and dismemberment insurance under this provision for 12 months from the day You are no longer Actively Employed in the event of a administrative leave of absence or any other leave of absence approved by the Policyholder.</p> <p>If state law requires an employer to allow a leave of absence related to pregnancy, childbirth, or adoption, We will continue insurance during that leave period subject to the terms and conditions of the Policy. Contact Your employer to determine whether or not You are eligible for this type of leave.</p>
Waiver of Premium Benefit	You may be able to continue Life insurance until age 65, without payment of premium, if You become Totally Disabled while insured under the Policy prior to age 60.
Portability	<p>You may be able to obtain Life and Accidental Death and Dismemberment insurance under the Portability provision when insurance ends prior to age 70 due to any of the following reasons:</p> <ul style="list-style-type: none"> • the Policy terminates and the Policyholder does not obtain similar group insurance from Us within 30 days; • employment with the Policyholder ends for reasons other than Your Injury, Sickness or Disability; • You are not Actively Employed; • You retire; or • You do not satisfy any other eligibility condition described in the Certificate. <p>Insurance under the Portability provision is available without providing Evidence of Good Health, subject to conditions described in Your Certificate.</p>
Conversion	If any of Your Life insurance ends because Your employment or membership in a class ends, You may apply for an individual policy of life insurance (called a conversion policy) without giving information about Your health. Issuance of a conversion policy is subject to conditions described in Your Certificate.

AD&D BENEFIT SCHEDULE

The AD&D Benefit is paid if an employee is injured as a result of an Accident, and that Injury is independent of Sickness and all other causes. Benefits are paid as indicated below:

Loss	Benefit
<ul style="list-style-type: none"> • Life; or • Both Hands; or • Both Feet; OR • Entire Sight of Both Eyes; or • One Hand and One Foot; or • One Hand and Entire Sight of One Eye; or • One Foot and Entire Sight of One Eye; or • Speech and Hearing (both ears) 	Principal Sum
<ul style="list-style-type: none"> • Entire Sight of One Eye; or • Speech or Hearing (both ears); OR • One Hand or One Foot 	One-half Principal Sum
<ul style="list-style-type: none"> • Loss of Thumb and Index Finger of Same Hand 	One-fourth Principal Sum
Other Benefits	Benefit
Airbag Benefit	10% of the Principal Sum, up to \$50,000.
Child Education Benefits	6% of the Principal Sum, up to \$6,000.
Seat Belt Benefits	10% of the Principal Sum, up to \$50,000.

AD&D EXCLUSIONS

We will not pay for any loss which:

- results, whether the Insured Person is sane or insane, from:
 - an intentionally self-inflicted Injury or Sickness; or
 - suicide or attempted suicide;
- results from the Insured Person's participation in a riot or in the commission of a felony;
- results from an act of declared or undeclared war;
- is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
- is not permanent, unless specifically provided;
- occurs more than 365 days after the Injury. NOTE: This 365 day limit will not apply if You are in a coma or being kept alive by an artificial support system at the end of the 365 days;
- does not result from an Accident;
- results from Injuries You receive in any aircraft while operating, riding as a passenger, boarding or leaving. This exception does not apply while You are riding as a passenger in a commercial aircraft on a regularly scheduled flight or while Traveling on Business of the Policyholder; or
- results in Injuries You receive while riding in any aircraft engaged in:
 - racing;
 - endurance tests; or
 - acrobatic or stunt flying.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No(s). GLUG-ADY1 (policy) has been issued to The President and Fellows of Middlebury College (Policyholder).

Insurance is provided for certain employees as described in the policy.

The benefits described in this Certificate are subject to the terms and conditions of the policy. Benefits are effective only if you are eligible for the insurance, become insured and remain insured as described in this Certificate.

This Certificate replaces any certificate previously issued under the Policy.

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer



Corporate Secretary

THE DEFINITIONS AND RIDERS ARE VERY IMPORTANT PARTS OF YOUR POLICY. PLEASE READ THOSE PAGES CAREFULLY.

SCHEDULE

The amount of insurance for You will be in accord with Your classification in this Schedule.

Classification(s)

All eligible full time and part time employees

**LIFE INSURANCE
For You**

Guarantee Issue Limit:

For You: All Amounts

Subject to any reductions shown below, **Guarantee Issue** means the amount of insurance applied for which does not require Evidence of Good Health.

Life Insurance Benefits

Amount of Life InsuranceAn amount equal to 1.5 times Your Annual Salary, up to \$600,000. Any Amount of Life Insurance not a multiple of \$1,000 will be changed to the next higher multiple of \$1,000.

Facility of Payment Amount.....*\$500

*This amount, if paid, will be deducted from the Amount of Life Insurance shown above.

Annual Salary means Your gross Annual Stated Salary, in effect just prior to your date of loss, before taxes and any deductions made for pretax 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 or any other extra compensation, shift differential, or income received from sources other than your employer.

NOTE: If you are on a covered leave of absence your annual earnings are your annual stated salary prior to beginning your leave.

Life Insurance Benefits reduce to 65% of the amount shown above on the day of Your 70th birthday, and further reduce to 50% of the amount shown above on the day of Your 75th birthday. This same reduction provision also applies if You are 70 or older prior to the date You become insured under the Policy.

Life Insurance Benefits end on the date of Your retirement.

NOTE: The Amount of Life Insurance outlined above will be reduced by the Amount of Living Benefits paid under the Living Benefits Option. In the event of Your death, the life insurance benefit will equal the original Amount of Life Insurance multiplied by the life reduction percentage, reduced by any Living Benefits paid under this Policy.

Living Benefits Option

Amount of Living Benefits50% of the amount of life insurance
in force on Your life, but not to exceed \$750,000.

**HEALTH INSURANCE
For You**

Accidental Death and Dismemberment Benefits

Principal Sum.....An amount equal to the Amount of Life Insurance in force on Your life;
however, if Your Life Insurance Benefit has been reduced by the
Living Benefits Option, such reduction will not apply to this
Accidental Death and Dismemberment Principal Sum.

EMPLOYEE ELIGIBILITY

Life Insurance and Accidental Death and Dismemberment Benefits

Definitions

Terms defined in this provision may be used in, or apply to, other provisions throughout the Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Actively Employed or **Active Employment** means:

- (a) Staff Employees who are Actively Working for the Policyholder 1,000 or more hours per year;
- (b) Faculty Employees who are Actively Working for the Policyholder teaching .5 FTE's (full time equivalents) or more per year;
- (c) Faculty employees who are appointed to an administrative assignment and are Actively Working for the Policyholder at least .5 FTE's (full time equivalents) or more per year; and
- (d) receiving compensation from the Policyholder for work performed for the Policyholder.

NOTE: Employees who are Totally Disabled will not be considered actively employed.

Actively Working or **Active Work** means performing the normal duties of the Employee's regular job for the Policyholder at:

- (a) the Policyholder's usual place of business;
- (b) an alternative work site at the direction of the Policyholder; or
- (c) a location to which one must travel to perform the job.

An Employee will not be considered actively working if confined:

- (a) in a Hospital as an inpatient;
- (b) in any institution or facility other than a Hospital; or
- (c) at home and under the care or supervision of a Physician;

on the day insurance is to begin.

An Employee will be considered actively working on any day that is a:

- (a) regular paid holiday or day of vacation;
- (b) regular or scheduled non-working day; or
- (c) day on which the Employee is on a qualified family or medical leave of absence as defined by the Family and Medical Leave Act of 1993, unless the leave is due to the Employee's own serious health condition;

provided the Employee was actively working on the last preceding regular work day.

An Employee who is confined:

- (a) in a Hospital as an inpatient;
- (b) in any institution or facility other than a Hospital; or
- (c) at home and under the care or supervision of a Physician due to an Injury or Sickness;

on the date insurance is to begin will not be considered actively working.

Certificate means this Certificate of Insurance form and all Riders to this certificate.

Eligibility Waiting Period means a continuous period of Active Employment that the Employee must satisfy before becoming eligible for insurance as described in the When An Employee Becomes Eligible For Coverage provision of this Certificate.

Employee means a citizen or permanent resident of the United States, or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations, who is Actively Employed:

- (a) in the United States; or
- (b) outside the United States for a period of 12 consecutive months or less.

An employee does not include a person:

- (a) working outside the United States for a period in excess of 12 consecutive months unless written approval has been received from an officer in Our Home Office;
- (b) unauthorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations;
- (c) working on a seasonal or temporary basis; or
- (d) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form, or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Good Health means proof, acceptable to Us, of the Employee's good health. Unless otherwise stated in the Policy, such evidence is required when an Employee:

- (a) applies for insurance more than 30 days after the date the Employee completes the Eligibility Waiting Period;
- (b) applies for insurance in excess of the Guarantee Issue Limit;
- (c) was eligible for insurance under a Prior Plan but did not elect such insurance; or
- (d) was insured under a Prior Plan but the Employee applied for insurance under this Policy in excess of the amount of insurance under the Prior Plan.

Guarantee Issue Limit means the maximum amount of insurance We may issue to an Employee without requiring Evidence of Good Health. The guarantee issue limit is shown in the Schedule in this Certificate.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Policy means the policy issued to the Policyholder by Us, including this Certificate.

Prior Plan means any plan of group life and accidental death and dismemberment insurance that has been replaced by insurance under part or all of this Policy. The prior plan must have been in effect and sponsored by the Policyholder on the day before the effective date of this Policy.

Rider means a document that is added to and made a part of the Policy. A rider amends, limits, restricts, or otherwise changes the provisions of the Policy.

When an Employee Becomes Eligible for Coverage

An Employee becomes eligible for insurance under the Policy on the day the Employee begins Active Employment.

When Employee Insurance Begins

When the Policyholder pays 100% of the cost of the Employee's insurance under the Policy, the Employee will become insured on the later of the first day of the month which coincides with or follows the day:

- (a) the Employee satisfies the Eligibility Waiting Period; or
- (b) We approve Evidence of Good Health, if required;

provided the Employee is Actively Employed on that date. If the Employee is not Actively Employed on that date, insurance will begin on the date the Employee returns to Active Employment.

When the Employee and the Policyholder share in the cost of the Employee's insurance or, when the Employee pays 100% of the cost of Employee insurance, the Employee must request insurance by properly completing and signing an enrollment form acceptable to Us and submitting this form to the Policyholder (who will then submit the form to Us) within 30 days following the day the Employee becomes eligible for the Policy.

The Employee will become insured on the first day of the month which coincides with or follows the later of the day:

- (a) the Employee becomes eligible; or
- (b) the Employee's enrollment form, acceptable to Us, is properly completed and signed;

and, if required, We approve Evidence of Good Health provided the Employee is Actively Employed on that date. If the Employee is not Actively Employed on that date, insurance will begin on the date the Employee returns to Active Employment.

If an Employee was eligible for group life insurance under a Prior Plan immediately prior to the effective date of this Policy, but did not elect insurance under such plan, the Employee may enroll for insurance under this Policy if the Employee is otherwise eligible and provides Us with Evidence of Good Health. Insurance will begin on the first day of the month which coincides with or follows the day We determine such evidence is acceptable, provided the Employee is Actively Employed on that date. If the Employee is not Actively Employed on that date, insurance will begin on the day the Employee returns to Active Employment.

Continuity of Coverage

If this Policy replaces a Prior Plan that contained a provision allowing for continuation of coverage due to Total Disability without payment of premium (the “Prior Plan’s Continuation Provision”), this Policy will provide life and Accidental Death and Dismemberment coverage, subject to all of the conditions below, for an Employee who:

- (a) was insured under the Prior Plan on the last day it was in effect;
- (b) is otherwise eligible under this Policy, but is not Actively Employed on this Policy’s effective date due to Injury or Sickness;
- (c) was eligible for continuation of coverage under the Prior Plan’s Continuation Provision, but has been denied continuation of coverage under the Prior Plan’s Continuation Provision after exhausting all reasonable attempts to apply for such continued coverage;
- (d) is not a retired Employee, unless this Policy provides coverage for retired Employees; and
- (e) is not Totally Disabled on this Policy’s effective date.

This Continuity of Coverage provision is subject to the following additional conditions:

- (a) coverage under this Policy will not exceed the Employee’s amount of coverage under the Prior Plan on the last day it was in effect;
- (b) the Policyholder must notify Us in writing prior to the effective date of this Policy of the Employee’s amount of coverage under the Prior Plan on the last day it was in effect;
- (c) coverage is subject to uninterrupted payment of premium to Us; and
- (d) coverage is subject to any reductions shown in the Schedule of this Certificate and all other terms and conditions of this Policy.

We reserve the right to request any information We need from the Policyholder to determine whether an Employee has satisfied the conditions necessary to be eligible for coverage under this Continuity of Coverage provision. If We do not receive such information or determine that the conditions necessary to be eligible for coverage under this Continuity of Coverage provision have not been satisfied, coverage will not be provided under this provision.

Employees who are not eligible for coverage under this Continuity of Coverage provision may be eligible to apply for conversion coverage under the Prior Plan and should contact the Policyholder for additional information.

Coverage under this Continuity of Coverage provision ends on the earliest of:

- (a) the date the Employee begins Active Employment for the Policyholder or full-time employment with any other employer;
- (b) the last day the Employee would have been covered under the Prior Plan, had the Prior Plan not terminated;
- (c) the date the Employee's insurance under this Policy terminates for any reason shown under the When Employee Insurance Ends provision; or
- (d) the last day of the Policy month following a period of 12 consecutive months after the effective date of this Policy.

If an Employee is eligible for coverage under this Continuity of Coverage provision, the Employee will not be eligible for coverage under the Waiver of Premium Benefit provision shown in this Certificate.

Changes in the Amount of Your Insurance

Decrease in the Amount of Your Insurance

Regardless of whether or not You are Actively Employed at the time, any decrease in the amount of insurance will take effect on the day of the decrease.

The amount of insurance cannot be decreased to an amount less than any plan minimums shown in the Schedule of this Certificate. Any reductions due to age as shown in the Schedule in this Certificate will apply.

Increase in the Amount of Your Insurance

You cannot request an increase to the amount of Your insurance unless You are Actively Employed on the day You submit such request. We will use the Policyholder's payroll records and the premium We have received to determine the appropriate insurance amount.

Any increase in the amount of Your insurance will take effect on the later of the day:

- (a) of the change; or
- (b) the day We approve Your Evidence of Good Health, if required by Us.

If You are not Actively Employed on the day the increase in insurance would otherwise take effect, the increase will become effective the day You return to Active Employment.

Reinstatement of Employee Insurance

An Employee may be eligible to reinstate insurance that has ended. A written request for reinstatement must be submitted to Us. The reinstated insurance will take effect on the first day of the month that coincides with or follows the date We approve the Employee's written request, provided the Employee is Actively Employed on the date the reinstatement would take effect.

The following reinstatement options are available and are each subject to the conditions described in the following paragraphs:

- (a) Non-Payment of Premium;
- (b) Involuntary Reduction in Hours; and
- (c) Rehired Employee.

Non-payment of Premium

If insurance ended due to non-payment of premiums, We will require Evidence of Good Health, acceptable to Us, to reinstate Your insurance.

Involuntary Reduction in Hours

If insurance ended because the Employee is no longer Actively Employed due to an involuntary reduction of hours worked, the Employee's insurance may be reinstated without satisfying another Eligibility Waiting Period if the Employee returns to Active Employment and there was no break in employment with the Policyholder after the date insurance ended.

We will require Evidence of Good Health if the amount of insurance being requested exceeds the amount of coverage in effect on the Employee's last day of Active Employment.

Rehired Employee

If insurance ended because the Employee is no longer Actively Employed due to termination of employment with the Policyholder, the Employee's insurance may be reinstated without satisfying another Eligibility Waiting Period if the Employee is rehired and becomes Actively Employed within 90 days from the date employment ended.

We will require Evidence of Good Health acceptable to Us if the amount of insurance being requested exceeds the amount of insurance in effect on the Employee's last day of Active Employment.

If employment terminated due to a military leave, the Employee is eligible to reinstate insurance up to the amount in effect on the last day of Active Employment upon return to Active Employment immediately after discharge from active duty, provided the Employee meets the eligibility requirements of the Policy.

If insurance has been elected and continued under the Portability provision while an Employee was not Actively Employed, the Employee is eligible to reinstate insurance up to the amount in effect on the last day of Active Employment. Any coverage provided under Portability will terminate upon reinstatement of insurance under this Policy.

When Employee Insurance Ends

Insurance will end on the earliest of the day:

- (a) the Policy terminates;
- (b) You are no longer Actively Employed;
- (c) You do not satisfy any other eligibility conditions described in this Certificate;
- (d) any applicable premium contribution is due and unpaid; or
- (e) You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less).

Exceptions to When Employee Insurance Ends

If You are no longer Actively Employed, You may be eligible to continue insurance under one of the following continuation options. The conditions for each continuation option are described within each provision.

For life insurance:

- (a) Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence
- (b) Waiver of Premium Benefit
- (c) Portability

For accidental death and dismemberment insurance:

- (a) Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence
- (b) Portability

Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence

You may be able to continue life and accidental death and dismemberment insurance under this provision until the last day of the month following 60 days from the day in the event of a temporary layoff approved by the Policyholder.

You may be able to continue life and accidental death and dismemberment insurance under this provision for 12 months from the day You are no longer Actively Employed in the event of a administrative leave of absence or any other leave of absence approved by the Policyholder.

Under this provision, insurance will continue subject to the following conditions:

- (a) We must continue to receive uninterrupted premium payment;
- (b) the Policyholder may be able to continue Your life and accidental death and dismemberment insurance for up to 12 months if You are no longer Actively Employed due to Injury or Sickness;
- (c) We must receive written notification from the Policyholder within 30 days from the date You are no longer Actively Employed; and
- (d) the amount of insurance will not be increased while You are laid off.

Insurance under this provision will end on the earliest of the day:

- (a) the Policy terminates;
- (b) any applicable premium contribution is due and unpaid;
- (c) You elect to obtain insurance under the Conversion Privilege or the Portability provision;
- (d) before You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less);
- (e) You return to Active Employment or begin employment with an employer other than the Policyholder; or
- (f) Your insurance would otherwise end under the Policy.

If state law requires an employer to allow a leave of absence related to pregnancy, childbirth, or adoption, We will continue insurance during that leave period subject to the terms and conditions of this Policy. Contact Your employer to determine whether or not You are eligible for this type of leave.

Waiver of Premium Benefit

You may be able to continue life insurance under this provision without payment of premium if You become Totally Disabled while insured under the Policy prior to age 60. If You are over age 60 You may apply for an individual life insurance conversion policy according to the terms of the Conversion Privilege described in this Certificate.

Continuation of insurance under this Waiver of Premium Benefit provision is subject to the following conditions:

- (a) the amount of insurance will not be increased while You are Totally Disabled;
- (b) the amount of insurance will be reduced or terminated in accordance with the terms shown in the Schedule in this Certificate;
- (c) the Waiver of Premium Benefit Elimination Period must be satisfied; and
- (d) Proof of Total Disability must be provided to Us as described in the following paragraphs.

If You are eligible to continue insurance under this Waiver of Premium Benefit provision You will not be eligible for Portability.

Waiver of Premium Benefit Elimination Period

The Waiver of Premium Benefit Elimination Period is a period of 6 consecutive months of Total Disability beginning on the date You became Totally Disabled while insured under the Policy. Your insurance will continue during this time without premium payment as long as You remain Totally Disabled.

Proof of Total Disability

You must notify Us in writing of Total Disability within 3 months from the date You became Totally Disabled. Satisfactory proof of Total Disability must be submitted to Us before the end of the Waiver of Premium Benefit Elimination Period. We will notify You in writing if this proof is not acceptable. You will have 30 days from the date of Our denial in which to exercise the Conversion Privilege described in this Certificate.

If You are approved for continuation of coverage under this Waiver of Premium provision, We will periodically require proof of continuing Total Disability. This will be at Your expense. If at any time We determine You are no longer Totally Disabled We will notify You in writing and You will have 30 days from the date of Our denial in which to exercise the Conversion Privilege described in this Certificate.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense. We may have You examined any time during the first two years of Total Disability and once a year thereafter.

Death While Satisfying the Waiver of Premium Benefit Elimination Period

If You die during the Waiver of Premium Benefit Elimination Period, benefits will be paid to Your beneficiary if We receive satisfactory proof of Total Disability and We determine that You were Totally Disabled on the day before the date of death.

When the Waiver of Premium Benefit Ends

Your continued insurance under the Waiver of Premium Benefit provision will end on the earliest of:

- (a) the day You are no longer Totally Disabled;
- (b) 90 days after a proof of Total Disability form is sent to You, but has not been returned to Us;
- (c) the day You fail to be examined by a Physician of Our choice or do not cooperate with an exam in accordance with the Proof of Total Disability provision; or
- (d) the day You reach age 65.

You will have 30 days from the date insurance under the Waiver of Premium Benefit provision ends in which to exercise the Conversion Privilege described in the Policy. You will not be eligible to continue insurance under the Portability provision.

Portability

You may be able to obtain life and Accidental Death and Dismemberment insurance under this provision when insurance ends prior to age 70 due to any of the following reasons:

- (a) the Policy terminates and the Policyholder does not obtain similar group insurance from Us within 30 days;
- (b) employment with the Policyholder ends for reasons other than Your Injury, Sickness or Disability;
- (c) You are not Actively Employed;
- (d) You retire; or
- (e) You do not satisfy any other eligibility condition described in this Certificate.

Insurance under this Portability provision is available without providing Evidence of Good Health, subject to the following conditions:

- (a) You must submit a written request and the first premium within 30 days after insurance ends;
- (b) the amount of insurance may not exceed the lesser of:
 - (1) the amount in effect on Your last day of Active Employment; or
 - (2) \$500,000; and
- (c) the amount of insurance under this Portability provision may not be increased.

If You are eligible and elect insurance under this Portability provision, You will not be eligible to continue insurance under the Waiver of Premium Benefit provision or Conversion Privilege provision in this Certificate.

Premium Rates for Portability

Premium rates will change as You enter a higher age category. Other than for this reason, rates will not be changed on an individual basis. Premium rates may be changed for all persons who have elected Portability coverage from Us. In the event of a change in premium rates, We will provide written notification 30 days prior to the date of the change.

For assistance in determining the amount of premium due contact the Policyholder.

When Portability Ends

Insurance under this Portability provision will end on the earliest of the day:

- (a) You reach 70 years of age;
- (b) any applicable premium contribution is due and unpaid;
- (c) You return to Active Employment for the Policyholder and Your insurance under the Policyholder's group plan is reinstated;
- (d) before You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less).

Continuation of Insurance Under Family and Medical Leave

The federal Family Medical Leave Act of 1993 (FMLA) and any amendments thereto as well as certain state statutes provide continuation of coverage in certain instances for leaves of absence.

You may be eligible for continued coverage under FMLA and/or any state family medical leave laws. You should check with Your employer for additional information regarding the continued coverage that may be available to You.

Any continued coverage for family medical leave will not exceed the continued coverage provided by FMLA and/or state required family medical leave.

Any family medical leave continuation is subject to all terms and conditions of the Policy, including, without limitation, payment of premium and eligibility. Any continued coverage will end in accordance with the When Employee Insurance Ends provision in Your Certificate.

LIFE INSURANCE BENEFITS

For You

Benefits

If You die while insured under this provision, We will pay the **Amount of Life Insurance** shown in the **SCHEDULE**. Benefits will be paid to the beneficiary You name. If You do not name a beneficiary or if no beneficiary survives You, benefits will be paid:

- (a) to Your surviving spouse; if none, then
- (b) to Your surviving natural and/or adopted children; if none, then
- (c) to Your surviving parent(s); if none, then
- (d) to Your estate.

Benefits will be paid equally among surviving children or surviving parents.

Mode of Payment

We will pay benefits in a lump sum.

Beneficiary or Mode of Payment Change

The beneficiary and mode of payment may be changed, subject to any restrictions or limitations in this Policy. To make a change, written request should be sent to the office where the beneficiary records are kept. If You do not know where the records are kept, send the request to us. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by us before the request was acknowledged.

Facility of Payment

We may pay up to the Facility of Payment Amount to any person who has incurred expenses for Your fatal illness or burial. The **Facility of Payment Amount** is shown in the **SCHEDULE**.

Conversion Privilege

If any of Your life insurance ends because Your employment or membership in a class ends, You may apply for an individual policy of life insurance (called a conversion policy) without giving information about Your health. Issuance of a conversion policy is subject to the following conditions:

- (a) You may apply for any of our individual life insurance policies except term insurance. You may not apply for any supplemental coverage.
- (b) You may apply for an amount which is not more than the amount of Your terminated group life insurance.

- (c) The premium for Your conversion policy will be at our standard rate for that type of policy according to:
 - (1) Your class of risk; and
 - (2) Your age on the date the policy takes effect.
- (d) You must submit Your written application and Your first conversion premium to Us within 30 days after Your group life insurance ends or reduces.

If Your group life insurance ends because of termination of the Policy or termination of a class, and You have been insured under the Policy at least five years, You may apply within 30 days for a conversion policy. Issuance of the conversion policy is subject to conditions (a), (c) and (d) above. Your converted life insurance may not exceed the lesser of:

- (a) \$2,000; or
- (b) the amount of Your terminated group life insurance less the amount of any other group life insurance for which You become eligible within 30 days.

If You die within the 30-day period after insurance ends, We will pay the amount of group life insurance You were entitled to convert.

If We issue a conversion policy and You again become eligible for group life insurance under the Policy, coverage will become effective only if:

- (a) You terminate the conversion policy; or
- (b) You submit, at Your own expense, evidence of good health acceptable to Us.

LIFE INSURANCE BENEFITS

For You - LIVING BENEFITS OPTION (ACCELERATED BENEFITS)

THIS PROVISION ACCELERATES AND REDUCES THE DEATH BENEFIT. IT IS NOT INTENDED TO BE USED AS LONG TERM CARE INSURANCE.

Definition

Terminal Condition means an Injury or Sickness:

- (a) expected to result in Your death within 12 months; and
- (b) from which there is no reasonable prospect of recovery;

as determined by Us.

Benefits

If You incur a Terminal Condition while insured under this provision, You or Your legal representative, while You are living, may request Living Benefits. The **Amount of Living Benefits** is shown in the **Schedule**, and will be payable provided You are living at the time payment is made. Benefits will be paid in one lump sum.

Conditions

1. To be insured for Living Benefits, You must be insured for group life insurance under this Policy.
2. We may require the beneficiary's written consent. Before Living Benefits are paid in community property states, Your spouse's written consent may be required.
3. The amount of Your group life insurance and the amount You may convert in accordance with the life **Conversion Privilege** provision will be reduced by the Living Benefit amount paid under this provision.
4. An Insured Person may receive Living Benefits only once.
5. Premium payments must continue to be paid on the full amount of group life insurance, unless You qualify for waiver of premium, in accordance with the **Continuation of Life Insurance Benefits Due to Total Disability** provision.

Exceptions

This **Living Benefits** provision will not apply:

- (a) when You have irrevocably assigned group life insurance under this Policy;
- (b) when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a divorce agreement;
- (c) to any intentionally self-inflicted Injury, Sickness or suicide attempt;
- (d) if Your life insurance benefits end;
- (e) if the required premium is due and unpaid; or
- (f) if the Master Policy terminates.

NOTE: Benefits paid under this provision may be taxable. If so, You may incur a tax obligation. As with all tax matters, You should consult a personal tax advisor to assess the impact of this benefit.

Benefit payments may affect qualifications for government entitlement programs.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For You

Definitions

Accident means a sudden, unexpected, unforeseeable and unintended event, independent of Sickness.

Accident does not include Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. Accident does include bacterial infection that is the natural and foreseeable result of an accidental bodily Injury or accidental food poisoning.

Automobile means a licensed private passenger motor vehicle for use on public highways.

Loss of a Hand or Foot means complete Severance of at least four whole fingers from one hand or Severance above the ankle joint.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Sight means the total and permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total, permanent and irrecoverable loss of audible communication. The loss of speech must be irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger means Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Seat Belt means a factory-installed lap and shoulder seat belt or other restraint device approved by the National Highway Traffic Safety Administration.

Severance means the complete separation and dismemberment of the part from the body.

Traveling on Business of the Policyholder means any trip made by You on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder. If this trip is made on a private aircraft, then the aircraft must:

- (a) have a current and valid Federal Aviation Administration of the United States (FAA) standard air worthiness certificate; and
- (b) is operated by a person holding a current and valid FAA pilot's certificate of rating authorizing him or her to operate the aircraft. The pilot or crew could be an Insured Person under the Policy.

Benefits

If You are Injured or die as a result of an Accident, We will pay the Benefit shown in the Table below for any of the following losses:

TABLE

<u>Loss</u>	<u>Benefit</u>
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes.....	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of One Hand and One Foot.....	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye.....	Principal Sum
Loss of Thumb and Index Finger of same Hand.....	One-fourth Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Speech or Hearing (both ears).....	One-half Principal Sum
Loss of One Hand or One Foot.....	One-half Principal Sum

The Principal Sum is shown on the **SCHEDULE**.

If an Injury causes more than one loss shown in the Table above, We will pay only the **largest** Benefit. However, some benefits are paid in addition to the Principal Sum shown in the Table, as specifically provided in other provisions below.

Payment For Loss of Life

Beneficiary

Benefits payable under this provision because of Your death will be paid to the beneficiary You name. If You do not name a beneficiary or if no beneficiary survives You, benefits will be paid:

- (a) to Your surviving spouse; if none, then
- (b) to Your surviving natural and/or adopted children; if none, then
- (c) to Your surviving parent(s); if none, then
- (d) to Your estate.

Benefits will be paid equally among surviving children or surviving parents.

Mode of Payment

We will pay death benefits in a lump sum.

Beneficiary or Mode of Payment Change

The beneficiary and mode of payment may be changed, subject to any restrictions or limitations in this Policy. To make a change, written request should be sent to the office where the beneficiary records are kept. If You do not know where the records are kept, send the request to Us. When recorded and acknowledged by Us, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by Us before the request was acknowledged.

Payment For Other Than Loss of Life

Benefits payable under this provision for any loss other than loss of life will be paid to You in a lump sum.

Exposure and Disappearance

You will be presumed to have died, for the purposes of this coverage, if after the forced landing, stranding, sinking or wrecking of a vehicle:

- (a) You disappear;
- (b) Your body is not found; and
- (c) a valid death certificate is issued by a court of appropriate jurisdiction.

Airbag Benefit

Definition

Airbag means any factory-installed, inflatable, supplemental restraint device which meets published federal safety standards.

Benefits

If You are Injured in an Automobile Accident and that Injury results in Your death, We will pay 10% of the amount of the Principal Sum, up to a maximum of \$50,000. This benefit is paid in addition to the Principal Sum.

Exception

We will not pay Airbag Benefits if the Automobile Accident occurs when You are not seated directly behind an Airbag.

Child Education Benefits

Definitions

Accredited School means a state accredited college, university, trade school or vocational school.

Full Time Basis means full-time as defined by the Accredited School being attended by the Eligible Dependent Student.

Eligible Dependent Student means each of Your unmarried children who are less than 25 years of age and are:

- (a) enrolled on a Full Time Basis in an Accredited School at Your death; or
- (b) enrolled on a Full Time Basis in an Accredited School within one year after Your death; and
- (c) natural-born;
- (d) legally adopted;
- (e) a stepchild living in Your home; or
- (f) a child:
 - (1) You are raising as Your own;
 - (2) who is living in Your home and chiefly dependent on You for support; and
 - (3) for whom You have full parental responsibility and control;

all as indicated by evidence acceptable to Us.

The term Eligible Dependent Student does not include:

- (a) anyone insured under this Policy as an Employee;
- (b) anyone who enters the Armed Forces on active duty (except for temporary active duty of two weeks or less);
- (c) Your married child(ren);
- (d) Your child who has been legally adopted by another person;
- (e) a child:
 - (1) temporarily living in Your home;
 - (2) placed in Your home by a social service agency which retains control over the child; or
 - (3) who has a natural parent in a position to exercise or share parental responsibility and control.

Benefits

If You are Injured, and that Injury results in Your death, We will pay benefits equal to 6% of the amount of the Principal Sum, up to \$6,000. This Child Education Benefit will be payable at the end of each school year for a maximum of four consecutive years.

This benefit is paid in addition to the Principal Sum, and will be paid to the Eligible Dependent Student or, if a minor child, to the Eligible Dependent Student's legal guardian.

When the parents of an Eligible Dependent Student are both insured under the Policy as employees, benefits will be limited to payment under only one parent's certificate.

Conditions

We will only pay the Child Education Benefit if:

- (a) there is an Eligible Dependent Student who continues to be enrolled for each consecutive term; and
- (b) a copy of the Eligible Dependent Student's most recent grade report is submitted with the claim.

Seat Belt Benefits

Benefits

If You are Injured in an Automobile Accident while You were wearing a Seat Belt, and that Injury results in Your death, We will pay 10% of the amount of the Principal Sum, up to \$50,000. We must receive satisfactory written proof that Your death resulted from an Automobile Accident and that You were wearing a Seat Belt at the time of the Accident. A copy of the police accident report must be submitted with the claim. This benefit is paid in addition to the Principal Sum.

Exclusions

We will not pay for any loss which:

- (a) results, whether the Insured Person is sane or insane, from:
 - (1) an intentionally self-inflicted Injury or Sickness; or
 - (2) suicide or attempted suicide;
- (b) results from the Insured Person's participation in a riot or in the commission of a felony;
- (c) results from an act of declared or undeclared war;
- (d) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
- (e) is not permanent, unless specifically provided;
- (f) occurs more than 365 days after the Injury; NOTE: This 365 day limit will not apply if You are in a coma or being kept alive by an artificial support system at the end of the 365 days.
- (g) does not result from an Accident;
- (h) results from Injuries You receive in any aircraft while operating, riding as a passenger, boarding or leaving. This exception does not apply while You are riding as a passenger in a commercial aircraft on a regularly scheduled flight or while Traveling on Business of the Policyholder; or
- (i) results in Injuries You receive while riding in any aircraft engaged in:
 - (1) racing;
 - (2) endurance tests; or
 - (3) acrobatic or stunt flying.

PAYMENT OF CLAIMS

How to File Claims

It is important for You to notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Before Your claim can be considered, We must be given a written proof of loss, as described below. In the event of Your death or incapacity, Your beneficiary or someone else may give Us the proof.

Proof of Loss Requirements

1. First, request a claim form from the Plan Administrator or from Us.

This request should be made:

- (a) within 20 days after a loss occurs; or
- (b) as soon as reasonably possible.

When We receive the request, We will send a claim form for filing proof of loss. If You do not receive the form within 15 days of Your request, You can meet the proof of loss requirement by giving Us a written statement of what happened. We must receive a written statement within the time shown in 3 below.

2. Next, You must complete and sign the claim form. If a Physician must complete part of the claim form, have the Physician complete and sign that part.
3. The claim form or written statement should be sent to Us or to the Plan Administrator within 90 days after the loss occurs; or as soon as reasonably possible. If it is not possible to give Us proof within 90 days, it must be given to Us no later than one year after the time proof is otherwise required, unless the claimant is not legally capable.

When Claims are Paid

Policy benefits will be paid as soon as We receive acceptable proof of loss.

If we do not pay benefits within 30 days after acceptable proof of loss is received, We will pay interest on any Life Insurance Benefit from the date of death to the date the claim is paid. Interest shall be the greater of 6% or the rate applicable to death proceeds left on deposit with Us.

Direct Payments

Any loss of life benefit will be paid in accord with the Life Insurance Benefits and/or Accidental Death and Dismemberment Benefits provision(s).

Any other benefits will be paid to You, except that benefits unpaid at Your death may be paid, at Our option to:

- (a) Your beneficiary; or
- (b) Your estate.

If Your beneficiary is unable to give a valid release or if benefits unpaid at Your death are not more than \$1,000, We may pay up to \$1,000 to any relative of Yours who We find is entitled to the benefit.

Any payment made in good faith will fully discharge Us to the extent of the payment.

Examination and Autopsy

We sometimes require that a claimant be examined by a Physician of Our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

Overpayments

We have the right to recover any overpayments due to:

- (a) fraud; or
- (b) any error We make in processing a claim.

You must reimburse Us in full. We will determine the method by which the repayment is to be made. We will not recover more money than the amount We paid You.

Authority to Interpret Policy

The Policyholder has delegated to Us the discretion to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Benefits under the Policy will be paid only if We decide, after exercising Our discretion, that the Insured Person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third parties.

The Insured Person has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person's claim for benefits is denied or ignored, in whole or in part, the Insured Person may file suit and a court will review the Insured Person's eligibility or entitlement to benefits under the Policy.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM REVIEW PROCEDURES

As Federally Mandated

DEFINITIONS

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of the Insured Person’s eligibility to participate in a plan.

A document, record, or other information will be considered “**Relevant**” to a claim if it:

- (a) was relied upon in making the claim decision;
- (b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
- (c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

INITIAL CLAIM DECISION

Initial Claim Decision. We will make a claim decision regarding a life or accidental death and dismemberment claim within 90 days after Our receipt of the claim.

Extensions. The initial 90 day period may be extended for up to 90 days, if We (1) determine that special circumstances require an extension of time for processing the claim and (2) notify the claimant, prior to the expiration of the initial 90 day period, of the special circumstances requiring the extension and the date by which We expect to render a decision.

Time Periods. The period of time within which a claim decision is required to be made will begin at the time a claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing.

NOTICE OF ADVERSE BENEFIT DETERMINATION

We will provide the claimant with written or electronic notice of any Adverse Benefit Determination within 90 days after Our receipt of the claim, subject to the extension described above. The notice will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) a description of any additional material or information necessary to complete the claim and the reason We need the material or information; and
- (d) a description of the Policy’s appeal procedures, including the time limits for such procedures and the right of the person submitting the claim to bring a civil action under the Employee Retirement Income Security Act (“ERISA”) following the appeal process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The claimant must appeal within 60 days following receipt of notification of an Adverse Benefit Determination.

The request for an appeal should include:

- (a) The Insured Person's name;
- (b) the name of the person filing the appeal if different from the Insured Person;
- (c) the Policy number; and
- (d) the nature of the appeal.

The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.

The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claim.

Our review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim decision.

APPEAL DECISION

Notice of Appeal Decision. We will notify the claimant of Our appeal decision within 60 days after receipt of a timely appeal request, unless We determine that special circumstances require an extension of time for processing the appeal. We will provide the claimant with written or electronic notice of Our appeal decision. Notice of an Adverse Benefit Determination will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) 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 claim; and
- (d) a statement of the right of the claimant to bring a civil action under ERISA.

Notice of Extension. If We determine that an extension is required, We will notify the claimant in writing of the extension prior to the termination of the initial 60 day period. In no event will the extension exceed 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

Time Periods. The period of time within which an appeal decision is required to be made will begin at the time an appeal is timely filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent to the claimant until the earlier of (1) the date on which We receive the claimant's response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the Policy;
- (b) the Policyholder's application attached to the Policy; and
- (c) Your application, if required.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

- (a) does not require You or Your beneficiary's consent; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of Our officers.

A change may affect any class of Insured Persons, including retirees if retiree coverage is included in the Policy.

Applications

We may use misstatements or omissions in Your application to contest the validity of insurance, reduce coverage or deny a claim, but We must first furnish You or Your beneficiary with a copy of that application. We will not use Your application to contest or reduce insurance which has been in force for two years or more during Your lifetime. However, if You are not eligible for insurance, there is no time limit on Our right to contest insurance or deny a claim.

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

VERMONT MANDATORY CIVIL UNION ENDORSEMENT

This Rider is made a part of Group Policy GLUG-ADY1.

This Rider is effective the later of January 1, 2010, or the day You become insured under the Policy.

In the event of a conflict between this Rider and any other provision of the Policy, including the Certificate, this Rider shall control. This Rider shall be subject to all provisions of the Policy, including the Certificate, not in conflict with this Rider.

PURPOSE

This endorsement is part of the policy, contract, certificate and/or riders and endorsements to which it is attached and is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS

The definitions, terms, conditions or any other provisions of the policy, contract, certificate 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” and any other such terms include the relationship created by a civil union.

Terms that mean or refer to a family relationship arising from a marriage such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include the family relationship created by a civil union.

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.

“Dependent” means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

“Child or covered child” means a child (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

CAUTIONARY DISCLOSURE

THIS ENDORSEMENT IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE “PURPOSE” PARAGRAPH ABOVE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS ENDORSEMENT. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

DEFINITIONS

Terms defined in this provision are used in, or apply to other provisions throughout the Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions.

Injury means an accidental bodily injury which requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Physician means any of the following licensed practitioners:

- (a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- (b) a licensed doctoral clinical psychologist;
- (c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
- (d) a licensed physician's assistant (PA); or
- (e) where required to cover by law, any other licensed practitioner who is acting within the scope of his/her license.

A physician does not include a person who lives with You or is part of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse).

Our, We, Us means the Company shown on Your Certificate of Insurance.

Rider means a provision added to the Policy or Your certificate to expand or limit benefits or coverage.

Sickness means a disease, disorder or condition, which requires treatment by a Physician.

Total Disability, Totally Disabled or Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

You, Your, Insured Person means an employee or member who is insured under the Policy.

Group Policy Number GLUG-ADY1



MUTUAL *of* OMAHA

Publication Date: February 8, 2011

APPENDIX H

**VOLUNTARY LIFE & ACCIDENTAL DEATH AND
DISMEMBERMENT INSURANCE PLAN**

**YOUR GROUP
VOLUNTARY TERM LIFE
BENEFITS**

The President and Fellows of Middlebury College

Revised May 1, 2010

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

The President and Fellows of Middlebury College
Middlebury College
Service Building, 2nd Floor
Middlebury, VT 05753

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

When contacting the Company please have your policy number available. Your policy number is GVTL-ADY1.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

GROUP VOLUNTARY TERM LIFE INSURANCE SUMMARY OF COVERAGE



The President and Fellows of Middlebury College
GVTL-ADY1

Revised: May 1, 2010

All eligible full time and part time employees

This Summary of Coverage provides a brief description of some of the terms, conditions, exclusions and limitations of Your employer's Policy. Definitions of capitalized terms in this Summary of Coverage can be found in the Certificate. For a complete description of the terms, conditions, exclusions and limitations of Your employer's Policy, refer to the appropriate section of the Certificate. In the event of a discrepancy between this Summary of Coverage and the Certificate, the Certificate will control. For a copy of the Certificate, contact the group Policyholder or Benefits or Plan Administrator.

This Summary of Coverage is not a contract. You are not necessarily entitled to insurance under the Policy because You received this Summary of Coverage. You are only entitled to insurance if You are eligible in accordance with the terms of the Certificate.

BENEFITS	
Guarantee Issue Limit	For You: \$200,000 For Your Spouse: \$25,000 For Your Dependent Child: All Amounts Subject to any reductions, Guarantee Issue means the amount of insurance applied for which does not require Evidence of Good Health.
Life Insurance Benefit for You	You can be insured for amounts of life insurance from \$10,000 to \$500,000 in \$10,000 increments. In no event shall Life Insurance Benefits exceed five times Your Annual Salary. Annual Salary means your annual stated salary, in effect just prior to your date of loss, before taxes and any deductions made for pretax 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 or any other extra compensation, shift differential, or income received from sources other than your employer. Note: If you are on a covered leave of absence your annual earnings are your annual stated salary prior to beginning your leave Note: In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living benefits previously paid under the Policy.

Reductions	<p>Your original Life Insurance Benefit will reduce to:</p> <ul style="list-style-type: none"> • 65% at age 70 • 50% at age 75 <p>If You are age 70 or older on the day You become insured under the Policy, the reduction will be made in accord with Your attained age.</p> <p>If You are no longer in the employ of the Policyholder (including retirement), any benefits that are being continued under the Portability provision in the Policy will end on the date You attain age 70.</p>
Life Insurance Benefit For Your Dependent Spouse	<p>Your lawful spouse can be insured for amounts of life insurance from \$5,000 to \$500,000 in \$5,000 increments. In no event shall the Dependent Life Insurance Benefit exceed 100% of Your Life Insurance Benefit.</p>
Reductions	<p>Your spouse's Life Insurance Benefit will reduce to:</p> <ul style="list-style-type: none"> • 65% at Your age 70 • 50% at Your age 75 <p>If You are age 70 or older on the day Your spouse becomes insured under the Policy, the reduction will be made in accord with Your attained age.</p> <p>If You are no longer in the employ of the Policyholder (including retirement), any benefits that are being continued under the Portability provision in the Policy will end on the date You attain age 70.</p>
Life Insurance Benefit For Your Dependent Child(ren) (Birth to 19 Years- 25 Years if Full-time Student)	<p>Six months to age 19 (Age 25 if in school): \$10,000 Birth to six months: \$1,000</p> <p>In no event shall the Dependent Life Insurance Benefit exceed 100% of Your Life Insurance Benefit.</p>
EMPLOYEE ELIGIBILITY	
Minimum Work Hours Required	<p>Staff Employees who are working 1,000 hours or more per year Faculty 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 and are actively working for the Policyholder at least .5 FTE's (full time equivalents) or more per year</p>
Eligibility Waiting Period	None
Other Group Plan Requirement	<p>An Employee is eligible for insurance under the Policy provided the Employee is also insured under another group life insurance plan sponsored by the Policyholder for which 100% of the employees may enroll and whereby at least 75% of the employees participate.</p>
When Employee Insurance Begins	<p>The Employee must request insurance by properly completing and signing an enrollment form acceptable to Us and submitting this form to the Policyholder. The Employee will become insured on the first day of the month which coincides with or follows the later of the day:</p> <ul style="list-style-type: none"> • the Employee becomes eligible; or • the Employee's enrollment form, acceptable to Us, is properly completed and signed; <p>and, if required, We approve Evidence of Good Health provided the Employee is Actively Employed on that date.</p>

<p>Changes in the Amount of Your Insurance</p>	<p>Decrease in the Amount of Your Insurance Regardless of whether or not You are Actively Employed at the time, any decrease in the amount of insurance will take effect on the day of the decrease. The amount of insurance cannot be decreased to an amount less than any plan minimums shown in the Schedule of the Certificate. Any reductions due to age as shown in the Schedule in the Certificate will apply.</p> <p>Increase in the Amount of Your Insurance You cannot request an increase to the amount of Your insurance unless You are Actively Employed on the day You submit such request. Any increase in the amount of Your insurance will take effect on the later of the day:</p> <ul style="list-style-type: none"> • of the change; or • the day We approve Your Evidence of Good Health, if required by Us.
<p>When Employee Insurance Ends</p>	<p>Insurance will end on the earliest of the day:</p> <ul style="list-style-type: none"> • the Policy terminates; • You are no longer Actively Employed; • You do not meet the conditions described in the Other Group Plan Requirement provision in the Certificate; • You do not satisfy any other eligibility conditions described in the Certificate; • any applicable premium contribution is due and unpaid; or • You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less).
<p>DEPENDENT ELIGIBILITY</p>	
<p>Definition of Dependent</p>	<p>Dependent means a citizen, permanent resident, or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:</p> <ul style="list-style-type: none"> • Your lawful spouse or domestic partner; • Your natural born or legally adopted child; • Your stepchild living in Your home; or • any other child who lives with the Employee in a regular parent-child relationship and for whom You claimed as a Dependent on Your last filed federal income tax return. <p>A dependent does not include a child who has attained the Limiting Age defined in the Certificate. Coverage for Your domestic partner is included as described in the Certificate.</p>
<p>Definition of Limiting Age</p>	<p>Limiting Age means a child's 19th birthday or 25th birthday if the child is a Full-Time student.</p>

<p>When Dependent Insurance Begins</p>	<p>You may request Dependent insurance by properly completing and signing an enrollment form acceptable to Us and submitting the form to the Policyholder. An eligible Dependent will be insured on the latest of the day:</p> <ul style="list-style-type: none"> • You become insured; • You acquire the eligible Dependent; or • You properly complete and sign an enrollment form acceptable to Us for Dependent insurance and submit it as described above. <p>If We do not receive Your request to insure Your Dependents within 30 days from the day the Dependent is eligible for insurance, We will require Evidence of Good Health for Your Dependent. If such evidence is acceptable to Us, Your Dependent will become insured on the date We approve the Dependent’s Evidence of Good Health. In order to insure an eligible Dependent child, You must insure all eligible Dependent children. You must also apply for the same amount of insurance for each eligible Dependent child. We do not require You to insure both Your spouse and children.</p>
<p>Changes in the Amount of Your Dependent’s Insurance</p>	<p>Decrease in the Amount of Your Dependent’s Insurance Any decrease in the amount of Dependent insurance will take effect on the day of the decrease.</p> <p>The amount of Dependent insurance cannot be decreased to an amount less than any plan minimums shown in the Schedule of the Certificate. Any reductions due to age as shown in the Schedule of the Policy will apply to Spouse coverage.</p> <p>Increase in the Amount of Your Dependent’s Insurance Any increase in the amount of Dependent insurance will take effect the day of the change, if We do not require Evidence of Good Health. If Evidence of Good Health is required, any increase in the amount of Dependent insurance will take effect the day We approve Evidence of Good Health, if required.</p>
<p>When Insurance for a Dependent Child Ends</p>	<p>Insurance for a Dependent child will end on the earliest of the:</p> <ul style="list-style-type: none"> • day the Policy terminates; • day any premium contribution for Dependent child insurance is due and unpaid; • day a Dependent child enters active duty or training in the Armed Forces, National Guard or Reserves of any state or country (except temporary active duty of two weeks or less); • day Your insurance ends; • day the Dependent child is no longer eligible; or • day Your insurance is continued without payment of premium under the Waiver of Premium Benefit provision in the Employee Eligibility section of the Certificate.
<p>When Insurance for a Dependent Spouse Ends</p>	<p>Insurance for a Dependent spouse will end on the earliest of the:</p> <ul style="list-style-type: none"> • day the Policy terminates; • day any premium contribution for Dependent spouse insurance is due and unpaid; • day a Dependent spouse enters active duty or training in the Armed Forces, National Guard or Reserves of any state or country (except temporary active duty of two weeks or less); • day Your insurance ends; • day the Dependent spouse is no longer eligible; or • day Your insurance is continued without payment of premium under the Waiver of Premium Benefit provision in the Employee Eligibility section of the Certificate.

FEATURES

Living Benefits Option For You	50% of the amount of the Life Insurance Benefit is available to You if You incur a Terminal Condition, but not to exceed \$500,000. Terminal Condition means an Injury or Sickness expected to result in Your death within 12 months and from which there is no reasonable prospect of recovery as determined by Us.
Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence	<p>You may be able to continue life insurance under this provision until the last day of the month following 60 days from the day in the event of a temporary layoff approved by the Policyholder.</p> <p>You may be able to continue life insurance under this provision for 12 months from the day You are no longer Actively Employed in the event of a administrative leave of absence or any other leave of absence approved by the Policyholder.</p> <p>If a state law requires an employer to allow a leave of absence related to pregnancy, childbirth, or adoption, We will continue insurance during that leave period subject to the terms and conditions of the Policy. Contact Your employer to determine whether or not You are eligible for this type of leave.</p>
Waiver of Premium Benefit	You may be able to continue Life insurance until age 65, without payment of premium, if You become Totally Disabled while insured under the Policy prior to age 60.
Portability	<p>You may be able to obtain Life insurance under the Portability provision when insurance ends prior to age 70 due to any of the following reasons:</p> <ul style="list-style-type: none"> • the Policy terminates and the Policyholder does not obtain similar group insurance from Us within 30 days; • employment with the Policyholder ends for reasons other than Your Injury, Sickness or Disability; • You are not Actively Employed; • You retire; or • You do not satisfy any other eligibility condition described in the Certificate. <p>Insurance under the Portability provision is available without providing Evidence of Good Health, subject to conditions described in Your Certificate.</p> <p>Dependent insurance under the Portability provision may be obtained without providing Evidence of Good Health for Your Dependents subject to conditions described in Your Certificate.</p>
Conversion	If any of Your Life insurance ends because Your employment or membership in a class ends, You may apply for an individual policy of life insurance (called a conversion policy) without giving information about Your health. Issuance of a conversion policy is subject to conditions described in Your Certificate.

LIFE EXCLUSIONS

We will not pay benefits for a death which results from suicide, while sane or insane within two years from the date insurance begins. Instead We will pay the sum of the premiums paid.

If death results from suicide, while sane or insane, within two years from the effective date of any increase in the amount of coverage, the amount of the increase will not be paid. Instead We will pay the total of the premiums paid on the increase.

Publication Date: July 2, 2010

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No(s). GVTL-ADY1 (policy) has been issued to The President and Fellows of Middlebury College (Policyholder).

You are insured as described in this Certificate, subject to the terms and conditions of the policy. Your insurance begins on the date shown on your Certificate Validation Form.

Attach Your Certificate Validation Form Here.

Your insurance ends as set forth in the When Your Insurance Ends section of this Certificate.

If the provisions of this Certificate and those of the policy do not agree, the provisions of the policy will apply.

This Certificate replaces any certificate previously issued under the Policy.

THE DEFINITIONS AND RIDERS ARE VERY IMPORTANT PARTS OF YOUR POLICY. PLEASE READ THOSE PAGES CAREFULLY.

SCHEDULE

The amount of insurance for You and Your dependents will be in accord with Your classification in this Schedule.

Classification(s)

All eligible full time and part time employees

Guarantee Issue Limit:

For You: \$200,000

For Your Spouse: \$25,000

For Your Dependent Child: All Amounts

Subject to any reductions shown below, **Guarantee Issue** means the amount of insurance applied for which does not require Evidence of Good Health.

Life Insurance Benefits For You

You can be insured for amounts of life insurance from \$10,000 to \$500,000 in \$10,000 increments. In no event shall Life Insurance Benefits exceed five times Your Annual Salary.

Facility of Payment Amount.....*\$500

*This amount, if paid, will be deducted from the Amount of Life Insurance shown above.

Annual Salary means your annual stated salary, in effect just prior to your date of loss, before taxes and any deductions made for pretax 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 or any other extra compensation, shift differential, or income received from sources other than your employer.

NOTE: If you are on a covered leave of absence your annual earnings are your annual stated salary prior to beginning your leave

Life Insurance Benefits reduce to 65% of the amount shown above on the day of Your 70th birthday, and further reduce to 50% of the amount shown above on the day of Your 75th birthday. This same reduction provision also applies if You are age 70 or older prior to the date You become insured under the Policy.

If You are no longer in the employ of the Policyholder (including retirement); any benefits that are being continued under the **Portability** provision will end on the date You attain age 70.

NOTE: The Amount of Life Insurance outlined above will be reduced by the Amount of Living Benefits paid under the Living Benefits Option. In the event of Your death, the life insurance benefit will equal the original Amount of Life Insurance multiplied by the life reduction percentage, reduced by any Living Benefits paid under this Policy.

Living Benefits Option

Amount of Living Benefits.....50% of the amount of life insurance
in force on Your life, but not to exceed \$500,000.

For Dependent Spouse

Your lawful spouse can be insured for amounts of life insurance from \$5,000 to \$500,000 in \$5,000 increments. In no event shall the dependent Life Insurance Benefit exceed 100% of Your Life Insurance Benefit. Spouse life insurance will terminate according to the When Insurance for a Dependent Spouse Ends provision.

Life Insurance Benefits for Your dependent spouse will reduce to 65% of the amount shown above on the day of Your 70th birthday, and further reduce to 50% of the amount shown above on the day of Your 75th birthday. This same reduction provision also applies if You are age 70 or older prior to the date Your spouse becomes insured under the Policy.

**For Dependent Children
(Birth to 19 Years-
25 Years if Full-time Student)**

Amount of Life Insurance*See below

In no event shall the dependent Life Insurance Benefit exceed 100% of Your Life Insurance Benefit.

Child, six months to age 19
(Age 25 if in school)\$10,000

Child, Birth to six months\$1,000

NOTE: The amount for which You and Your dependents are insured is shown on the **Certificate Validation Form.**

EMPLOYEE ELIGIBILITY

Life Insurance Benefits

Definitions

Terms defined in this provision may be used in, or apply to, other provisions throughout the Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Actively Employed or **Active Employment** means:

- (a) Staff Employees who are Actively Working for the Policyholder 1,000 or more hours per year;
- (b) Faculty Employees who are Actively Working for the Policyholder teaching .5 FTE's (full time equivalents) or more per year;
- (c) Faculty employees who are appointed to an administrative assignment and are actively working for the Policyholder at least .5 FTE's (full time equivalents) or more per year; and
- (d) receiving compensation from the Policyholder for work performed for the Policyholder.

NOTE: Employees who are Totally Disabled will not be considered actively employed.

Actively Working or **Active Work** means performing the normal duties of the Employee's regular job for the Policyholder at:

- (a) the Policyholder's usual place of business;
- (b) an alternative work site at the direction of the Policyholder; or
- (c) a location to which one must travel to perform the job.

An Employee will not be considered actively working if confined:

- (a) in a Hospital as an inpatient;
- (b) in any institution or facility other than a Hospital; or
- (c) at home and under the care or supervision of a Physician;

on the day insurance is to begin.

An Employee will be considered actively working on any day that is a:

- (a) regular paid holiday or day of vacation;
- (b) regular or scheduled non-working day; or
- (c) day on which the Employee is on a qualified family or medical leave of absence as defined by the Family and Medical Leave Act of 1993, unless the leave is due to the Employee's own serious health condition;

provided the Employee was actively working on the last preceding regular work day.

An Employee who is confined:

- (a) in a Hospital as an inpatient;
- (b) in any institution or facility other than a Hospital; or
- (c) at home and under the care or supervision of a Physician due to an Injury or Sickness;

on the date insurance is to begin will not be considered actively working.

Certificate means this Certificate of Insurance form and all Riders to this certificate.

Eligibility Waiting Period means a continuous period of Active Employment that the Employee must satisfy before becoming eligible for insurance as described in the When An Employee Becomes Eligible For Coverage provision of this Certificate.

Employee means a citizen or permanent resident of the United States, or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations, who is Actively Employed:

- (a) in the United States; or
- (b) outside the United States for a period of 12 consecutive months or less.

An employee does not include a person:

- (a) working outside the United States for a period in excess of 12 consecutive months unless written approval has been received from an officer in Our Home Office;
- (b) unauthorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations;
- (c) working on a seasonal or temporary basis; or
- (d) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form, or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Employee also means an expatriate working on assignment outside the United States on United States Payroll.

Evidence of Good Health means proof, acceptable to Us, of the Employee's good health. Unless otherwise stated in the Policy, such evidence is required when an Employee:

- (a) applies for insurance more than 30 days after the date the Employee completes the Eligibility Waiting Period;
- (b) applies for insurance in excess of the Guarantee Issue Limit;
- (c) was eligible for insurance under a Prior Plan but did not elect such insurance; or
- (d) was insured under a Prior Plan but the Employee applied for insurance under this Policy in excess of the amount of insurance under the Prior Plan.

Guarantee Issue Limit means the maximum amount of insurance We may issue to an Employee without requiring Evidence of Good Health. The guarantee issue limit is shown in the Schedule in this Certificate.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Policy means the policy issued to the Policyholder by Us, including this Certificate.

Prior Plan means any plan of group life insurance that has been replaced by insurance under part or all of this Policy. The prior plan must have been in effect and sponsored by the Policyholder on the day before the effective date of this Policy.

Rider means a document that is added to and made a part of the Policy. A rider amends, limits, restricts, or otherwise changes the provisions of the Policy.

When an Employee Becomes Eligible for Coverage

An Employee becomes eligible for insurance under the Policy on the day the Employee begins Active Employment.

Other Group Plan Requirement

An Employee is eligible for insurance under this Policy provided the Employee is also insured under another group life insurance plan sponsored by the Policyholder for which 100% of the employees may enroll and whereby at least 75% of the employees participate.

When Employee Insurance Begins

When the Employee and the Policyholder share in the cost of the Employee's insurance or, when the Employee pays 100% of the cost of Employee insurance, the Employee must request insurance by properly completing and signing an enrollment form acceptable to Us and submitting this form to the Policyholder (who will then submit the form to Us) within 30 days following the day the Employee becomes eligible for the Policy.

The Employee will become insured on the first day of the month which coincides with or follows the later of the day:

- (a) the Employee becomes eligible; or
- (b) the Employee's enrollment form, acceptable to Us, is properly completed and signed;

and, if required, We approve Evidence of Good Health provided the Employee is Actively Employed on that date. If the Employee is not Actively Employed on that date, insurance will begin on the date the Employee returns to Active Employment.

If an Employee was eligible for group life insurance under a Prior Plan immediately prior to the effective date of this Policy, but did not elect insurance under such plan, the Employee may enroll for insurance under this Policy if the Employee is otherwise eligible and provides Us with Evidence of Good Health. Insurance will begin on the first day of the month which coincides with or follows the day We determine such evidence is acceptable, provided the Employee is Actively Employed on that date. If the Employee is not Actively Employed on that date, insurance will begin on the day the Employee returns to Active Employment.

Continuity of Coverage

If this Policy replaces a Prior Plan that contained a provision allowing for continuation of coverage due to Total Disability without payment of premium (the “Prior Plan’s Continuation Provision”), this Policy will provide life coverage, subject to all of the conditions below, for an Employee who:

- (a) was insured under the Prior Plan on the last day it was in effect;
- (b) is otherwise eligible under this Policy, but is not Actively Employed on this Policy’s effective date due to Injury or Sickness;
- (c) was eligible for continuation of coverage under the Prior Plan’s Continuation Provision, but has been denied continuation of coverage under the Prior Plan’s Continuation Provision after exhausting all reasonable attempts to apply for such continued coverage;
- (d) is not a retired Employee, unless this Policy provides coverage for retired Employees; and
- (e) is not Totally Disabled on this Policy’s effective date.

This Continuity of Coverage provision is subject to the following additional conditions:

- (a) coverage under this Policy will not exceed the Employee’s amount of coverage under the Prior Plan on the last day it was in effect;
- (b) the Policyholder must notify Us in writing prior to the effective date of this Policy of the Employee’s amount of coverage under the Prior Plan on the last day it was in effect;
- (c) coverage is subject to uninterrupted payment of premium to Us; and
- (d) coverage is subject to any reductions shown in the Schedule of this Certificate and all other terms and conditions of this Policy.

We reserve the right to request any information We need from the Policyholder to determine whether an Employee has satisfied the conditions necessary to be eligible for coverage under this Continuity of Coverage provision. If We do not receive such information or determine that the conditions necessary to be eligible for coverage under this Continuity of Coverage provision have not been satisfied, coverage will not be provided under this provision.

Employees who are not eligible for coverage under this Continuity of Coverage provision may be eligible to apply for conversion coverage under the Prior Plan and should contact the Policyholder for additional information.

Coverage under this Continuity of Coverage provision ends on the earliest of:

- (a) the date the Employee begins Active Employment for the Policyholder or full-time employment with any other employer;
- (b) the last day the Employee would have been covered under the Prior Plan, had the Prior Plan not terminated;
- (c) the date the Employee’s insurance under this Policy terminates for any reason shown under the When Employee Insurance Ends provision; or
- (d) the last day of the Policy month following a period of 12 consecutive months after the effective date of this Policy.

If an Employee is eligible for coverage under this Continuity of Coverage provision, the Employee will not be eligible for coverage under the Waiver of Premium Benefit provision shown in this Certificate.

Changes in the Amount of Your Insurance
Decrease in the Amount of Your Insurance

Regardless of whether or not You are Actively Employed at the time, any decrease in the amount of insurance will take effect on the day of the decrease.

The amount of insurance cannot be decreased to an amount less than any plan minimums shown in the Schedule of this Certificate. Any reductions due to age as shown in the Schedule in this Certificate will apply.

Increase in the Amount of Your Insurance

You cannot request an increase to the amount of Your insurance unless You are Actively Employed on the day You submit such request. We will use the Policyholder's payroll records and the premium We have received to determine the appropriate insurance amount.

Any increase in the amount of Your insurance will take effect on the later of the day:

- (a) of the change; or
- (b) the day We approve Your Evidence of Good Health, if required by Us.

If You are not Actively Employed on the day the increase in insurance would otherwise take effect, the increase will become effective the day You return to Active Employment.

Exceptions to Changes in the Amount of Your Insurance

Life Event

Within 30 days of a Life Event, You must submit a written request to Us to change Your amount of insurance. If Your request is submitted more than 30 days from the date of the Life Event, We will also require Evidence of Good Health.

Insurance may be issued up to the Guarantee Issue Limit without Evidence of Good Health. For any amount over the Guarantee Issue Limit, Evidence of Good Health is required. We will use the Policyholder's payroll records and premium We have received to determine the appropriate amount of insurance.

Any increased insurance amount will take effect on the date We approve Your written request, provided You are Actively Employed on the date the increase would take effect.

If You are not Actively Employed on the day the increase in insurance would otherwise take effect, the insurance will begin on the day You return to Active Employment.

Life Event means:

- (a) You become lawfully married or divorced;
- (b) You have a natural-born child, adopt a child or acquire a stepchild;
- (c) Your spouse's life insurance under another employer's group plan ends;

- (d) Your spouse's employment is terminated; or
- (e) Your lawful spouse dies.

Reinstatement of Employee Insurance

An Employee may be eligible to reinstate insurance that has ended. A written request for reinstatement must be submitted to Us. The reinstated insurance will take effect on the first day of the month that coincides with or follows the date We approve the Employee's written request, provided the Employee is Actively Employed on the date the increase would take effect.

The following reinstatement options are available and are each subject to the conditions described in the following paragraphs:

- (a) Non-Payment of Premium;
- (b) Involuntary Reduction in Hours; and
- (c) Rehired Employee.

Non-payment of Premium

If insurance ended due to non-payment of premiums, We will require Evidence of Good Health, acceptable to Us, to reinstate Your insurance.

Involuntary Reduction in Hours

If insurance ended because the Employee is no longer Actively Employed due to an involuntary reduction of hours worked, the Employee's insurance may be reinstated without satisfying another Eligibility Waiting Period if the Employee returns to Active Employment and there was no break in employment with the Policyholder after the date insurance ended.

We will require Evidence of Good Health if the amount of insurance being requested exceeds the amount of coverage in effect on the Employee's last day of Active Employment.

Rehired Employee

If insurance ended because the Employee is no longer Actively Employed due to termination of employment with the Policyholder, the Employee's insurance may be reinstated without satisfying another Eligibility Waiting Period if the Employee is rehired and becomes Actively Employed within 90 days from the date employment ended.

We will require Evidence of Good Health acceptable to Us if the amount of insurance being requested exceeds the amount of insurance in effect on the Employee's last day of Active Employment.

If employment terminated due to a military leave, the Employee is eligible to reinstate insurance up to the amount in effect on the last day of Active Employment upon return to Active Employment immediately after discharge from active duty, provided the Employee meets the eligibility requirements of the Policy.

If insurance has been elected and continued under the Portability provision while an Employee was not Actively Employed, the Employee is eligible to reinstate insurance up to the amount in effect on the last day of Active Employment. Any coverage provided under Portability will terminate upon reinstatement of insurance under this Policy.

When Employee Insurance Ends

Insurance will end on the earliest of the day:

- (a) the Policy terminates;
- (b) You are no longer Actively Employed;
- (c) You do not meet the conditions described in the Other Group Plan Requirement provision in this Certificate;
- (d) You do not satisfy any other eligibility conditions described in this Certificate;
- (e) any applicable premium contribution is due and unpaid; or
- (f) You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less).

Exceptions to When Employee Insurance Ends

If You are no longer Actively Employed, You may be eligible to continue insurance under one of the following continuation options. The conditions for each continuation option are described within each provision.

For life insurance:

- (a) Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence
- (b) Waiver of Premium Benefit
- (c) Portability

Temporary Layoff, Administrative Leave of Absence or any other Leave of Absence

You may be able to continue life insurance under this provision until the last day of the month following 60 days from the day in the event of a temporary layoff approved by the Policyholder.

You may be able to continue life insurance under this provision for 12 months from the day You are no longer Actively Employed in the event of a administrative leave of absence or any other leave of absence approved by the Policyholder.

Under this provision, insurance will continue subject to the following conditions:

- (a) We must continue to receive uninterrupted premium payment;
- (b) the temporary layoff or leave of absence is not due to Injury or Sickness;
- (c) We must receive written notification from the Policyholder within 30 days from the date You are no longer Actively Employed; and
- (d) the amount of insurance will not be increased while You are laid off.

Note: If You have any Injury or Sickness during a temporary layoff, insurance under this provision will not be extended past the last day of the month following 60 days from the day Your layoff began.

Note: If You have any Injury or Sickness during an approved administrative leave of absence, or any other approved leave of absence, insurance under this provision will not be extended past 12 months from the day Your leave of absence began.

Insurance under this provision will end on the earliest of the day:

- (a) the Policy terminates;
- (b) any applicable premium contribution is due and unpaid;
- (c) You elect to obtain insurance under the Conversion Privilege or the Portability provision;
- (d) before You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less); or
- (e) You return to Active Employment or begin employment with an employer other than the Policyholder.

If state law requires an employer to allow a leave of absence related to pregnancy, childbirth, or adoption, We will continue insurance during that leave period subject to the terms and conditions of this Policy. Contact Your employer to determine whether or not You are eligible for this type of leave.

Waiver of Premium Benefit

You may be able to continue life insurance under this provision without payment of premium if You become Totally Disabled while insured under the Policy prior to age 60. If You are over age 60 You may apply for an individual life insurance conversion policy according to the terms of the Conversion Privilege described in this Certificate.

Continuation of insurance under this Waiver of Premium Benefit provision is subject to the following conditions:

- (a) the amount of insurance will not be increased while You are Totally Disabled;
- (b) the amount of insurance will be reduced or terminated in accordance with the terms shown in the Schedule in this Certificate;
- (c) the Waiver of Premium Benefit Elimination Period must be satisfied; and
- (d) Proof of Total Disability must be provided to Us as described in the following paragraphs.

If You are eligible to continue insurance under this Waiver of Premium Benefit provision You will not be eligible for Portability.

Waiver of Premium Benefit Elimination Period

The Waiver of Premium Benefit Elimination Period is a period of 6 consecutive months of Total Disability beginning on the date You became Totally Disabled while insured under the Policy. Your insurance will continue during this time without premium payment as long as You remain Totally Disabled.

Proof of Total Disability

You must notify Us in writing of Total Disability within 3 months from the date You became Totally Disabled. Satisfactory proof of Total Disability must be submitted to Us before the end of the Waiver of Premium Benefit Elimination Period. We will notify You in writing if this proof is not acceptable. You will have 30 days from the date of Our denial in which to exercise the Conversion Privilege described in this Certificate.

If You are approved for continuation of coverage under this Waiver of Premium provision, We will periodically require proof of continuing Total Disability. This will be at Your expense. If at any time We determine You are no longer Totally Disabled We will notify You in writing and You will have 30 days from the date of Our denial in which to exercise the Conversion Privilege described in this Certificate.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense. We may have You examined any time during the first two years of Total Disability and once a year thereafter.

Death While Satisfying the Waiver of Premium Benefit Elimination Period

If You die during the Waiver of Premium Benefit Elimination Period, benefits will be paid to Your beneficiary if We receive satisfactory proof of Total Disability and We determine that You were Totally Disabled on the day before the date of death.

When the Waiver of Premium Benefit Ends

Your continued insurance under the Waiver of Premium Benefit provision will end on the earliest of:

- (a) the day You are no longer Totally Disabled;
- (b) 90 days after a proof of Total Disability form is sent to You, but has not been returned to Us;
- (c) the day You fail to be examined by a Physician of Our choice or do not cooperate with an exam in accordance with the Proof of Total Disability provision; or
- (d) the day You reach age 65.

You will have 30 days from the date insurance under the Waiver of Premium Benefit provision ends in which to exercise the Conversion Privilege described in the Policy. You will not be eligible to continue insurance under the Portability provision.

Portability

You may be able to obtain life insurance under this provision when insurance ends prior to age 70 due to any of the following reasons:

- (a) the Policy terminates and the Policyholder does not obtain similar group insurance from Us within 30 days;
- (b) employment with the Policyholder ends for reasons other than Your Injury, Sickness or Disability;
- (c) You are not Actively Employed;

- (d) You retire; or
- (e) You do not satisfy any other eligibility condition described in this Certificate.

Insurance under this Portability provision is available without providing Evidence of Good Health, subject to the following conditions:

- (a) You must submit a written request and the first premium within 30 days after insurance ends;
- (b) the amount of insurance may not exceed the lesser of:
 - (1) the amount in effect on Your last day of Active Employment; or
 - (2) \$500,000; and
- (c) the amount of insurance under this Portability provision may not be increased.

If You are eligible and elect insurance under this Portability provision, You will not be eligible to continue insurance under the Waiver of Premium Benefit provision or Conversion Privilege provision in this Certificate.

Premium Rates for Portability

Premium rates will change as You enter a higher age category. Other than for this reason, rates will not be changed on an individual basis. Premium rates may be changed for all persons who have elected Portability coverage from Us. In the event of a change in premium rates, We will provide written notification 30 days prior to the date of the change.

For assistance in determining the amount of premium due contact the Policyholder.

When Portability Ends

Insurance under this Portability provision will end on the earliest of the day:

- (a) You reach 70 years of age;
- (b) any applicable premium contribution is due and unpaid;
- (c) You return to Active Employment for the Policyholder and Your insurance under the Policyholder's group plan is reinstated;
- (d) before You enter the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary active duty of twelve weeks or less).

Continuation of Insurance Under Family and Medical Leave

The federal Family Medical Leave Act of 1993 (FMLA) and any amendments thereto as well as certain state statutes provide continuation of coverage in certain instances for leaves of absence.

You may be eligible for continued coverage under FMLA and/or any state family medical leave laws. You should check with Your employer for additional information regarding the continued coverage that may be available to You.

Any continued coverage for family medical leave will not exceed the continued coverage provided by FMLA and/or state required family medical leave.

Any family medical leave continuation is subject to all terms and conditions of the Policy, including, without limitation, payment of premium and eligibility. Any continued coverage will end in accordance with the When Employee Insurance Ends provision in Your Certificate.

DEPENDENT ELIGIBILITY

Life Insurance Benefits

Definitions

Terms defined in this provision may be used in, or apply to, other provisions throughout this Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Certificate means this Certificate of Insurance form and all Riders to this certificate.

Dependent means a citizen, permanent resident, or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

- (a) Your lawful spouse or domestic partner;
- (b) Your natural born or legally adopted child;
- (c) Your stepchild living in Your home; or
- (d) any other child who lives with the Employee in a regular parent-child relationship and for whom You claimed as a Dependent on Your last filed federal income tax return.

A dependent does not include:

- (a) anyone insured under this Policy as an Employee;
- (b) anyone who is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country (except temporary active duty of two weeks or less);
- (c) a child who has attained the Limiting Age defined in this Certificate;
- (d) anyone who is not a citizen, permanent resident, or lawful resident of the United States;
- (e) Your divorced or legally separated spouse;
- (f) Your married child(ren);
- (g) Your child if the child has been legally adopted by another person; or
- (h) a child:
 - (1) temporarily living in Your home;
 - (2) placed in Your home by a social service agency which retains control over the child; or
 - (3) who has a natural parent in a position to exercise parental responsibility and control.

Evidence of Good Health means proof, acceptable to Us, of the Dependent's good health. Unless otherwise stated in the Policy, such evidence is required when:

- (a) You apply for Dependent coverage after the 30-day limit described within the When Dependent Insurance Begins provision;
- (b) You apply for Dependent coverage in excess of the Guarantee Issue Limit;

- (c) the Dependent was eligible for insurance under a Prior Plan but did not elect such insurance; or
- (d) the Dependent was insured under a Prior Plan but You applied for Dependent coverage under this Policy in excess of the amount insured for under the Prior Plan.

Full-Time Student means an insured Dependent child who is attending an accredited high school, trade school, college, university or other institution of learning and is enrolled for a minimum of 12 course credit hours per semester as indicated by evidence acceptable to Us. If the accredited institution of learning establishes full-time status in any other manner, We reserve the right to determine whether the student is an eligible Dependent.

Guarantee Issue Limit means the maximum amount of insurance We may issue for Your Dependent without requiring Evidence of Good Health. The guarantee issue limit is shown in the Schedule in this Certificate.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated with respect to a Dependent child, means that Dependent child is continuously

- (a) incapable of self-sustaining employment by reason of mental retardation, developmental disability, mental illness, or physical handicap; and
- (b) primarily dependent upon You for financial support and maintenance.

Limiting Age means a child's 19th birthday or 25th birthday if the child is a Full-Time Student.

Policy means the policy issued to the Policyholder by Us, including this Certificate.

Prior Plan means any plan of group life insurance that has been replaced by insurance under part or all of this Policy. The prior plan must have been in effect and sponsored by the Policyholder on the day before the effective date of this Policy.

Rider means a document that is added to and made a part of the Policy. A rider amends, limits, restricts, or otherwise changes the provisions of the Policy.

When a Dependent Becomes Eligible

When both You and Your lawful spouse are eligible for insurance under this Policy as an Employee, You may each enroll either as an Employee or the Dependent of an Employee, but not both.

When both You and Your lawful spouse are eligible for insurance under this Policy as an Employee, only one of You may insure Your child or children under this Policy.

A Dependent who is neither confined nor disabled as described in the following paragraphs or, regardless of confinement, is:

- (a) born while You are insured under this Policy; or

- (b) insured under a Prior Plan on the day immediately preceding the effective date of this Policy provided the amount of insurance does not exceed the amount the Dependent was insured for under the Prior Plan;

becomes eligible for insurance on the later of the day You are eligible or the day You acquire the Dependent.

When Dependent Insurance Begins

When You and the Policyholder share in the cost of Dependent insurance or, when You pay 100% of the cost of Dependent insurance, You may request Dependent insurance by properly completing and signing an enrollment form acceptable to Us and submitting the form to the Policyholder (who will then submit the form to Us) within 30 days following the day the Dependent becomes eligible.

Insurance for a Dependent, other than a child born while You are insured under this Policy, who is confined:

- (a) in a Hospital as an inpatient;
- (b) in any institution or facility other than a Hospital; or
- (c) at home and currently under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until such confinement ends or is no longer medically necessary as determined by Us or an independent medical review arranged by Us. Insurance for a Dependent born while You are insured under this Policy will take effect from birth.

Insurance for a Dependent who is physically or mentally disabled to the extent such Dependent is unable to perform all of the usual and customary duties and activities of a person who is the same age and sex who is in good health or is not able to engage in any work or occupation for wage or profit will not take effect until the Dependent is able to fully resume all usual and customary duties and activities or is able to work for wage or profit.

An eligible Dependent will be insured on the latest of the day

- (a) You become insured;
- (b) You acquire the eligible Dependent; or
- (c) You properly complete and sign an enrollment form acceptable to Us for Dependent insurance and submit it as described above.

If We do not receive Your request to insure Your Dependents within 30 days from the day the Dependent is eligible for insurance, We will require Evidence of Good Health for Your Dependent. If such evidence is acceptable to Us, Your Dependent will become insured on the date We approve the Dependent's Evidence of Good Health.

In order to insure an eligible Dependent child, You must insure all eligible Dependent children. You must also apply for the same amount of insurance for each eligible Dependent child. We do not require You to insure both Your spouse and children.

During the first enrollment period, if a Dependent was eligible for group life coverage under a Prior Plan immediately prior to the effective date of this Policy but did not elect insurance under such plan, You may enroll the Dependent under this Policy if the Dependent is otherwise eligible, subject to Evidence of Good Health acceptable to Us. Insurance will begin on the first day of the month which coincides with or follows the day We determine such evidence is acceptable.

Changes in the Amount of Your Dependent's Insurance

Decrease in the Amount of Your Dependent's Insurance

Any decrease in the amount of Dependent insurance will take effect on the day of the decrease.

The amount of Dependent insurance cannot be decreased to an amount less than any plan minimums shown in the Schedule of this Certificate. Any reductions due to age as shown in the Schedule of the Policy will apply to Spouse coverage.

Increase in the Amount of Your Dependent's Insurance

Any increase in the amount of Dependent insurance will take effect the day of the change, if We do not require Evidence of Good Health. If Evidence of Good Health is required, any increase in the amount of Dependent insurance will take effect the day We approve Evidence of Good Health, if required.

Exceptions to When the Amount of Dependent Insurance Changes

Life Event

Within 30 days of a Life Event, You must submit a written request to Us to change the amount of Dependent insurance. Insurance may be issued up to the Guarantee Issue Limit without Evidence of Good Health. For any amount over the Guarantee Issue Limit, Evidence of Good Health is required. We will use the Policyholder's payroll records and premium We have received to determine the appropriate amount of insurance. We will also require Evidence of Good Health if You do not submit Your written request within 30 days after the Life Event.

If You make a written request to begin Dependent insurance under the Policy within 30 days after a Life Event, insurance for Your Dependent will begin on the first day of the month that coincides with or follows the day We receive Your written request, provided You are Actively Employed on that date and subject to the When Dependent Insurance Begins provision of this Certificate.

If Your written request for Dependent insurance is received more than 30 days after a Life Event, We will require Evidence of Good Health be submitted for the Dependent and if such evidence is acceptable to Us, the Dependent will become insured on the date We approve the Dependent's Evidence of Good Health.

If You make a written request to end Dependent insurance under the Policy within 30 days after a Life Event, Dependent insurance will end in accordance with the When Insurance for a Dependent Child Ends and When Insurance for a Dependent Spouse Ends provisions of this Certificate.

Life Event means:

- (a) You become lawfully married or divorced;
- (b) You have a natural-born child, adopt a child, or acquire a stepchild;
- (c) Your lawful spouse's life insurance under a group plan sponsored by an employer other than the Policyholder ends because the spouse's employment is terminated; or
- (d) Your lawful spouse dies.

Reinstatement of Dependent Insurance

To reinstate insurance for a Dependent after insurance has ended, You must submit to Us a written request for reinstatement along with Evidence of Good Health for the Dependent. If such evidence is acceptable to Us, the reinstated insurance will take effect on the first day of the month that coincides with or follows the date We approve the request for reinstatement.

When Insurance for a Dependent Child Ends

Insurance for a Dependent child will end on the earliest of the:

- (a) day this Policy terminates;
- (b) day any premium contribution for Dependent child insurance is due and unpaid;
- (c) day a Dependent child enters active duty or training in the Armed Forces, National Guard or Reserves of any state or country (except temporary active duty of two weeks or less);
- (d) day Your insurance ends;
- (e) day the Dependent child is no longer eligible; or
- (f) day Your insurance is continued without payment of premium under the Waiver of Premium Benefit provision in the Employee Eligibility section of this Certificate.

Exceptions to When Dependent Insurance Ends

Incapacitated Child

Insurance for a child who is mentally or physically Incapacitated on the day the child attains the Limiting Age may be continued if the child:

- (a) is insured under this Policy or a Prior Plan immediately prior to reaching the Limiting Age; and
- (b) became incapacitated prior to attaining the Limiting Age under this Policy or a similar provision in a Prior Plan;

as indicated by evidence acceptable and received by Us within 30 days after the child attains the Limiting Age; and thereafter as We may require, but not more than once every two years. Insurance under this provision will end in accordance with the When Insurance for a Dependent Child Ends provision, without application of the Limiting Age requirement.

When Insurance for a Dependent Spouse Ends

Insurance for a Dependent spouse will end on the earliest of the:

- (a) day this Policy terminates;
- (b) day any premium contribution for Dependent spouse insurance is due and unpaid;
- (c) day a Dependent spouse enters active duty or training in the Armed Forces, National Guard or Reserves of any state or country (except temporary active duty of two weeks or less);
- (d) day Your insurance ends;
- (e) day the Dependent spouse is no longer eligible; or
- (f) day Your insurance is continued without payment of premium under the Waiver of Premium Benefit provision in the Employee Eligibility section of this Certificate.

Portability

When You elect life insurance under the Portability provision in this Certificate, You may also elect to continue life insurance for Your Dependents.

In addition, when Your insured spouse is no longer eligible under this Policy due to, without limitation, divorce or Your death he or she may elect coverage under this Portability provision for such spouse and his or her eligible Dependents.

Benefits for a child insured under this Policy may be provided under this Portability provision by only one parent, but not both.

Dependent insurance under this Portability provision may be obtained without providing Evidence of Good Health for Your Dependents subject to the following conditions:

- (a) Your insured spouse is less than age 70;
- (b) You must submit a written request and the first premium to Us within 30 days after the Dependent insurance ends;
- (c) the amount of insurance may not exceed the lesser of:
 - (1) the amount in effect on the day Dependent insurance ends; or
 - (2) \$250,000; and
- (d) the amount of Dependent insurance under this Portability provision cannot be increased.

If You elect insurance for Your eligible Dependent under this Portability provision, Your Dependents will not be eligible to obtain insurance under the Conversion Privilege provision in this Certificate.

Premium Rates for Portability

Premium rates will change as a spouse enters a higher age category. Premium rates do not change based on the age of a child insured under this Portability provision. Other than for this reason, rates will not be changed on an individual basis. Premium rates may be changed for all persons who have elected portability insurance from Us. In the event of a change in premium rates, We will provide written notification 30 days prior to the date of the change.

For assistance in determining the amount of premium due contact the Policyholder.

When Portability Ends

A Dependent's insurance under this Portability provision will end on the earliest of the day:

- (a) Your lawful spouse becomes 70 years of age;
- (b) Your child reaches the Limiting Age or is no longer Incapacitated;
- (c) Your child marries;
- (d) Your Dependent enters active duty or training in the Armed Forces, National Guard or Reserves of any state or country (except temporary active duty of two weeks or less); or
- (e) any premium contribution for Dependent insurance is due and unpaid.

DOMESTIC PARTNERS ELIGIBILITY RIDER

This Rider is made a part of Group Policy GVTL-ADY1.

This Rider is effective January 1, 2010.

If provisions of this Rider and those of the Policy or Your certificate do not agree, the provisions of this Rider will apply.

This DOMESTIC PARTNERS ELIGIBILITY provision is subject to all applicable terms and conditions of the Policy relating to dependent eligibility.

The provision in the Policy describing persons who are eligible dependents for insurance is amended to include the following:

Your same sex or opposite sex domestic partner if:

- (1) You submit to the plan administrator a written declaration of domestic partnership signed by You and Your partner in a form acceptable to Us. This written declaration of domestic partnership must truthfully declare that all of the requirements described in the Domestic Partnership Requirements provision below have been met; or
- (2) You submit to the plan administrator evidence acceptable to Us that all applicable requirements of the state, city and/or county in which You reside regarding the establishment of domestic partnership have been met.

For the purposes of eligibility, any dependent child of Your domestic partner will be treated the same as any other eligible dependent child.

Domestic Partnership Requirements

All of the following requirements must be met in order for Your domestic partner to be eligible for coverage under the Policy:

- (a) Each partner is the other's sole domestic partner and intends to remain so indefinitely. The partners have an exclusive mutual commitment similar to that of marriage;
- (b) Each partner must be of the minimum age at which a person may be legally married in the state in which the partners share the same permanent address;
- (c) The partners cannot be related by blood to a degree that would prohibit marriage;
- (d) The partners cannot be legally married to anyone else or in a domestic partnership with another individual;
- (e) The partners share the same permanent address;
- (f) The partners share joint financial responsibility for basic living expenses, including food, shelter and insurance expenses;

- (g) The partners are financially interdependent, which must be demonstrated by at least 2 of the following:
- (1) Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;
 - (2) Joint ownership of a residence; or evidence of a joint mortgage or lease;
 - (3) Evidence of common household expenses, e.g. utility, phone;
 - (4) Execution of wills naming each other as executor and/or beneficiary;
 - (5) Granting each other durable powers of attorney;
 - (6) Designation of each other as beneficiary under a retirement benefit account; or
 - (7) Evidence of other joint financial responsibility acceptable to Us and;
- (h) The partners have not had a previous domestic partner covered within the last 6 months unless the previous domestic partnership was terminated due to the death of a partner.

When Domestic Partners Coverage Begins

Coverage for Your domestic partner will begin in accordance with the dependent eligibility provisions of the Policy.

Change In Coverage For Domestic Partners

Any change in coverage for Your domestic partner will take effect in accordance with the dependent eligibility provisions of the Policy.

When Domestic Partners Coverage Ends

Coverage for Your domestic partner will end on the earliest of:

- (a) the date a statement of termination of domestic partnership signed by You and acceptable to Us is submitted to Your plan administrator;
- (b) the day You and Your domestic partner fail to meet any of the requirements described in the Domestic Partnership Requirements provision; or
- (c) the day insurance would otherwise end for a dependent in accordance with the dependents eligibility provision of the Policy.

Other Termination of Coverage Information

In the event a domestic partnership is terminated for reasons other than death of a domestic partner, You cannot re-enroll for domestic partnership coverage under the Policy for a period of 6 months following termination of the domestic partnership.

In addition, if coverage for Your domestic partner ends in accordance with the When Domestic Partners Coverage Ends provision, any coverage for a child of Your domestic partner will also end unless such child is otherwise eligible for coverage under the Policy as Your dependent.

In the event coverage for Your domestic partner ends in accordance with the When Domestic Partners Coverage Ends provision, such person and his or her children will be eligible for continuation of coverage under any provision in the Policy providing for continuation of coverage.

Notification of Termination

You must immediately notify Your plan administrator of any event that results in termination of coverage as described in sections (b) and (c) under the When Domestic Partners Coverage Ends provision. In addition, if Your domestic partnership terminates, You must submit to Your plan administrator a signed statement of termination of domestic partnership. You may obtain this form from Your plan administrator. You must also satisfy any applicable requirements of the state, city and/or county in which You reside regarding termination of domestic partnership.

Reference of Domestic Partner as “spouse”

Unless prohibited by law or otherwise not applicable under the terms of the Policy, all references to “spouse” in the Policy, Your certificate, Rider(s) or Our communication materials to You shall include Your same sex or opposite sex domestic partner.

LIFE INSURANCE BENEFITS

For You

Benefits

If You die while insured under this provision, We will pay the **Amount of Life Insurance** shown on the **Certificate Validation Form**. Benefits will be paid to the beneficiary You name. If You do not name a beneficiary or if no beneficiary survives You, benefits will be paid:

- (a) to Your surviving spouse; if none, then
- (b) to Your surviving natural and/or adopted children; if none, then
- (c) to Your surviving parent(s); if none, then
- (d) to Your estate.

Benefits will be paid equally among surviving children or surviving parents.

Mode of Payment

We will pay benefits in a lump sum.

Beneficiary or Mode of Payment Change

The beneficiary and mode of payment may be changed, subject to any restrictions or limitations in this Policy. To make a change, written request should be sent to the office where the beneficiary records are kept. If You do not know where the records are kept, send the request to us. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by us before the request was acknowledged.

Facility of Payment

We may pay up to the Facility of Payment Amount to any person who has incurred expenses for Your fatal illness or burial. The **Facility of Payment Amount** is shown in the **SCHEDULE**.

Conversion Privilege

If any of Your life insurance ends because Your employment or membership in a class ends, You may apply for an individual policy of life insurance (called a conversion policy) without giving information about Your health. Issuance of a conversion policy is subject to the following conditions:

- (a) You may apply for any of our individual life insurance policies except term insurance. You may not apply for any supplemental coverage.
- (b) You may apply for an amount which is not more than the amount of Your terminated group life insurance.

- (c) The premium for Your conversion policy will be at our standard rate for that type of policy according to:
 - (1) Your class of risk; and
 - (2) Your age on the date the policy takes effect.
- (d) You must submit Your written application and Your first conversion premium to Us within 30 days after Your group life insurance ends or reduces.

If Your group life insurance ends because of termination of the Policy or termination of a class, and You have been insured under the Policy at least five years, You may apply within 30 days for a conversion policy. Issuance of the conversion policy is subject to conditions (a), (c) and (d) above. Your converted life insurance may not exceed the lesser of:

- (a) \$2,000; or
- (b) the amount of Your terminated group life insurance less the amount of any other group life insurance for which You become eligible within 30 days.

If You die within the 31-day period after insurance ends, We will pay the amount of group life insurance You were entitled to convert.

If We issue a conversion policy and You again become eligible for group life insurance under the Policy, coverage will become effective only if:

- (a) You terminate the conversion policy; or
- (b) You submit, at Your own expense, evidence of good health acceptable to Us.

LIFE INSURANCE BENEFITS

For You - LIVING BENEFITS OPTION (ACCELERATED BENEFITS)

THIS PROVISION ACCELERATES AND REDUCES THE DEATH BENEFIT. IT IS NOT INTENDED TO BE USED AS LONG TERM CARE INSURANCE.

Definition

Terminal Condition means an Injury or Sickness:

- (a) expected to result in Your death within 12 months; and
- (b) from which there is no reasonable prospect of recovery;

as determined by Us.

Benefits

If You incur a Terminal Condition while insured under this provision, You or Your legal representative, while You are living, may request Living Benefits. The **Amount of Living Benefits** is shown in the **Schedule**, and will be payable provided You are living at the time payment is made. Benefits will be paid in one lump sum.

Conditions

1. To be insured for Living Benefits, You must be insured for group life insurance under this Policy.
2. We may require the beneficiary's written consent. Before Living Benefits are paid in community property states, Your spouse's written consent may be required.
3. The amount of Your group life insurance and the amount You may convert in accordance with the life **Conversion Privilege** provision will be reduced by the Living Benefit amount paid under this provision.
4. An Insured Person may receive Living Benefits only once.
5. Premium payments must continue to be paid on the full amount of group life insurance, unless You qualify for waiver of premium, in accordance with the **Continuation of Life Insurance Benefits Due to Total Disability** provision.

Exceptions

This **Living Benefits** provision will not apply:

- (a) when You have irrevocably assigned group life insurance under this Policy;
- (b) when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a divorce agreement;
- (c) to any intentionally self-inflicted Injury, Sickness or suicide attempt;
- (d) if Your life insurance benefits end;

(e) if the required premium is due and unpaid; or

(f) if the Master Policy terminates.

NOTE: Benefits paid under this provision may be taxable. If so, You may incur a tax obligation. As with all tax matters, You should consult a personal tax advisor to assess the impact of this benefit.

Benefit payments may affect qualifications for government entitlement programs.

LIFE INSURANCE BENEFITS

For Your Dependents

Benefits

If a dependent dies while insured under this provision, we will pay the **Amount of Life Insurance** shown on the **Certificate Validation Form**. Benefits will be payable to you, if you are living. If you are not living, the following will apply.

1. If your spouse dies, benefits will be paid to your spouse's estate.
2. If a child dies, benefits will be paid to your spouse, if your spouse is living. If your spouse is not living, benefits will be paid in equal shares to the child's surviving brothers and sisters. If none survive, benefits will be paid to the estate of the deceased child.

Facility of Payment

Any benefits payable to a minor in accord with the above paragraph may be paid to the legally appointed guardian of the minor. If there is no legally appointed guardian, payment may be made up to \$50.00 a month to the adult or adults who, in our opinion, have assumed custody and principal support of the minor.

Conversion Privilege

If your dependent's Life Insurance ends:

- (a) because of your death;
- (b) under circumstances where you have the right of conversion; or
- (c) because your life insurance is being continued under the **Continuance of Life Insurance If You Become Totally Disabled** provision (if provided in this policy);

your dependent may apply for an individual policy of life insurance (called a conversion policy) without giving health information.

Issuance of a conversion policy to your dependent is subject to the following.

1. Your dependent may apply for any of our individual life insurance policies except term insurance. Your dependent may not apply for supplemental coverage.
2. Your dependent may apply for an amount which is not more than the amount of terminated life insurance.
3. The premium for the conversion policy will be at our standard rate for that type of policy, according to:
 - (a) your dependent's class of risk; and
 - (b) your dependent's age on the date the conversion policy takes effect.

4. Your dependent must submit a written application and the first conversion premium to us within 30 days after his or her life insurance ends.

If we issue your dependent a conversion policy and your dependent again becomes eligible for group life insurance under the policy, coverage will become effective only if:

- (a) your dependent terminates the conversion policy; or
- (b) your dependent submits at his or her own expense, evidence of good health acceptable to us.

Extended Insurance

If a dependent dies within 30 days from the day dependents life insurance is terminated, we will still pay benefits. Upon receipt of proof within one year after death, we will pay the amount for which the dependent was last insured.

If a conversion policy has been issued to the deceased dependent, we will pay benefits under this **Extended Insurance** provision only if the conversion policy is returned to us without claim. We will refund all paid conversion premiums if the conversion policy is surrendered for this reason.

AMENDMENT RIDER

This rider is made a part of Group Policy GVTL-ADY1.

This rider is effective the later of January 1, 2010, or the day You become insured under the Policy.

If the provisions of this rider and those of the policy or your certificate do not agree, the provisions of this rider will apply.

The LIFE INSURANCE BENEFITS provisions For You and For Your Dependents are amended to include the following:

Exception

We will not pay benefits for a death which results from suicide, while sane or insane within two years from the date insurance begins. Instead we will pay the sum of the premiums paid.

If death results from suicide, while sane or insane, within two years from the effective date of any increase in the amount of coverage, the amount of the increase will not be paid. Instead we will pay the total of the premiums paid on the increase.

PAYMENT OF CLAIMS

How to File Claims

Before benefits are paid, We must be given a written proof of loss, as described below. Upon Your death, Your beneficiary or someone else must give Us the proof.

Proof of Loss Requirements

1. First, a claim form is to be requested from the Plan Administrator or from Us.

This request should be made:

- (a) within 20 days after a loss occurs; or
- (b) as soon as reasonably possible.

When We receive the request, We will send a claim form for filing proof of loss. If We do not send the form within 15 days, the proof of loss requirement can be met by giving Us a written statement of what happened. We must receive a written statement within the time shown in 3 below.

1. Next, the claim form must be completed and signed.
2. The claim form or written statement should be sent to Us or to the Plan Administrator within 90 days after the loss occurs; or as soon as reasonably possible.

When Claims are Paid

Policy benefits will be paid in accord with the Life Insurance Benefits provision as soon as We receive acceptable proof of loss.

If we do not pay benefits within 30 days after acceptable proof of loss is received, We will pay interest on any Life Insurance Benefit from the date of death to the date the claim is paid. Interest shall be the greater of 6% or the rate applicable to death proceeds left on deposit with Us.

Authority to Interpret Policy

The Policyholder has delegated to Us the discretion to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Benefits under the Policy will be paid only if We decide, after exercising Our discretion, that the Insured Person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third parties.

The Insured Person has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person's claim for benefits is denied or ignored, in whole or in part, the Insured Person may file suit and a court will review the Insured Person's eligibility or entitlement to benefits under the Policy.

LIFE CLAIM REVIEW PROCEDURES

As Federally Mandated

DEFINITIONS

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of the Insured Person’s eligibility to participate in a plan.

A document, record, or other information will be considered “**Relevant**” to a claim if it:

- (a) was relied upon in making the claim decision;
- (b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
- (c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

INITIAL CLAIM DECISION

Initial Claim Decision. We will make a claim decision regarding a life claim within 90 days after Our receipt of the claim.

Extensions. The initial 90 day period may be extended for up to 90 days, if We (1) determine that special circumstances require an extension of time for processing the claim and (2) notify the claimant, prior to the expiration of the initial 90 day period, of the special circumstances requiring the extension and the date by which We expect to render a decision.

Time Periods. The period of time within which a claim decision is required to be made will begin at the time a claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing.

NOTICE OF ADVERSE BENEFIT DETERMINATION

We will provide the claimant with written or electronic notice of any Adverse Benefit Determination within 90 days after Our receipt of the claim, subject to the extension described above. The notice will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) a description of any additional material or information necessary to complete the claim and the reason We need the material or information; and

- (d) a description of the Policy’s appeal procedures, including the time limits for such procedures and the right of the person submitting the claim to bring a civil action under the Employee Retirement Income Security Act (“ERISA”) following the appeal process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The claimant must appeal within 60 days following receipt of notification of an Adverse Benefit Determination.

The request for an appeal should include:

- (a) The Insured Person’s name;
- (b) the name of the person filing the appeal if different from the Insured Person;
- (c) the Policy number; and
- (d) the nature of the appeal.

The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.

The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claim.

Our review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim decision.

APPEAL DECISION

Notice of Appeal Decision. We will notify the claimant of Our appeal decision within 60 days after receipt of a timely appeal request, unless We determine that special circumstances require an extension of time for processing the appeal. We will provide the claimant with written or electronic notice of Our appeal decision. Notice of an Adverse Benefit Determination will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) 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 claim; and
- (d) a statement of the right of the claimant to bring a civil action under ERISA.

Notice of Extension. If We determine that an extension is required, We will notify the claimant in writing of the extension prior to the termination of the initial 60 day period. In no event will the extension exceed 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

Time Periods. The period of time within which an appeal decision is required to be made will begin at the time an appeal is timely filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent to the claimant until the earlier of (1) the date on which We receive the claimant's response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the Policy;
- (b) the Policyholder's application attached to the Policy; and
- (c) any application for You or Your dependents.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

- (a) does not require the consent of any Insured Person or beneficiary; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of Our officers.

A change may affect any class of Insured Persons, including retirees if retired coverage is included in the Policy.

Applications

We may use misstatements or omissions in the application of an Insured Person to contest the validity of insurance, reduce coverage or deny a claim, but We must first furnish You or Your beneficiary with a copy of that application. We will not use a person's application to contest or reduce insurance which has been in force for two years or more during that person's lifetime. However, if You or Your dependent are not eligible for insurance, there is no time limit on Our right to contest insurance or deny a claim.

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

VERMONT MANDATORY CIVIL UNION ENDORSEMENT

This Rider is made a part of Group Policy GVTL-ADY1.

This Rider is effective the later of January 1, 2010, or the day You become insured under the Policy.

In the event of a conflict between this Rider and any other provision of the Policy, including the Certificate, this Rider shall control. This Rider shall be subject to all provisions of the Policy, including the Certificate, not in conflict with this Rider.

PURPOSE

This endorsement is part of the policy, contract, certificate and/or riders and endorsements to which it is attached and is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS

The definitions, terms, conditions or any other provisions of the policy, contract, certificate 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” and any other such terms include the relationship created by a civil union.

Terms that mean or refer to a family relationship arising from a marriage such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include the family relationship created by a civil union.

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.

“Dependent” means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

“Child or covered child” means a child (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

CAUTIONARY DISCLOSURE

THIS ENDORSEMENT IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE “PURPOSE” PARAGRAPH ABOVE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS ENDORSEMENT. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

DEFINITIONS

Terms defined in this provision are used in, or apply to other provisions throughout the Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions.

Insured Person means You and/or Your dependents who are insured under the Policy.

Injury means an accidental bodily injury which requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Physician means any of the following licensed practitioners:

- (a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- (b) a licensed doctoral clinical psychologist;
- (c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
- (d) a licensed physician's assistant (PA); or
- (e) where required to cover by law, any other licensed practitioner who is acting within the scope of his/her license.

A physician does not include a person who lives with You or is part of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse).

Our, We, Us means the Company shown on Your Certificate of Insurance.

Rider means a provision added to the Policy or Your certificate to expand or limit benefits or coverage.

Sickness means a disease, disorder or condition, which requires treatment by a Physician.

Total Disability, Totally Disabled or Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

You, Your means an employee or member who is insured under the Policy.

Group Policy Number GVTL-ADY1



Mutual of Omaha

Publication Date: July 2, 2010

**YOUR GROUP
VOLUNTARY ACCIDENTAL DEATH
AND DISMEMBERMENT
BENEFITS**

The President and Fellows of Middlebury College

Effective January 1, 2010



Eligibility: All active full-time and part-time employees, on U.S. payroll, and their eligible dependents. Staff employees must work at least 1,000 hours per year. Faculty employees must be teaching at least .5 FTE's (full time equivalents) or more per year. Faculty employees who are appointed to an administrative assignment and are actively working for the Policyholder at least .5 FTE's (full time equivalents) or more per year.

Coverage can remain in force for all individuals on Policyholder approved medical or personal leaves of absence, up to one year, provided the appropriate premiums are paid. Coverage can remain in force for all individuals on Policyholder approved sabbatical, up to one year, provided the appropriate premiums are paid.

Employee means a citizen or permanent resident of the United States, or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

Dependents of enrolled Employees may also be insured, provided the requirements for eligibility are met, Spouse or Children coverage is applied for, and the proper premium paid.

No eligible person may be covered more than once under this Policy. If they are covered as an Employee, they cannot also be covered as a dependent of another Employee.

Effective Date of Individual Insurance:

Each eligible person becomes an Insured Person on the later of:

- (a) Policy effective date; or
- (b) the first day of the month following the date the eligible Employee's completed enrollment form and payroll deduction authorization are received by the Accountholder.

SCHEDULE

Accountholder: The President and Fellows of Middlebury College
Middlebury College
Middlebury, VT 05753
T66BA-P-51817

Certificateholder (Insured): As Specified on the Enrollment Form on File

Certificate Number: As Specified on the Enrollment Form on File

Certificate Date: January 1, 2010 or As Specified on the Enrollment Form on File, whichever is later.

Amounts of Insurance: The eligible person may select the Principal Sum for which they are to be insured.

Employee: Minimum \$10,000.00 to \$500,000.00 Maximum in \$10,000.00 increments (rounded to the next highest \$10,000.00). Principal Sum maximum amount is subject to 5 times annual stated salary.

Spouse: 100% of Employee's Principal Sum amount in \$5,000.00 increments (rounded to the next highest \$5,000.00).

Child(ren): 100% of Employee's Principal Sum amount to \$10,000.00 maximum in \$1,000.00 increments (rounded to the next highest \$1,000.00).

The Principal Sum Amount each Insured selects shall be the amount specified on the enrollment form on file with the Accountholder.

Principal Sum Benefits for any Insured age 70 and over shall be payable in accordance with the following schedule:

Age 70 through 74	65% of the original Principal Sum Benefit Amount
Age 75 and over	50% of the original Principal Sum Benefit Amount

Premiums: The monthly premium for each \$1,000 unit of Principal Sum shall be:

	<u>Effective 01/01/2010</u>	<u>Effective 01/01/2011</u>	<u>Effective 01/01/2012</u>
Employee	\$0.01	\$0.0175	\$0.025
Spouse	\$0.0117	\$0.0184	\$0.025
Child(ren)	\$0.04	\$0.04	\$0.04

Rider(s), if any

Seat Belt Usage Benefits
Benefit Amount
Maximum Benefit Amount

Air Bag Benefits
Benefit Amount
Maximum Benefit Amount

Education Benefits Rider
Dependent Child Benefit
Maximum Benefit
Beneficiary Benefit

Premium Waiver
Benefit Period

Benefit Amount(s), if any

Rider 8472M
10% of Insured's Principal Sum
\$25,000.00

Rider 0KM0M Rev.
5% of Insured's Principal Sum
\$5,000.00

Rider 6801M
6% of the Insured's Principal Sum
\$6,000.00 Annually per Child
\$1,000.00

Rider 0605M
12 Months

The following riders are attached to and made a part of this certificate:

Exposure and Disappearance Amendment Rider	3888M
Air Travel Coverage Amendment Rider	6798M
Conversion Privilege Rider	6806M
Beneficiary Designation Amendment Rider	9008M
Domestic Partners Eligibility Rider	0GT8M
Dependent Amendment Rider	0AH0M
Claim Review & Appeal Procedure	0KW5M
Certificate Adjustment Rider	1694M-NN

- Amend "Notice of Claim" section of Claims Provisions
- Amend Education Benefits Rider 6801M

110209:bd



This certificate is issued to the Insured (called "you" or "your") named in the attached Schedule under a Group Master Policy (called the policy) issued by Mutual of Omaha (called "we," "us" or "our") to the Policyholder. The Policyholder is named in the Schedule.

Your application and premium put this certificate in force as of the Certificate Date. That date is shown in the Schedule.

PLEASE READ

Please read your certificate. If you are not satisfied, send it back within 15 days after you receive it. Any premium you paid will be refunded. That will mean coverage was never in force.

RENEWAL AGREEMENT

As long as the policy remains in force and you remain eligible, we will renew your certificate upon receipt of the premium. The premium must be paid on or before the date it is due or during the 31-day grace period that follows. This certificate stays in force during the grace period.

PREMIUM CHANGE

Other than for a change in coverage, your premium cannot be changed unless the same change is made on all certificates of the same Form issued to persons of the same class. We will give you at least 30 days' advance written notice.

DEFINITIONS

"Dependent" means a person eligible and insured in accord with the Family Member Provisions. Only those for whom a Principal Sum is shown in the Schedule will be insured, even though this certificate refers to others.

"Injuries" means accidental bodily injuries received while insured under this certificate. They must result in covered loss independently of sickness and other causes.

"Principal Sum" means a benefit amount payable for certain covered losses. The Principal Sum applicable to you or a dependent is shown in the Schedule.

EXCEPTIONS AND LIMITATIONS

This certificate does not cover:

- (a) suicide or any attempt thereat while sane;
- (b) loss caused by act of declared and undeclared war;
- (c) injuries received while participating in training exercises or maneuvers of an armed service while a member of an armed service;
- (d) injuries received while traveling by air (except as provided under the Air Travel Coverage section);
- (e) injuries received because the insured person was under the influence of any controlled substance unless administered on the advice of a physician;
- (f) injuries received because the insured person was intoxicated.

Certificate of Accident Insurance

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

BENEFITS FOR SPECIFIC LOSS

When you or a dependent suffers any of the following specific losses because of injuries within 12 months from the date of the accident, we will pay for loss of:

Life	Principal Sum
Both Hands or Both Feet or Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
One Hand and One Eye or One Foot and One Eye	Principal Sum
Speech and Hearing	Principal Sum
One Hand or One Foot or One Eye	One-half Principal Sum
Speech or Hearing	One-half Principal Sum
Thumb and Index Finger of Same Hand	One-quarter Principal Sum

Loss of hand or hands, or foot or feet, means actual severance at or above the wrist joint or ankle joint, respectively. Loss of eye or eyes, speech or hearing, means the total, uncorrectable and irrecoverable loss of the entire sight, speech or hearing, respectively.

In the event you or a dependent suffers more than one of the above losses as a result of the same accident, only one of the amounts specified (the largest applicable) will be paid for all such losses. The amounts for loss of: (a) two limbs; (b) two eyes; and (c) one limb and one eye will be payable only when such double loss occurs as the result of the same accident.

AIR TRAVEL COVERAGE

You or a dependent is covered for injuries received while traveling as a passenger (not as a pilot or member of a crew) and getting on or off:

- (a) any licensed U.S. civil aircraft or its foreign equivalent:
 - (1) operated by a person holding a valid and in-force pilot certificate (other than a student certificate) of a rating authorizing him or her to operate it;
 - (2) where the primary purpose of the flight is transporting passengers or passengers and cargo;
- (b) any transport-type, multiengine fixed-wing aircraft operated by:
 - (1) the Military Airlift Command (MAC) of the United States;
 - (2) the Department of National Defence (Canada);
 - (3) the Royal Air Force Air Transport Command of Great Britain; or
- (c) any aircraft of the United States Department of Defense, other than a single-engine jet:
 - (1) operated by a pilot with proper authorization;
 - (2) where the primary purpose of the flight is transporting passengers or passengers and cargo.

FAMILY MEMBER PROVISIONS

1. **Eligibility:** Coverage is provided for your eligible family members only if you apply for coverage for them and pay the required premium. Family members eligible for coverage include your lawful spouse and dependent, unmarried children of yours and/or your spouse who are under 19 years (23 years if enrolled as a full-time student in an accredited college or university). Your Eligible children shall include any legally adopted children and foster children provided they are dependent on you for support and maintenance. Family members eligible but not covered on the Certificate Date may be covered upon acceptance, by us, of your written application and payment of any required additional premium.

2. **Newborn Children:** Any child of yours and/or your spouse born while this certificate is in force will be included automatically as a covered dependent child under this certificate until the first day of the second month following birth. Coverage for such newborn child will continue in effect thereafter, without evidence of insurability, if dependent child coverage is in effect or upon receipt by us of your written request for dependent child coverage and payment of the required additional premium prior to the end of the automatic coverage period. Coverage will be subject to all provisions of this certificate applicable to dependent child coverage.

3. **Termination of Coverage:** Coverage for each dependent child will terminate on the renewal date following his or her 19th birthday (23rd birthday if enrolled as a full-time student at an accredited college or university) or marriage, whichever is first.

If a dependent child, on the termination date, is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is dependent upon you for support and maintenance, and if satisfactory proof of incapacity is submitted to us within 31 days of termination, the coverage for such child shall continue while this certificate is in force and so long as such incapacity continues and the applicable premium is paid.

You should notify us in writing when or if an insured spouse and/or your last child is no longer eligible for coverage. If we accept a premium for spouse or child after we get your written notice, the insurance for them will continue until the end of the period for which the premium is paid. If you do not give us notice, we will refund the premium we accept for family members coverage after they are no longer eligible.

CLAIMS PROVISIONS

Notice of Claim: You must give us written notice of claim within 20 days after a loss occurs or starts, or as soon as is reasonably possible. You may give the notice or have someone do it for you. The notice should give your name and certificate number as shown on the Schedule. Notice should be mailed to us at Omaha, Nebraska, or to any of our agents.

Claim Forms: When we receive your notice, we will send you forms for filing proof of loss. If we do not send them within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive this statement within the time given for filing proof of loss.

Proof of Loss: For a loss for which this certificate provides periodic payment, you must give us written proof of loss within 90 days after the end of the period for which we are liable. For other losses, written proof must be given within 90 days after the date of the loss. If you cannot give us proof within the time required, it may be given as soon as is reasonably possible. It must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

Payment of Claims: If your certificate provides loss of time coverage, we will make periodic payment for loss of time for which benefits accrue during a period of more than one month. Subject to written proof of loss, all accrued benefits for such loss of time will be paid at the end of each month. Any balance unpaid when our liability for such loss of time ends will be paid as soon as we receive proof of loss. All other benefits will be paid as soon as we receive proof of loss.

All benefits will be paid to you, your beneficiary or your estate.

Benefits for loss of life will be paid to your beneficiary (your estate if no beneficiary is named). Other benefits unpaid at your death will be paid, at our option, to your estate or your beneficiary.

If any benefits are payable to your estate, to a minor or to any person not legally able to give a valid release, we may pay up to \$1,000.00 to any relative of yours who we find entitled to the payment. Payment made in good faith shall fully discharge us to the extent of the payment.

GENERAL PROVISIONS

Term of Coverage: Your coverage starts on the Certificate Date at 12:01 a.m., Standard Time where the main office of the Policyholder is located. It ends at 12:01 a.m., the same Standard Time, on the first certificate renewal date. Each time your certificate is renewed, the new term begins when the old term ends.

Premiums and Payment of Premiums: The premiums for the coverage provided under this certificate are shown in the Schedule. The first premium for each person who is to be insured is due with the person's application. A renewal premium must be paid before the end of the preceding term of insurance. All premiums and applications will be submitted to us or to our authorized agent.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. This certificate stays in force during your grace period. You always have your grace period unless we write and tell you it does not apply.

Reinstatement: Your certificate will lapse if you do not pay the premium before the end of the grace period. Your insurance will be reinstated if we accept a premium after this certificate has lapsed. The reinstated certificate only covers loss due to an injury that is received after the date of reinstatement.

Other Insurance with Us: A person may be insured under only one certificate of this Form at any one time. If a person is insured under more than one, the certificateholder may select the one that is to remain in effect. In the event of death, the selection will be made by the beneficiary or estate. We will return all premiums paid (less claims paid) for certificates that do not remain in effect.

Termination: Unless otherwise shown in the Schedule or attached rider(s), your insurance will end on the first of the following dates:

- (a) The date you cease to be eligible;
- (b) The date any premium is due and unpaid, subject to the grace period; or
- (c) The date the policy terminates.

Change: Any change in coverage will become effective on the renewal date of this certificate which next follows acceptance of the change by you and us.

If there is a change in the amount or type of benefits provided to you under this certificate, such change shall apply only to loss due to an injury that is received on or after the effective date of change.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make any change in this certificate. Also, no such consent is required for surrender or assignment of this certificate.

Physical Examinations and Autopsy: We, at our expense, may have a covered person examined when and as often as is reasonable while a claim is pending. We may also have an autopsy done (at our expense) where it is not forbidden by law.

Legal Actions: You can't bring a legal action to recover under your certificate for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years after the date proof of loss is required.

Conformity with State Statutes: The provisions of this certificate must conform with the laws of the state in which the Master Policy is issued. If any do not, they are hereby amended to conform.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



SEAT BELT USAGE BENEFITS RIDER

This rider is made a part of the policy or certificate to which it is attached and is subject to all provisions of the policy or certificate which are not in conflict with the provisions of this rider.

Rider Date (same as the Policy Date or the Certificate Date if no date is shown)

Rider Premium (included in the premium shown in the policy or certificate if no amount is shown)

DEFINITIONS

"Injuries", as used in this rider, means accidental bodily injuries which are received by the Insured or a covered dependent while insured under this rider and which result in loss of life independently of sickness and all other causes.

"Seat Belt" means any factory-installed passive restraint device or any child passive restraint device which meets published federal safety standards.

BENEFITS

When the Insured or a covered dependent receives injuries covered by the policy which result in loss of life, the Company will pay the lesser of 10% of the applicable Principal Sum or \$25,000; if at the time of the accident the Insured or covered dependent was: (a) the operator of or a passenger in a private passenger automobile; and (b) utilizing a seat belt. Seat belt usage must be verified by a doctor, a coroner or a traffic officer, or other person of competent authority. This benefit will be payable in addition to any benefits otherwise payable under the policy.

MUTUAL OF OMAHA INSURANCE COMPANY

Michael Huss

Corporate Secretary



AIR BAG BENEFIT RIDER

This rider applies to the class or classes of Insured persons specified in the Schedule or Plan of Insurance.

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (same as the policy or certificate effective date if no date is shown)

Rider Premium (included in premium shown in the policy or certificate if no amount shown)

DEFINITIONS

Air bag means any factory-installed, inflatable, supplemental restraint device which meets published federal safety standards.

BENEFIT

If at the time of the accident:

- (a) a front or side Air Bag restraint system designed to protect the occupant was in place and engaged; and
- (b) the Insured or covered dependent receives Injuries that result in loss of life covered by the policy or certificate.

We will pay the Air Bag Benefit Amount shown on the Schedule or Plan of Insurance. This benefit will be payable in addition to any benefits otherwise payable under the policy or certificate.

CONDITIONS

In order to receive this benefit a coroner, traffic officer, or other person of competent authority must verify the Air Bag availability.

NON-DUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



EDUCATION BENEFITS RIDER

This rider is made a part of the policy/certificate to which it is attached. It is issued in consideration of the payment of the Rider Premium. All policy/certificate provisions not in conflict with this rider apply to this rider.

Rider Date:

For the policy (same as the Policy Date if no date is shown)

For certificates (same as the Certificate Date if no date is shown)

Rider Premium (as shown in the Schedule if no amount is shown)

DEFINITIONS

The definitions in the certificate apply to this rider. In applying them, the word "rider" is substituted for the word "certificate".

BENEFIT

If a dependent child is enrolled in and attending either the 12th grade or an accredited college or university on the date of a covered accident which results in your death, we will pay benefits in the amount of 6% of the Principal Sum then applicable to you for each year of full-time uninterrupted college or university attendance subsequently completed by the child, subject to the following:

- (a) Benefits may not exceed \$6,000 annually nor a maximum of four annual payments.
- (b) Benefits are payable only for each of the four consecutive years next following the date the dependent child graduated from the 12th grade.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



PREMIUM WAIVER RIDER

This rider is made a part of the policy or certificate to which it is attached. It is subject to all provisions of the policy or certificate which are not in conflict with this rider.

Rider Date (same as the Policy or Certificate Date if no date is shown)

Rider Premium (included in the premium shown in the policy or certificate if no amount is shown)

The policy or certificate is amended by adding the following to the General Provision called Dependent Insurance.

If the Insured, due to a covered injury, suffers loss of life, the insurance of any dependent insured hereunder will continue without premium payment until whichever of the following occurs first:

- (a) The date the spouse remarries;
- (b) The date the insurance terminates;
- (c) The date an unmarried dependent child ceases to be eligible due to age or marriage; or
- (d) The date the Benefit Period ends. The Benefit Period is shown below.

Benefit Period is 12 months beginning on the date of the Insured's death.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



AMENDMENT RIDER

This rider is made a part of the policy or certificate to which it is attached and is subject to all provisions of such policy or such certificate that are not in conflict with the provisions of this rider.

Rider Date: For the policy (same as Policy Date if no date is shown)
For certificates (same as Certificate Date if no date is shown)

The following provision is hereby made a part of the policy:

EXPOSURE AND DISAPPEARANCE

If, while insured under the policy, an Insured or a dependent is unavoidably exposed to the elements because of a covered accident which results in the disappearance, sinking or damaging of a conveyance on which the Insured or dependent is covered by the policy and in which the Insured or dependent was riding, and if as a result of such exposure the Insured or dependent suffers a loss for which benefits are otherwise payable hereunder, such loss will be covered under the policy.

If, while insured under the policy, an Insured or dependent disappears because of a covered accident resulting in the sinking or disappearance of a conveyance on which the Insured or dependent is covered by the policy and in which the Insured or dependent was riding, and if the body of the Insured or dependent has not been found within 52 weeks after the date of such accident, it will be presumed, subject to no evidence to the contrary, that the Insured or dependent suffered loss of life as a result of injuries covered by the policy.

MUTUAL OF OMAHA INSURANCE COMPANY

Michael Huss
Corporate Secretary



AIR TRAVEL COVERAGE AMENDMENT RIDER

This rider is made a part of the policy/certificate to which it is attached. All policy/certificate provisions not in conflict with this rider apply to this rider.

Rider Date:

For the policy (same as the Policy Date if no date is shown)

For certificates (same as the Certificate Date if no date is shown)

DEFINITIONS

The definitions in the certificate apply to this rider. In applying them the word "rider" is substituted for the word "certificate".

AMENDMENT

Benefits are not payable under the policy/certificate for injuries received by you or a dependent on or after the Rider Date while traveling in any aircraft which is owned or leased by: (a) the Policyholder, subsidiary or affiliate of the Policyholder; or (b) a director, officer or employee of the Policyholder, subsidiary or affiliate of the Policyholder.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



CONVERSION PRIVILEGE RIDER

This rider is made a part of the policy/certificate to which it is attached. All policy/certificate provisions not in conflict with this rider apply to this rider.

Rider Date:

For the policy (same as Policy Date if no date is shown)

For certificates (same as Certificate Date if no date is shown)

Conversion coverage is available to you and a dependent in the event the insurance provided by the certificate should end because your eligibility ends. You must send us a written application for conversion coverage and the initial premium within 31 days after your coverage under the policy ends. The conversion coverage will be issued in accord with: (a) our rules; and (b) the conversion law in effect when application is made.

The effective date of the conversion coverage is: (a) the date the insurance provided by the certificate ends; or (b) the date we receive your application for the conversion coverage, whichever is later.

The conversion coverage: (a) shall provide indemnity for specific loss in an amount not to exceed the Principal Sum applicable to you or a dependent under the certificate; and (b) may be substantially different from the certificate.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



BENEFICIARY DESIGNATION AMENDMENT RIDER

This rider applies only to the class or classes of Insureds specified in the Plan of Insurance.

This rider is made a part of the policy or certificate to which it is attached and is subject to all of the terms of the policy or certificate which are not in conflict with this rider.

Rider Date (same as the Policy Date or Certificate Date if no date is shown)

PART A. DEFINITIONS

The definitions in the policy, certificate, Insuring Provision(s) and Benefit Provision(s) apply to this rider.

PART B. AMENDMENT

The General Provision captioned Payment of Claims is hereby deleted in its entirety and the following is substituted.

Payment of Claims: Indemnity for loss of life will be payable in accord with the beneficiary designation made in writing by the Insured and on file with the Company. In the absence of such beneficiary designation, or in the event the designated beneficiary predeceases the Insured, indemnity for loss of life will be paid to the first of the following surviving beneficiaries: the Insured's: (a) lawful spouse; (b) child or children, jointly; (c) parents, jointly if both are living, or the surviving parent if only one survives; (d) brothers and sisters, jointly; (e) estate. Any other accrued indemnities unpaid at the Insured's death may, at Our option, be paid either to the Insured's beneficiary or to his or her estate. All other indemnities will be payable to the Insured.

PART C. EXCLUSIONS AND LIMITATIONS

This rider is subject to the Exclusions and Limitations of the Insuring Provision(s) and Benefit Provision(s) applicable to the Insured.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



DOMESTIC PARTNERS ELIGIBILITY RIDER

This rider is made a part of the policy or certificate to which it is attached. It is subject to all the terms of the policy or certificate which are not in conflict with this rider.

Rider Date (same as the Policy Date or Certificate Date if no date is shown)
Rider Premium (included in the policy or certificate premium if no amount shown)

DEFINITIONS

The following is added to the definition of dependents as specified in the policy or certificate.

(1) the Insured's same sex or opposite sex domestic partner, for whom an enrollment form and premium have been received by the policyholder or us, provided they are living together and a written declaration of domestic partnership acceptable to us, and submitted at the time of enrollment, has been completed and/or any applicable requirements of the state, city and/or country in which they reside regarding domestic partnership have been met; and

(2) the Insured's domestic partner's unmarried child under the age of nineteen years who is qualified and claims as an IRS-defined dependent by the domestic partner.

Child can include an Insured's and/or domestic partner's stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child residing with the Insured or domestic partner and who chiefly depends on the Insured and/or domestic partner for his full support.

The following definition is added:

"Living Together" means that both parties share a place to live.

NEWBORN CHILDREN

The following is added to the section of the policy or certificate concerning newborn children.

A domestic partner's newborn child is automatically covered from the moment of birth until he is 31 days old.

If coverage for a dependent child is in effect, notice of the birth is not required for the newborn's coverage to continue. However, if the Insured is not paying the additional dependent child premium, the coverage for the domestic partner's newborn will continue only if, within 31 days of the birth, we receive:

- (1) notice of the birth; and
- (2) payment of the additional dependent child premium, if any.

TERMINATION OF DEPENDENT COVERAGE

The following is added to the section of the policy or certificate concerning termination of coverage.

Additionally, coverage will end:

- (1) For the domestic partner,
 - (a) the day the Insured or domestic partner sends the other a notice for ending the domestic partnership;
 - (b) the day the Insured or domestic partner gets married to another person;
 - (c) the day the Insured and domestic partner stop living together.

- (2) For a child of the domestic partner, on the first premium due date following the first to occur of:
 - (a) the date of the child's marriage;
 - (b) the child's 19th birthday, if the child is then incapable of self-sustaining employment due to mental or physical handicap, the date the incapacity ends. Proof of the incapacity and dependency must be furnished to us by the Insured within 31 days after insurance would terminate because of age and as often as we may subsequently request but not more often than once a year;
 - (c) the date the domestic partner no longer qualifies as a dependent.

NOTE: The Insured must notify us within 30 days if there is any change in the status between the Insured and domestic partner as domestic partners. A signed statement of termination of domestic partnership will be required.

In the event a domestic partnership is terminated for reasons other than death of a domestic partner, the Insured cannot enroll for coverage for a new domestic partner for a period of 6 months.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



DEPENDENT AMENDMENT RIDER

This rider is made a part of the policy or certificate to which it is attached and is subject to all provisions of such policy or such certificate that are not in conflict with the provisions of this rider.

The policy or certificate is amended. The Eligibility and Termination of Coverage provisions of the Family Member Provisions are amended as follows.

1. The Eligibility provision is deleted and replaced by the following.

Coverage is provided for your eligible family members only if you apply for coverage for them and pay the required premium. Family members eligible for coverage include your lawful spouse and dependent, unmarried children of yours and/or your spouse who are under age 19 years (25 years if enrolled as a full-time student in an accredited college or university). Your eligible children shall include any legally adopted children and foster children provided they are dependent on you for support and maintenance. Family members eligible but not covered on the Certificate Date may be covered upon acceptance, by us, of your written application and payment of any required additional premium.

2. The first paragraph of the Termination of Coverage provision is deleted and replaced by the following.

Coverage for each dependent child will terminate on the renewal date following his or her 19th birthday (25th birthday if enrolled as a full-time student at an accredited college or university) or marriage, whichever is first.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary

**CLAIM REVIEW
AND APPEAL PROCEDURES**
(As Federally Mandated)

For the employer-employee accidental death and/or dismemberment policy under which you are insured, this provision is effective the later of:

- (a) the effective date of the Policy; or
- (b) the date required by Federal law.

Definitions

Capitalized terms have the same meaning as shown in the Policy.

For the purposes of this provision the following term has the following meaning:

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon the Insured Person's ineligibility for insurance under the Policy.

Claim Review Procedures

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. Please refer to the Payment of Claims provision of the Policy.

In the event an extension is necessary due to matters beyond Our control, We will notify the person submitting the claim of the extension and the circumstances requiring the extension. Extensions are limited as set forth below.

If an extension is necessary due to failure to submit complete information, We will notify the person submitting the claim of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below.

We may contact the person submitting the claim at any time for additional details about the processing of the claim.

Claim Review Decisions

- (a) Initial review: We will notify the person submitting the claim of Our claim decision within 45 days after Our receipt of the claim, unless additional information is requested as set forth below;
- (b) Extension period: 30 days; and
- (c) Maximum number of extensions: two.

If additional information is needed, We will notify the person submitting the claim within 30 days of Our receipt of the claim. Once Our request for additional information is received, the person submitting the claim will have 45 days to submit the additional information to Us. We will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond Our control) to process the claim. If We do not receive the additional information within the specified time period, We will make Our determination based on the available information.

Claim Denials

If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic notice of the denial which will include:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Policy provisions on which the denial is based;
- (c) if applicable, a description of any additional material or information necessary to complete the claim and the reason We need the material or information;
- (d) a description of the appeal procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
- (e) any other information which may be required under state or federal laws and regulations.

Opportunity To Request An Appeal

The person submitting the claim may appeal Our claim review decision in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, We will perform a full and fair review of the decision.

The request for an appeal can be written, electronically or orally submitted to Us and should include any additional information that the person submitting the claim believes may have been omitted from Our review that should be considered by Us.

The request for an appeal should include:

- (a) the name of the person for whom the claim has been submitted;
- (b) the name of the person filing the appeal;
- (c) the policy number; and
- (d) the nature of the appeal.

We will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification of Our claim review decision will include instructions on how and where to submit an appeal.

The person submitting the claim will:

- (a) have 180 days from receipt of notification to submit a request for an appeal;
- (b) be provided the opportunity to submit written comments, documents, records and other information relating to the claim; and
- (c) be provided, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim.

In reviewing the appeal We will consider all comments, documents, records and other information submitted by the person submitting the claim relating to the claim, without regard to whether such information was submitted or considered in the claim decision.

Request for an appeal authorizes Us, or anyone designated by Us, to review records relevant to the claim.

Our Response To An Appeal

Once We receive a request for an appeal, We will respond within 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

- (a) extension period: 45 days; and
- (b) maximum number of extensions: one.

We will have a total of 90 days to process the appeal.

When We make Our decision, the person submitting the claim will be provided with:

- (a) information regarding Our decision; and
- (b) information regarding other internal or external appeal or dispute resolution alternatives, if available, including any required state mandated appeal rights.



CERTIFICATE ADJUSTMENT RIDER

This rider is made a part of the certificate to which it is attached and is subject to all provisions of the certificate which are not in conflict with the provisions of this rider.

The effective date of this rider is January 1, 2010.

The certificate to which this rider is attached is hereby amended as follows:

- Within the section of the certificate entitled “**CLAIMS PROVISIONS,**” the first sentence of the sub-section entitled “**Notice of Claim**” is amended to read as follows:

“You must give us written notice of claim within **90 days** after a loss occurs or starts, or as soon as is reasonable possible.”

- Within rider **6801M** entitled “**EDUCATION BENEFITS RIDER,**” the following paragraph is added to the “**BENEFITS**” section:

“If, on the date of such covered accident, Dependent Children are insured under the Policy or certificate but none qualify for Education Benefits, **a benefit of \$1,000.00** is payable to your designated beneficiary.”

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary

The President and Fellows of Middlebury College (VT)
T66BA-P-51817
102809:bdt

APPENDIX I
LONG-TERM DISABILITY PLAN

**YOUR GROUP
LONG-TERM DISABILITY
BENEFITS**

The President and Fellows of Middlebury College

Revised January 1, 2011

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll Free: 1-800-877-5176

When contacting the Company please have your policy number available. Your policy number is GLTD-ADY1.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

GROUP LONG-TERM DISABILITY INSURANCE SUMMARY OF COVERAGE



The President and Fellows of Middlebury College
GLTD-ADY1

Revised: January 1, 2011

All eligible full time and part time employees

This Summary of Coverage provides a brief description of some of the terms, conditions, exclusions and limitations of Your employer's Policy. Definitions of capitalized terms in this Summary of Coverage can be found in the Certificate. For a complete description of the terms, conditions, exclusions and limitations of Your employer's Policy, refer to the appropriate section of the Certificate. In the event of a discrepancy between this Summary of Coverage and the Certificate, the Certificate will control. For a copy of the Certificate, contact the group Policyholder or Benefits or Plan Administrator.

This Summary of Coverage is not a contract. You are not necessarily entitled to insurance under the Policy because You received this Summary of Coverage. You are only entitled to insurance if You are eligible in accordance with the terms of the Certificate.

BENEFITS	
Elimination Period	<p>The Elimination Period is the later of:</p> <ul style="list-style-type: none">• 180 calendar days; or• the date Your short-term Disability benefits end. <p>For accumulating days of Total and/or Partial Disability to satisfy the Elimination Period, the following will apply:</p> <ul style="list-style-type: none">• a period of disability will be treated as continuous during the Elimination Period unless Total or Partial Disability stops for more than 180 accumulated days during the Elimination Period; and• days You are not Totally or Partially Disabled will not be used to satisfy the Elimination Period.
Monthly Benefit	<p>If You are Totally Disabled and earning less than 20% of Your Basic Monthly Earnings, the Monthly Benefit while Disabled is the lesser of:</p> <ul style="list-style-type: none">• 60% of Your Basic Monthly Earnings, less Other Income Benefits; or• the Maximum Monthly Benefit. The Maximum Monthly Benefit is \$10,000, less any Other Income Benefits. <p>You may work for wage or profit while Partially Disabled. As a work incentive, You will receive the Monthly Benefit, unless the sum of:</p> <ul style="list-style-type: none">• the Gross Monthly Benefit while You are Partially Disabled; plus• Current Earnings; <p>exceeds 100% of Your Basic Monthly Earnings. If this sum exceeds 100% of Your Basic Monthly Earnings, the Monthly Benefit will be reduced by that excess amount.</p>

Minimum Monthly Benefit	Your Monthly Benefit will never be less than \$100 or 10% of the Gross Monthly Benefit, whichever is greater.										
Maximum Benefit Period	If You are Totally or Partially Disabled because of an Injury or Sickness, We will pay benefits as follows.										
	<table border="1"> <thead> <tr> <th>Age at Disability</th> <th>Maximum Benefit Period</th> </tr> </thead> <tbody> <tr> <td>59 or less</td> <td>to Your Social Security Normal Retirement Age</td> </tr> <tr> <td>60 through 64</td> <td>to Your 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 one year</td> </tr> <tr> <td>70 or over</td> <td>one year</td> </tr> </tbody> </table>	Age at Disability	Maximum Benefit Period	59 or less	to Your Social Security Normal Retirement Age	60 through 64	to Your Social Security Normal Retirement Age, or 5 years, whichever is longer	65 through 69	to age 70, but not less than one year	70 or over	one year
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	59 or less	to Your Social Security Normal Retirement Age									
	60 through 64	to Your Social Security Normal Retirement Age, or 5 years, whichever is longer									
65 through 69	to age 70, but not less than one year										
70 or over	one year										
EMPLOYEE ELIGIBILITY											
Minimum Work Hours Required	Staff Employees who are working 1,000 hours or more per year Faculty 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 and are actively working for the Policyholder at least .5 FTE's (full time equivalents) or more per year										
Eligibility Waiting Period	None										
Confinement Rule	If an eligible Employee is confined due to an Injury or Sickness: <ul style="list-style-type: none"> • in a Hospital as an inpatient; • in any institution or facility other than a Hospital; or • at home and under the supervision of a Physician; insurance will begin on the day the Employee returns to Active Employment. If an eligible Employee is Actively Employed and is not: <ul style="list-style-type: none"> • confined; and • available for work because of an Injury or Sickness; insurance will begin on the day the Employee returns to Active Employment.										
When Insurance Begins	An Employee will become insured on the first day of the policy month which coincides with or follows the day the Employee becomes eligible, provided the Employee is Actively Working on that day.										
When Your Classification or the Amount of Insurance Changes	Any change in Your classification, coverage or amount of Your insurance will take effect on the day of the change, provided You are Actively Working on that day. If You are not Actively Working on the day of the change, the following conditions will apply: <ul style="list-style-type: none"> • If the change involves an increase in the amount of insurance, the change will not take effect until the day You return to Active Work. • If the change involves a decrease in the amount of insurance, the change will take effect on the day of the change. In no event will any change take effect during a period of Disability.										

When Your Insurance Ends	<p>Your insurance will end at midnight at the main office of the Policyholder on the earliest of:</p> <ul style="list-style-type: none"> • the day the Policy ends; • the day any premium contribution for Your insurance is due and unpaid; • the day before You enter the Armed Forces on active duty (except for temporary active duty of twelve weeks or less); or • the day You are no longer eligible. <p>You will no longer be eligible when the earliest of the following occurs:</p> <ul style="list-style-type: none"> • You are not in an eligible classification described in the Schedule; • Your employment with the Policyholder ends; • You are not Actively Employed; or • You do not satisfy any other eligibility condition described in the Policy.
DEFINITIONS	
Definition of Disability	<p>Partial Disability and Partially Disabled mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You, while unable to perform all of the Material Duties of Your Regular Occupation on a full-time basis, are:</p> <ul style="list-style-type: none"> • able to perform at least one of the Material Duties of Your Regular Occupation on a part-time or full-time basis; and • unable to generate Current Earnings which exceed 99% of Your Basic Monthly Earnings due to that same Injury or Sickness. <p>After a Monthly Benefit has been paid for 2 years, partial disability and partially disabled mean You are able to perform at least one of the Material Duties of any Gainful Occupation on a part-time or full-time basis.</p> <p>Partial disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with Your employer</p> <p>Total Disability and Totally Disabled mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You are prevented from performing all of the Material Duties of Your Regular Occupation on a full-time basis.</p> <p>After a Monthly Benefit has been paid for 2 years, total disability and totally disabled mean You are unable to perform all of the Material Duties of any Gainful Occupation.</p> <p>Total disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with Your employer.</p>
Definition of Monthly Earnings	<p>Basic Monthly Earnings means 1/12th your pre-disability stated salary, before taxes and 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 or any other extra compensation, shift differential, or income received from sources other than your Employer.</p> <p>NOTE: If you are on a covered leave of absence your annual earnings are your annual stated salary prior to beginning your leave.</p>
FEATURES	
Continuation of Insurance During Total or Partial Disability	<p>If You become Totally Disabled or Partially Disabled, Your insurance will continue without payment of premium for as long as You are entitled to receive Monthly Benefits, provided the premium is paid during the Elimination Period.</p>

Continuation of Insurance Due to a Temporary Layoff	Your insurance will continue through the end of the month following 60 days from the date of Your temporary layoff approved by the Policyholder.
Continuation of Insurance for Approved Administrative Leave of Absence or any other approved Leave of Absence	You may be able to continue insurance for up to 12 months from the day You are no longer Actively Employed in the event of an administrative leave of absence or any other leave of absence approved by the Policyholder.
Cost Of Living Adjustment	Beginning on the first anniversary of the date on which Monthly Benefit Payments begin, a Cost of Living Adjustment will be made to Your Monthly Benefit.
Vocational Rehabilitation	If You are Disabled and are receiving Disability benefits as provided by the Policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to: <ul style="list-style-type: none"> • job modification; • job placement; • retraining; and • other activities reasonably necessary to help You return to work.
Conversion	Conversion coverage is available to You if Your long-term Disability insurance ends because Your eligibility ends; except conversion coverage is not available when: <ul style="list-style-type: none"> • the Policy ends; • You have similar individual or group Disability coverage; • You have been insured under the Policy (including any similar group coverage the Policy replaces) less than 12 months immediately before Your long-term Disability insurance ends; • You retire from employment with Your employer; • You are Disabled; or • You are age 70 or older.
Employer Sponsored Pension Plan/Savings And Investment Plan Contribution	While You are receiving Disability benefits, an extra benefit will be paid to Your employer for deposit in the plan on Your behalf. You must have been a participant in the plan for at least 3 months.
Survivor Benefit	We will pay a survivor benefit to Your Eligible Survivor when We receive proof that You died: <ul style="list-style-type: none"> • after being Disabled; and • while receiving, or eligible to receive, a Monthly Benefit under the Policy. The survivor benefit will be an amount equal to 3 times Your Monthly Benefit payable for the month immediately prior to Your death.

EXCLUSIONS

General Exclusions	<p>We will not pay benefits for any Disability which is caused by, contributed to by, or resulting from:</p> <ul style="list-style-type: none">• declared or undeclared war or any act of war or armed aggression;• Your participation in a riot, insurrection or rebellion;• Your commission of a felony for which You have been charged under state or federal law;• an intentionally self-inflicted Injury or Sickness, whether You are sane or insane; or• attempted suicide, whether You are sane or insane. <p>We also will not pay benefits for any Disability:</p> <ul style="list-style-type: none">• with respect to Alcohol and Drug Abuse and/or Substance Abuse, while You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or if none, by Us;• while You are incarcerated or imprisoned for any period exceeding 60 days; or• that is solely a result of a loss of a professional license, occupational license or certification.
Pre-Existing Conditions	<p>We will not provide benefits for any Disability:</p> <ul style="list-style-type: none">• caused by or contributed to by a Pre-existing Condition; or• resulting from a Pre-existing Condition. <p>We will provide benefits for that Disability once You have performed all of the Material Duties of Your Regular Occupation:</p> <ul style="list-style-type: none">• on Your pre-Disability full-time work schedule; and• for at least five consecutive days after You become insured under the Policy. <p>A Pre-existing Condition means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken within 30 days prior to the day You become insured under the Policy.</p>

Publication Date: February 8, 2011

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No(s). GLTD-ADY1 (policy) has been issued to The President and Fellows of Middlebury College (Policyholder).

Insurance is provided for certain employees as described in the policy.

The benefits described in this Certificate are subject to the terms and conditions of the policy. Benefits are effective only if you are eligible for the insurance, become insured and remain insured as described in this Certificate.

This Certificate replaces any certificate previously issued under the Policy.

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer



Corporate Secretary

THIS SCHEDULE DESCRIBES THE AMOUNT OF BENEFITS AND CERTAIN OTHER REQUIREMENTS AND LIMITATIONS APPLICABLE TO BENEFITS FOR TOTAL AND PARTIAL DISABILITY. OUR OBLIGATION TO CONSIDER BENEFITS DESCRIBED IN THIS SCHEDULE IS SUBJECT TO ALL TERMS OF THE POLICY, INCLUDING, BUT NOT LIMITED TO, ALL DEFINITIONS, GENERAL EXCLUSIONS AND RIDERS. PLEASE REFER TO THE TABLE OF CONTENTS IN THE CERTIFICATE TO LOCATE THE PROVISIONS OF THE POLICY.

SCHEDULE

The amount of insurance for You will be in accordance with Your classification in this Schedule.

Classification(s)

All eligible full time and part time employees

For You LONG-TERM DISABILITY BENEFITS

Elimination Period

The Elimination Period is the later of:

- (a) 180 calendar days; or
- (b) the date Your short-term Disability benefits end.

For accumulating days of Total and/or Partial Disability to satisfy the Elimination Period, the following will apply:

- (a) a period of disability will be treated as continuous during the Elimination Period unless Total or Partial Disability stops for more than 180 accumulated days during the Elimination Period; and
- (b) days You are not Totally or Partially Disabled will not be used to satisfy the Elimination Period.

Definitions

Basic Monthly Earnings means 1/12th your pre-disability stated salary, before taxes and 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 or any other extra compensation, shift differential, or income received from sources other than your Employer.

NOTE: If you are on a covered leave of absence your annual earnings are your annual stated salary prior to beginning your leave.

Other Income Benefits has the meaning set forth in the Other Income Benefits provision of this Schedule.

Monthly Benefit

If You are Totally Disabled, the Monthly Benefit is the lesser of:

- (a) 60% of Your Basic Monthly Earnings, less Other Income Benefits; or
- (b) the Maximum Monthly Benefit. The Maximum Monthly Benefit is \$10,000, less any Other Income Benefits.

You may work for wage or profit while Partially Disabled. As a work incentive, You will receive the Monthly Benefit, unless the sum of:

- (a) the Gross Monthly Benefit while You are Partially Disabled; plus
- (b) Current Earnings;

exceeds 100% of Your Basic Monthly Earnings. If this sum exceeds 100% of Your Basic Monthly Earnings, the Monthly Benefit will be reduced by that excess amount.

Your Monthly Benefit will never be less than \$100 or 10% of the Gross Monthly Benefit, whichever is greater.

When less than one month of Total or Partial Disability benefits is due, a pro rata benefit will be paid for each day of Total or Partial Disability. This pro rata benefit will be equal to 1/30th of Your Monthly Benefit as calculated above.

While You are participating in a plan of vocational rehabilitation approved by Us, Your Monthly Benefit, as calculated above, will be increased by 10%.

Maximum Benefit Period

If You are Totally or Partially Disabled because of an Injury or Sickness, We will pay benefits as follows.

<u>Age at Disability</u>	<u>Maximum Benefit Period</u>
59 or less.....	to Your Social Security Normal Retirement Age;
60 through 64.....	to Your Social Security Normal Retirement Age, or 5 years, whichever is longer;
65 through 69.....	to age 70, but not less than one year;
70 or over	one year.

Social Security Normal Retirement Age means Your normal retirement age under the United States Social Security Act determined as follows.

<u>Year of Birth</u>	<u>Social Security Normal Retirement Age</u>
1937 or earlier.....	65 Years
1938.....	65 years and 2 months
1939.....	65 years and 4 months
1940.....	65 years and 6 months
1941.....	65 years and 8 months
1942.....	65 years and 10 months
1943 through 1954.....	66 years
1955.....	66 years and 2 months

1956.....	66 years and 4 months
1957.....	66 years and 6 months
1958.....	66 years and 8 months
1959.....	66 years and 10 months
1960 or later.....	67 years

NOTE: Your Social Security Normal Retirement Age may change subject to any changes to the United States Social Security Act.

Other Income Benefits

We take into account the total of all Your income from other sources of income in determining the amount of Your Monthly Benefit. Your Other Income Benefits are any of the following amounts that you receive or You are eligible to receive as a result of Your Total or Partial Disability:

1. Any amounts under:
 - (a) a workers’ compensation law;
 - (b) an occupational disease law;
 - (c) the Jones Act, (46 U.S.C. Statute 688(a) (1920)); or
 - (d) any other act or law of like intent to the laws described in 1(a), (b) or (c) above.
2. Amount under another group short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost or for which the Policyholder has made payroll deductions, except any group short-term or long-term disability insurance policy or plan underwritten by Us. Any benefits payable by a group short-term or long-term disability policy underwritten by Us will not be considered as Other Income Benefits.
3. Any amounts as disability income payments under any:
 - (a) state compulsory benefit act or law;
 - (b) government retirement system as a result of Your job with the Policyholder; or
 - (c) work loss provision in a no-fault motor vehicle insurance plan, unless state law or regulation does not allow group disability income benefits to be reduced by benefits from no-fault motor vehicle coverage.
4. Any amount of Retirement Benefits under the Policyholder’s Retirement Plan. Benefits payable before the plan’s normal retirement age are considered Other Income Benefits only if You voluntarily elect to receive these benefits.
5. Any benefits for You or Your spouse and child(ren) under:
 - (a) the U.S. Social Security Act;
 - (b) the Canada Pension Plan;
 - (c) the Quebec Pension Plan;
 - (d) the Railroad Retirement Act;
 - (e) the Public Employee Retirement Plan;

- (f) the Teachers Employment Retirement Plan; or
- (g) any similar plan or act that provides:
 - (1) disability benefits; or
 - (2) Retirement Benefits (except this will not apply if Your Total or Partial Disability begins after Your Social Security Normal Retirement Age and You were already receiving Social Security retirement benefits. This exception only applies to U.S. Social Security Benefits).
- 6. Any severance pay for which You are eligible or that You are receiving from the Policyholder.
- 7. Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.
- 8. Any amounts from any unemployment insurance law or program.

Social Security Assistance

In order to be eligible for assistance from Our Social Security claimant advocacy program, You must be receiving Monthly Benefits from Us. We can arrange for advice regarding Your claim and assist You with Your application or appeal.

Receiving Social Security benefits may enable:

- (a) You to receive Medicare after 24 months of disability payments;
- (b) You to protect Your retirement benefits; and
- (c) Your family to be eligible for Social Security benefits.

We can arrange assistance in obtaining Social Security disability benefits by:

- (a) helping You find appropriate representation;
- (b) obtaining medical and vocational evidence; and
- (c) reimbursing pre-approved case management expense.

Explanation of Other Income Benefits

You must apply for Other Income Benefits for which You are or may become eligible and do what is needed to obtain them. If Your Social Security application is denied, You must appeal the decision by Social Security to a level that is satisfactory to Us and provide written proof of all levels of appeal.

As part of Your proof of Total or Partial Disability, We require that You furnish evidence to Us that You have applied for Other Income Benefits for which You are or may become eligible.

After the first reduction for each of the Other Income Benefits, We will not further reduce Your Monthly Benefit due to any cost of living increases payable under these Other Income Benefits.

Other Income Benefits that are paid in a lump sum will be prorated on a monthly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the lesser of the following:

- (a) The Policy's Maximum Benefit Period; or
- (b) 60 equal payments.

If Other Income Benefits which are paid in a lump sum are paid on a retroactive basis, then we may adjust the Monthly Benefit to recover any overpayment.

Until You have signed Our Reimbursement Agreement and have given written proof to Us that application has been made or all available appeals have been exhausted for Other Income Benefits, We may:

- (a) estimate Your Other Income Benefits; and
- (b) reduce Your Monthly Benefit by that amount.

If We reduce Your benefit on this basis, and if all of Your appeals are denied, We will restore the reduced amounts to You in one payment.

EMPLOYEE ELIGIBILITY

Disability Insurance

Definitions

Terms defined in this provision may be used in, or apply to other provisions throughout this Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Active Employment or Actively Employed means Staff Employees who are Actively Working for the Policyholder 1,000 hours or more per year. A Totally Disabled Employee will not be considered actively employed.

Active Employment or Actively Employed means Faculty Employees who are Actively Working for the Policyholder teaching .5 FTE's (full time equivalents) or more per year. A Totally Disabled Employee will not be considered actively employed.

Active Employment or Actively Employed means Faculty employees who are appointed to an administrative assignment and are actively working for the Policyholder at least .5 FTE's (full time equivalents) or more per year. A Totally Disabled Employee will not be considered actively employed.

Actively Working or Active Work means performing the normal duties of a regular job for the Policyholder at:

- (a) the Policyholder's usual place of business;
- (b) an alternative work site at the direction of the Policyholder; or
- (c) a location to which one must travel to perform the job.

An Employee will be considered Actively Working on any day that is:

- (a) a regular paid holiday or day of vacation; or
- (b) a regular or scheduled non-working day.

provided the Employee was actively working on the last preceding regular work day.

If an Employee's customary place of employment is at home, the Employee will be considered actively working if not confined on that day as described in the Confinement Rule.

Confinement Rule

1. If an eligible Employee is confined due to an Injury or Sickness:

- (a) in a Hospital as an inpatient;
- (b) in any institution or facility other than a Hospital; or
- (c) at home and under the supervision of a Physician;

insurance will begin on the day the Employee returns to Active Employment.

2. If an eligible Employee is Actively Employed and is not:

- (a) confined; and
- (b) available for work because of an Injury or Sickness;

insurance will begin on the day the Employee returns to Active Employment.

Employee means a person who receives compensation from the Policyholder for work performed for the Policyholder. An employee will not include a person who is unauthorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

The term Employee does not include any person performing services for the Policyholder:

- (a) pursuant to an independent contractor relationship with the Policyholder;
- (b) subject to the terms of a leasing agreement between the Policyholder and a leasing organization;
- (c) who receives income which is reported by the Policyholder on IRS form 1099;
- (d) while outside the United States for any period in excess of 12 consecutive months, unless approval has been received from the Home Office;
- (e) on a seasonal basis; or
- (f) on a temporary basis.

Eligible Employees

An Employee becomes eligible for insurance under this Policy on the day the Employee begins Active Employment.

When Insurance Begins

An Employee will become insured on the first day of the policy month which coincides with or follows the day the Employee becomes eligible, provided the Employee is Actively Working on that day. If the Employee is not Actively Working on that day, insurance will begin on the day the Employee returns to Active Work.

If an Employee was eligible for group disability coverage under a plan maintained by the Policyholder immediately prior to the effective date of this Policy but did not elect coverage under such plan, the Employee may enroll for insurance under this Policy if the Employee is otherwise eligible and provides Us with evidence of good health. If such evidence is acceptable to Us, We will determine the day insurance begins.

Reinstatement of Insurance

If an eligible Employee wants to reinstate insurance after insurance has ended, the following will apply:

Rehire: If insurance ended because the Employee ceased to be eligible under this Policy and the Employee becomes eligible again within 90 days after insurance ended, the waiting period will be waived. All other Policy provisions, including Preexisting Conditions, will apply.

When Your Classification or Amount of Insurance Changes

Any change in Your classification, coverage or amount of Your insurance as shown in the Schedule will take effect on the day of the change, provided You are Actively Working on that day. If You are not Actively Working on that day, the following conditions will apply:

- (a) If the change involves an increase in amount of insurance, the change will not take effect until the day You return to Active Work.
- (b) If the change involves a decrease in amount of insurance, the change will take effect on the day of the change.

In no event will any change take effect during a period of Total or Partial Disability.

When Your Insurance Ends

Your insurance will end at midnight at the main office of the Policyholder on the earliest of:

- (a) the day this Policy ends;
- (b) the day any premium contribution for Your insurance is due and unpaid;
- (c) the day before You enter the Armed Forces on active duty (except for temporary active duty of twelve weeks or less); or
- (d) the day You are no longer eligible. You will no longer be eligible when the earliest of the following occurs:
 - (1) You are not in an eligible classification described in the Schedule;
 - (2) Your employment with the Policyholder ends;
 - (3) You are not Actively Employed; or
 - (4) You do not satisfy any other eligibility condition described in this Policy. We will provide benefits for a payable claim which occurs while You are covered under this Policy.

Continuation of Insurance Due to a Temporary Layoff

Your insurance will continue through the end of the month following 60 days from the date of Your temporary layoff approved by the Policyholder.

Continuation of Insurance for Approved Administrative Leave of Absence or any other approved Leave of Absence

You may be able to continue insurance for up to 12 months from the day You are no longer Actively Employed in the event of an administrative leave of absence or any other leave of absence approved by the Policyholder.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as certain state statutes, provide continuation of insurance in specific instances for leaves of absence. Since You may be eligible for continued insurance under these regulations, You should check with the Policyholder or Benefits Administrator for additional information regarding the options available.

Under this provision, insurance will continue subject to the following conditions:

- (a) the duration will not exceed 12 months, or the duration allowed by FMLA, USERRA or the state statute that allows for continuation;
- (b) We must continue to receive premium payment (premiums must be paid by You or on Your behalf); and
- (c) benefits will be based on Your Basic Monthly Earnings in effect on the date Your approved absence began.

Insurance under this provision will end on the day:

- (a) that is 12 months from the day insurance under this provision began;
- (b) the duration allowed by FMLA, USERRA or the state statute that allows for continuation has been fulfilled;
- (c) You return to Active Employment;
- (d) the Policy terminates;
- (e) any applicable premium contribution is due and unpaid; or
- (f) You begin employment with an employer other than the Policyholder.

Continuation of Insurance During Total or Partial Disability

If You become Totally Disabled or Partially Disabled, Your insurance will continue without payment of premium for as long as You are entitled to receive Monthly Benefits, provided the premium is paid during the Elimination Period.

Continuation of Insurance Under Family and Medical Leave

The federal Family Medical Leave Act of 1993 (FMLA) and any amendments thereto as well as certain state statutes provide continuation of coverage in certain instances for leaves of absence.

You may be eligible for continued coverage under FMLA and/or any state family medical leave laws. You should check with Your employer for additional information regarding the continued coverage that may be available to You.

Any continued coverage for family medical leave will not exceed the continued coverage provided by FMLA and/or state required family medical leave.

Any family medical leave continuation is subject to all terms and conditions of the Policy, including, without limitation, payment of premium and eligibility. Any continued coverage will end in accordance with the **When Your Insurance Ends** provision in Your Certificate.

Continuity of Coverage Upon Transfer of Insurance Carrier

If You are not Actively Employed on the effective date of this Policy due to Injury or Sickness, upon payment of the premium, You will be insured under this Policy if You:

- (a) were covered under a group disability plan maintained by the Policyholder immediately prior to the effective date of this Policy; and
- (b) You resume Active Employment.

Effect of a Pre-existing Condition

If You become insured under this Policy on its effective date and were covered under a group disability plan maintained by the Policyholder immediately prior to the effective date of this Policy, any benefits payable under this Policy for a Total or Partial Disability due to a Pre-existing Condition will be determined as follows:

1. If You cannot satisfy the Pre-existing Conditions provision of this Policy, but have satisfied the pre-existing condition provision under the prior disability plan, giving consideration towards continuous time covered under both plans, We will pay the lesser of:
 - (a) the benefit that would have been paid under the prior plan; or
 - (b) the benefit payable under this Policy.
2. If You cannot satisfy the Pre-existing Conditions provision under this Policy or of the prior plan, no benefit under this Policy will be payable.

LONG-TERM DISABILITY BENEFITS

Benefits

If, while insured under this provision, You become Totally Disabled or Partially Disabled due to Injury or Sickness, We will pay the Monthly Benefit shown in the Schedule. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

Pre-existing Conditions

We will not provide benefits for any Total or Partial Disability:

- (a) caused by or contributed to by a Pre-existing Condition; or
- (b) resulting from a Pre-existing Condition.

We will provide benefits for that disability once You have performed all of the Material Duties of Your Regular Occupation:

- (a) on Your pre-disability work schedule; and
- (b) for at least five consecutive days after You become insured under this Policy.

A **Pre-existing Condition** means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken within 30 days prior to the day You become insured under this Policy.

Recurrent Disability

A Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Elimination Period if:

- (a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
- (b) Your Recurrent Disability occurs within six months of the end of Your prior claim.

In order to prevent over-insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to You under any other group disability income policy or plan.

Survivor Benefit

We will pay a survivor benefit to Your Eligible Survivor when We receive proof that You died:

- (a) after being Totally or Partially Disabled; and
- (b) while receiving or eligible to receive a Monthly Benefit under this Policy.

However, if there are no Eligible Survivors, the survivor benefit will be paid to Your estate.

Eligible Survivor means Your spouse, if living; otherwise, it means Your natural and/or adopted children who are living and under age 25. An Eligible Survivor must be living at the time of Your death.

The survivor benefit will be an amount equal to 3 times Your Monthly Benefit payable for the month immediately prior to Your death.

If a Survivor Benefit is payable to Your child and, if there is more than one such child, then the survivor benefit will be divided equally among such children.

If payment becomes due to Your child or children, the payment will be made to:

- (a) Your child or children; or
- (b) a person named by Us to receive payments on the child's or children's behalf. This payment will be valid and effective against all claims by the child or children or by others representing or claiming to represent said child or children.

When Benefits End

Benefits will be paid during a period of Total or Partial Disability until the earliest of:

- (a) the day You are no longer Totally or Partially Disabled;
- (b) the day You die;
- (c) the end of the Maximum Benefit Period shown in the Schedule;
- (d) the day You fail to provide Us satisfactory proof of continuous Total or Partial Disability and/or any Current Earnings during Partial Disability;
- (e) the day You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;
- (f) the day You are not under Regular Care for the Injury or Sickness that caused the Total or Partial Disability;
- (g) the day You are able to return to work on a part-time or full-time basis and do not do so; or
- (h) the day Monthly Benefits have been paid to You for a cumulative period of 12 months, when You are outside the United States or Canada on such day. If You are in the United States or Canada on such day, Monthly Benefits are payable to the end of the Maximum Benefit Period shown in the Schedule, subject to all other Policy provisions.

General Exclusions

We will not pay benefits for any Total or Partial Disability which is caused by, contributed to by, or resulting from:

- (a) declared or undeclared war or any act of war;
- (b) Your participation in a riot or insurrection;
- (c) Your commission of a felony for which You have been charged under state or federal law;
- (d) an intentionally self-inflicted Injury or Sickness, whether You are sane or insane; or
- (e) Your attempted suicide, whether You are sane or insane.

We also will not pay benefits for any Total or Partial Disability:

- (a) with respect to Alcohol and Drug Abuse and/or Substance Abuse, while You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or if none, by Us; or
- (b) that is solely a result of a loss of a professional license, occupational license or certification.

COST OF LIVING ADJUSTMENT RIDER

This Rider is made a part of Group Policy GLTD-ADY1.

This Rider is effective the later of January 1, 2010, or the day You become insured under the Policy.

In the event of a conflict between this Rider and any other provision of the Policy, including the Certificate, this Rider shall control. This Rider shall be subject to all provisions of the Policy, including the Certificate, not in conflict with this Rider.

Definition

For purposes of this provision and other provisions of the Policy, the following terms have the following meaning:

Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of a typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally-published index that We determine, in Our discretion, to be comparable to the CPI-W. For the purposes of this definition, the percentage change in the CPI-W means the difference between the current year's CPI-W and the prior year's CPI-W divided by the prior year's CPI-W.

Monthly Benefit is defined in the Schedule. The Monthly Benefit will be determined each month. For the purpose of calculating adjustments, the Monthly Benefit includes any prior years' Cost of Living Adjustments.

Cost of Living Adjustment

Beginning on the first anniversary of the date on which Monthly Benefit Payments begin, a Cost of Living Adjustment will be made to Your Monthly Benefit as defined in the Schedule. Your Monthly Benefit payable under the Policy will be increased by the lesser of 3% or the percentage change in the Consumer Price Index (CPI-W). These increases will continue annually thereafter, as long You are receiving Monthly Benefits. Cost of Living Adjustments are not subject to the Maximum Monthly Benefit.

VOCATIONAL REHABILITATION PROVISION

If You are disabled and are receiving disability benefits as provided by the policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to:

- (a) job modification;
- (b) job placement;
- (c) retraining; and
- (d) other activities reasonably necessary to help You return to work.

Eligibility for vocational rehabilitation services is based on Your education, training, experience and physical/mental capabilities. Before vocational rehabilitation services will be considered:

- (a) Your disability must not allow You to perform Your regular occupation;
- (b) You must not have the necessary skills to allow You to perform another occupation;
- (c) You must have the physical and mental capability for successful completion of a rehabilitation program; and
- (d) there must be reasonable expectation that rehabilitation services will help You return to active employment.

All vocational rehabilitation programs will be developed with input from You, Your physician, Your employer and Us and described on an Individual Written Rehabilitation Plan (IWRP), which states:

- (a) the vocational rehabilitation goals;
- (b) the responsibilities of Us, You and any third parties associated with the IWRP;
- (c) the times and dates of the vocational rehabilitation services; and
- (d) all costs associated with the services.

Either We, Your physician, or You may initiate consideration for Your participation in vocational rehabilitation. Failure to participate without good cause will result in reduction or termination of Disability benefits. Reduction of benefits will be based on Your income potential if You were employed after a vocational rehabilitation program.

Definitions

Good Cause means documented physical or mental impairments not identified in Your existing disability claim that:

- (a) renders You incapable of rehabilitation;
- (b) interferes with a medical program You are currently participating in; or
- (c) conflicts with any other program You are participating in that will allow You to return to active employment.

We will make the final determination of any vocational rehabilitation services provided, eligibility for participation and any continued benefit payments.

The definition of Disability will not apply during the term of the vocational rehabilitation program but will be reapplied after such program ends.

RIDER

EMPLOYER SPONSORED PENSION PLAN/SAVINGS AND INVESTMENT PLAN CONTRIBUTION

This rider is made a part of Group Policy GLTD-ADY1.

This rider is effective the later of January 1, 2010, or the day you become insured under the policy.

If the provisions of this rider and those of the policy or your certificate do not agree, the provisions of this rider will apply.

MONTHLY BENEFIT

While you are receiving disability benefits, an extra benefit will be paid to your employer for deposit in the plan on your behalf. However, you must have been a participant in the plan for at least 3 months.

To figure the amount of this benefit take 15% of your basic monthly earnings but not to exceed the maximum allowable by law.

But, if you are earning more than 20% of your indexed pre-disability earnings in your regular occupation or another occupation for the employer, the following formula will be used to figure the benefit.

$$(A \text{ divided by } B) \times C$$

A= Your indexed pre-disability earnings minus your monthly earnings received while you are disabled.

B= Your indexed pre-disability earnings.

C= The benefit as figured above.

No reductions for other income benefits will be taken under this extra benefit.

This benefit will not be payable, or payments will cease when you are no longer eligible to participate in the plan.

LONG-TERM DISABILITY CONVERSION

Definition

Conversion Coverage means long-term disability insurance, then available, issued without evidence of good health.

NOTE: Conversion coverage does not provide the same insurance benefits you had while insured under the policy. Consequently, coverage under the policy may not be covered by the conversion coverage or may be covered at a different level. You may contact the Plan Administrator or us at any time for a description of the conversion benefits then available. Conversion benefits are subject to change.

Available To You

Conversion coverage is available to you if your long-term disability insurance ends because your eligibility ends; except conversion coverage is not available when:

- (a) the policy ends;
- (b) you have similar individual or group disability coverage;
- (c) you have been insured under the policy (including any similar group coverage the policy replaces) less than 12 months immediately before your long-term disability insurance ends;
- (d) you retire from employment with your employer;
- (e) you are disabled; or
- (f) you are age 70 or older.

Option To Obtain Conversion Coverage

If a completed application and the first premium payment is sent to us within 30 days from when long-term disability insurance ends, conversion coverage will be issued in accord with:

- (a) our rules; and
- (b) the conversion law in effect when application is made.

Conditions

Conversion coverage begins immediately after insurance under the policy ends. Coverage for conditions which are excluded under the policy may be excluded under the conversion coverage.

PAYMENT OF CLAIMS

How To File Claims

It is important for You to notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Before Your claim can be considered, We must be given a written proof of loss, as described below. In the event of Your death or incapacity, Your beneficiary or someone else may give Us the proof.

Proof of Loss Requirements

1. First, request a claim form from the Plan Administrator or from Us.

This request should be made:

- (a) within 20 days after a loss occurs; or
- (b) as soon as reasonably possible.

When We receive the request, We will send a claim form for filing proof of loss. If You do not receive the form within 15 days of Your request, You can meet the proof of loss requirement by giving Us a written statement of what happened. Such statement should include:

- (a) that You are under the Regular Care of a Physician;
 - (b) the appropriate documentation of Your job duties at Your regular occupation and Your Basic Monthly Earnings;
 - (c) the date Your Disability began;
 - (d) the cause of Your Disability;
 - (e) any restrictions and limitations preventing You from performing Your regular occupation;
 - (f) the name and address of any Hospital or institution where You received treatment, including attending Physicians.
2. Next, You and Your employer must complete and sign Your sections of the claim form, and then give the claim form to the Physician. Your Physician should fill out his or her section of the form, sign it, and send it directly to Us.
 3. The claim form should be sent to Us within 90 days after the end of Your Elimination Period. Failure to furnish proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish proof within such time, provided proof was furnished as soon as possible.

How Claims are Paid

Benefits will be paid monthly after We receive acceptable proof of loss.

Benefits will be paid to You, except benefits due but unpaid at Your death may be paid, at Our option, to:

- (a) any member of Your family; or
- (b) Your estate.

This provision does not apply to any Survivor Benefits payable under the Policy.

Examination

We sometimes require that a claimant be examined by a Physician or vocational rehabilitation expert of our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations.

Overpayments

We have the right to recover any overpayments due to:

- (a) fraud;
- (b) any error We make in processing a claim; and
- (c) Your receipt of Other Income Benefits.

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

We will not recover more money than the amount We paid You.

Authority to Interpret Policy

The Policyholder has delegated to Us the discretion to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Benefits under the Policy will be paid only if We decide, after exercising Our discretion, that the Insured Person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third parties.

The Insured Person has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person's claim for benefits is denied or ignored, in whole or in part, the Insured Person may file suit and a court will review the Insured Person's eligibility or entitlement to benefits under the Policy.

DISABILITY CLAIM REVIEW PROCEDURES

(As Federally Mandated)

DEFINITIONS

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of Your eligibility to participate in a plan.

A document, record, or other information will be considered “**Relevant**” to a claim if it:

- (a) was relied upon in making the claim decision;
- (b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision;
- (c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants; or
- (d) constitutes a statement of policy or guidance with respect to the Policy concerning the denied benefit for the diagnosis, without regard to whether such advice or statement was relied upon in making the claim decision.

INITIAL CLAIM DECISION

Initial Claim Decision. We will make a claim decision regarding Your disability claim within 45 days after Our receipt of the claim.

Extensions. This 45 day period may be extended for up to 30 days, if We (1) determine that such an extension is necessary due to matters beyond Our control and (2) notify You, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension and the date by which We expect to render a decision. If, prior to the end of the first 30 day extension period, We determine that, due to matters beyond Our control, a decision cannot be rendered within that extension period, the period for making the decision may be extended for up to an additional 30 days; provided that We notify You, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which We expect to render a decision.

Notice of Extension. Our notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a claim decision and the additional information needed to resolve those issues. You will have 45 days within which to provide the specified information.

Time Periods. The period of time within which a claim decision is required to be made will begin at the time a claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. If a period of time is extended as described above due to Your failure to submit information necessary to decide a claim, the period for making the claim decision will be “tolled” or suspended from the date on which notice of the extension is sent to You until the earlier of: (1) the date on which We receive Your response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

(****)

NOTICE OF ADVERSE BENEFIT DETERMINATION

We will provide written or electronic notice of any Adverse Benefit Determination within 45 days after Our receipt of the claim, subject to the extensions described above. The notice will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) a description of any additional material or information necessary to complete the claim and the reason We need the material or information;
- (d) a description of the Policy's appeal procedures, including the time limits for such procedures and Your right to bring a civil action under the Employee Retirement Income Security Act (ERISA) following the appeal process;
- (e) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that it was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request; and
- (f) if the Adverse Benefit Determination was based on a medical necessity or experimental treatment or similar exclusion, a statement that it was relied upon in making the Adverse Benefit Determination and that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to You upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

You may appeal within 180 days following Your receipt of notification of an Adverse Benefit Determination.

The request for an appeal should include:

- (a) Your name;
- (b) the name of the person filing the appeal if different from You;
- (c) the Policy number; and
- (d) the nature of the appeal.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claim.

Our review will take into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial claim decision.

Our review will not give deference to the initial Adverse Benefit Determination.

Our review will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

We will identify any medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal will consult with a health care professional:

- (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
- (b) who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

APPEAL DECISION

Notice of Appeal Decision. We will notify You of Our appeal decision within 45 days after receipt of Your timely appeal request, unless We determine that special circumstances require an extension of time for processing the appeal. We will provide You with written or electronic notice of Our appeal decision.

Notice of an Adverse Benefit Determination will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to Your claim;
- (d) if an internal rule, guideline, protocol, or other similar criterion was used in making the Adverse Benefit Determination, a statement that it was used in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request;
- (e) if the Adverse Benefit Determination was based on a medical necessity or experimental treatment or similar exclusion, a statement that it was relied upon in making the Adverse Benefit Determination and that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to You upon request; and
- (f) a statement of Your right to bring a civil action under ERISA.

Notice of Extension. If We determine that an extension is required, We will notify You in writing of the extension prior to the termination of the initial 45 day period. In no event will the extension exceed 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

Time Periods. The period of time within which an appeal decision is required to be made will begin at the time an appeal is timely filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to Your failure to submit information necessary to decide a claim, the period for making the appeal decision shall be “tolled” or suspended from the date on which the extension notice is sent to You until the earlier of (1) the date on which We receive Your response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the Policy;
- (b) the Policyholder's application attached to the Policy; and
- (c) Your application, if required.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

- (a) does not require You or Your beneficiary's consent; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of Our officers.

A change may affect any class of Insured Persons, including retirees if retiree coverage is included in the Policy.

Applications

We may use misstatements or omissions in Your application to contest the validity of insurance, reduce coverage or deny a claim, but We must first furnish You or Your beneficiary with a copy of that application. We will not use Your application to contest or reduce insurance which has been in force for two years or more during Your lifetime. However, if You are not eligible for insurance, there is no time limit on Our right to contest insurance or deny a claim.

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

VERMONT MANDATORY CIVIL UNION ENDORSEMENT

This Rider is made a part of Group Policy GLTD-ADY1.

This Rider is effective the later of January 1, 2010, or the day You become insured under the Policy.

In the event of a conflict between this Rider and any other provision of the Policy, including the Certificate, this Rider shall control. This Rider shall be subject to all provisions of the Policy, including the Certificate, not in conflict with this Rider.

PURPOSE

This endorsement is part of the policy, contract, certificate and/or riders and endorsements to which it is attached and is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS

The definitions, terms, conditions or any other provisions of the policy, contract, certificate 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” and any other such terms include the relationship created by a civil union.

Terms that mean or refer to a family relationship arising from a marriage such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include the family relationship created by a civil union.

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.

“Dependent” means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

“Child or covered child” means a child (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

CAUTIONARY DISCLOSURE

THIS ENDORSEMENT IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE “PURPOSE” PARAGRAPH ABOVE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS ENDORSEMENT. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

LONG-TERM DISABILITY DEFINITIONS

Terms defined in this provision are used in, or apply to, other provisions throughout the Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Appropriate Care and Treatment means medical care and treatment that meet all of the following:

- (a) It is received from a Physician whose expertise, medical training and clinical experience are suitable for treating Your Injury or Sickness;
- (b) It is Medically Necessary;
- (c) It is consistent in type, frequency and duration of treatment with relevant guidelines based on national medical research or published by health care organizations and government agencies;
- (d) It is consistent with the diagnosis of Your condition; and
- (e) Its purpose is to improve Your medical condition and thereby aid in Your ability to return to work.

Deferred Compensation means contributions You make through a salary reduction agreement with Your employer to a plan or arrangement under Internal Revenue Code (IRC) §:

- (a) 401A;
- (b) 403(b);
- (c) 457(b) Deferred Compensation arrangement; or
- (d) any other deferred compensation agreement or arrangement defined under the Internal Revenue Code.

Elimination Period means the number of days of Total and/or Partial Disability which must be satisfied before You are eligible to receive benefits. The elimination period is shown in the Schedule. The elimination period begins on the first day of Total or Partial Disability. If You are not continuously disabled, the elimination period must be satisfied within a period of time which does not exceed two times the length of the elimination period; otherwise, a new elimination period will apply.

Gainful Occupation, during Total Disability, means an occupation for which You are reasonably fitted by training, education or experience.

Gainful occupation, during Partial Disability, means an occupation which:

- (a) You are reasonably fitted for by training, education or experience; and
- (b) provides or can be expected to provide You with Current Earnings at least equal to 85% of Basic Monthly Earnings within 12 months of Your return to work.

Gross Monthly Benefit means Your Monthly Benefit amount before any reduction for Other Income Benefits and Current Earnings.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing Your Total or Partial Disability. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Injury means an accidental bodily injury sustained by the Insured Person and directly caused by an accident which is not the result of disease or bodily infirmity. Total or Partial Disability due to such injury must begin while You are insured under the Policy. Injury does not include elective or cosmetic surgery or procedures, or complications resulting therefrom. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.

Material Duties means the essential tasks, functions, and operations relating to an occupation that cannot be reasonably omitted or modified. In no event will We consider working an average of more than 40 hours per week in itself to be a part of material duties. One of the material duties of Your Regular Occupation is the ability to work for an employer on a full-time basis.

Maximum Capacity means, based on Your medical restrictions and limitations:

- (a) during the first 24 months of Partial Disability payments, the greatest extent of work You are able to do in Your Regular Occupation; and
- (b) After 24 months of Partial Disability payments, the greatest extent of work You are able to do in any occupation that is reasonably available and for which You are reasonably fitted by education training or experience.

Medically Necessary means care that is ordered, prescribed or rendered by a Physician or Hospital and is determined by Us, or a qualified party or entity selected by Us, to be:

- (a) provided for the diagnosis or direct treatment of Your Injury or Sickness;
- (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of Your Injury or Sickness; and
- (c) provided in accordance with generally accepted professional standards and/or medical practice.

Partial Disability and Partially Disabled mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You, while unable to perform all of the Material Duties of Your Regular Occupation on a full-time basis, are:

- (a) able to perform at least one of the Material Duties of Your Regular Occupation on a part-time or full-time basis; and
- (b) unable to generate Current Earnings which exceed 99% of Your Basic Monthly Earnings due to that same Injury or Sickness.

After a Monthly Benefit has been paid for 2 years, partial disability and partially disabled mean You are able to perform at least one of the Material Duties of any Gainful Occupation on a part-time or full-time basis.

Partial disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with Your employer

Physician means any of the following licensed practitioners:

- (a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- (b) a licensed doctoral clinical psychologist; or
- (c) where required by law, any other licensed practitioner who is acting within the scope of his/her license.

A physician does not include You, a person who lives with You or is a part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

Policyholder's Retirement Plan means any retirement plan:

- (a) which is part of any federal, state, county, municipal or association retirement system; and
- (b) for which You are eligible as a result of employment with the Policyholder.

Recurrent Disability means a Total or Partial Disability which is related to or due to the same cause(s) of a prior Disability for which You received a Monthly Benefit under this Policy.

Regular Care means:

- (a) You visit a Physician as frequently as is medically required, according to standard medical practice, to effectively manage and treat Your disabling condition; and
- (b) You receive Appropriate Care and Treatment.

Regular Occupation means the occupation You are routinely performing when Your Total or Partial Disability begins. Your regular occupation is not limited to the specific position You held with the Policyholder, but will instead be considered to be a similar position or activity based on job descriptions included in the most current edition of the U.S. Department of Labor Dictionary of Occupational Titles (DOT). We have the right to substitute or replace the DOT with a service or other information that We determine of comparable purpose, with or without notice. To determine Your regular occupation, We will look at Your occupation as it is normally performed in the national economy, instead of how work tasks are performed for a specific employer, at a specific location, or in a specific area or region.

Retirement Benefit means money which:

- (a) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
- (b) does not represent contributions made by You; and
- (c) is payable upon the later of:
 - (1) early or normal retirement as defined in the Policyholder's Retirement Plan or under the U.S. Social Security Act; or
 - (2) Total or Partial Disability, if the payment does not reduce the amount of money which would have been paid at the normal retirement age under the plan if the Total or Partial Disability had not occurred.

NOTE: Regardless of how the retirement funds from the Retirement Plan are distributed, We will consider Your contributions and Your employer's contributions to be distributed simultaneously during Your lifetime.

Retirement Plan means a plan which provides Your Retirement Benefits and which is not funded wholly by Your contributions. The term shall not include a profit-sharing plan or a plan such as a 401(k), 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.

Rider means a provision added to the Policy or Your Certificate to expand or limit benefits or coverage.

Sickness means a disease, disorder or condition, including pregnancy, for which you are under the care of a Physician and which first manifests itself after the effective date of the Policy. Total or Partial Disability must begin while you are insured under the Policy. Sickness does not include elective or cosmetic surgery or procedures, or complications resulting therefrom. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.

Total Disability and Totally Disabled mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You are prevented from performing all of the Material Duties of Your Regular Occupation on a full-time basis.

After a Monthly Benefit has been paid for 2 years, total disability and totally disabled mean You are unable to perform all of the Material Duties of any Gainful Occupation.

Total disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with Your employer.

We, Our, Us means the Insurance Company shown on Your Certificate of Insurance.

You, Your and Insured Person means an insured employee or member.

Group Policy Number GLTD-ADY1



MUTUAL *of* OMAHA

Publication Date: February 8, 2011

APPENDIX J

SHORT-TERM DISABILITY PLAN

The President and Fellows of Middlebury College

Short-Term Disability Insurance Plan

Effective Date: August 1, 2011

Contact Information

**Plan Administrator:
Address and Telephone #:**

The President and Fellows of Middlebury College
Middlebury, VT 05753
(802)443-5465

**Claims Administrator:
Address and Telephone #:**

Mutual of Omaha
Disability Claims
8-Group Disability Management Services
Mutual of Omaha Plaza
Omaha, NE 68175
Phone: 800-877-5176
Fax: 402-997-1865

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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, which is referred to as your booklet.

The short-term disability insurance benefit is a self-funded, employer-paid benefit as provided in the Summary of Benefits section of this booklet. The Employer has engaged Mutual of Omaha to provide certain administrative claims handling services for the short-term disability insurance benefit. Neither Mutual of Omaha nor any of its affiliates or related insuring entities insures 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 College is the Plan Sponsor. The College 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 College has discretionary authority to determine your eligibility for benefits and to interpret and enforce the terms and provisions of the Plan. The College may delegate some or all of this authority to Mutual of Omaha at any time.

This booklet 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 in this booklet are defined in the Definitions Section. Be sure to read all the definitions so that you will understand the short-term disability insurance benefits provided under the Plan fully.

The provisions of this Appendix are effective as of August 1, 2011.

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: GUSI:05 BADY1

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:

Employee Category	Eligibility	Bi-Weekly Benefit Amount
Middlebury Staff and Monterey Staff NOT enrolled in CA SDI	Eligible	60% of bi-weekly earnings
Middlebury Staff and Monterey Staff enrolled in CA SDI <i>and</i> whose earnings are <u>above</u> the CA SDI wage ceiling	Eligible	60% of bi-weekly earnings <i>in excess of</i> the CA SDI wage ceiling
Middlebury Staff and Monterey Staff enrolled in CA SDI <i>and</i> whose earnings are <u>below</u> the CA SDI wage ceiling	Not Eligible	N/A
Monterey Faculty enrolled in CA SDI <i>and</i> whose earnings are <u>below</u> the CA SDI wage ceiling	Eligible	45% of bi-weekly earnings
Monterey Faculty enrolled in CA SDI <i>and</i> whose earnings are <u>above</u> the CA SDI wage ceiling	Eligible	45% of bi-weekly earnings below the wage ceiling PLUS 100% of bi-weekly earnings above the wage ceiling
Monterey Faculty NOT enrolled in CA SDI	Eligible	100% of bi-weekly earnings
Middlebury Faculty	Not Eligible	N/A

Faculty Employees of the College may be eligible for other short-term salary continuation benefits, as set forth in the Faculty Handbook, and should discuss the need for such benefits with the Provost.

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.

MINIMUM WORK REQUIREMENT:

To be eligible for benefits, you must meet the following requirements:

Staff Employees at the College or MIIS must be working at least 1,000 hours per year. MIIS Faculty Employees must be at least .5 FTE.

WAITING PERIOD:

The Waiting Period shall be the first of the month coincident with or next following your 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 the later of:

- 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.

Your payment may be reduced by Deductible Sources of Income and, in some cases, by the income you earn while disabled. Some disabilities may not be covered under this Plan.

BI-WEEKLY BENEFIT AMOUNT:

Please see the chart above beginning on page 4 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. Some disabilities may not be covered under this Plan.

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. 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. 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 or any other extra compensation, or income received from sources other than your Employer.

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 primary 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 College;
- 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 an administrative **Leave of Absence** you will be covered for a maximum of 12 months, as agreed by your Employer and stipulated in writing, following the date your administrative Leave of Absence begins.

If you are on any other **Leave of Absence** you will 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 prior 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 part of 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 send 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, or
- Employer Retirement Plan.

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)
- vacation time

Only deductible sources of income that are payable as a result of the same disability will be subtracted from the Bi-Weekly Payment.

Retirement Plan payments will be those benefits that are based on your Employer's contribution to the Retirement Plan. 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.

WHAT IS A "PREEXISTING CONDITION" AND HOW WILL IT AFFECT MY BENEFITS?

A "Preexisting Condition" is a mental or physical condition whether or not diagnosed or misdiagnosed, for which you have done any of the following:

- consulted a physician or other licensed medical professional,
- received medical treatment, services or advice,
- undergone diagnostic procedures, including self-administered procedures,
- taken prescribed drugs or medications,

which, as a result of any medical examination, including routine examination, was discovered or suspected at any time during the 90-day period just before your eligibility for Benefits.

VII. Claim and Appeal Information

WHEN DO YOU NOTIFY THE PLAN OF A CLAIM?

The Plan encourages you to notify Mutual of Omaha 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 Mutual of Omaha within 30 days after the date your disability begins. In addition, you must send Mutual of Omaha 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 Mutual of Omaha 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 Mutual of Omaha of your claim.

HOW DO YOU FILE A CLAIM?

A claim form, which can be used as your proof of claim, is available from Mutual of Omaha or from your Employer. If you do not receive the form within 15 days of your request, send Mutual of Omaha 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 Mutual of Omaha. Alternatively, you may follow any claims filing procedures approved by the Plan and Mutual of Omaha. The Plan 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 Mutual of Omaha 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 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.

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 MUTUAL OF OMAHA.

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 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.

RETIREMENT 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.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by the Plan 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.

MUTUAL OF OMAHA means the organization engaged to provide certain administrative claims handling services for the short-term disability insurance benefits under the Plan as identified on the cover page of this booklet.

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 College Employee and Family Assistance Program (“EFAP”) is designed to assist individuals in accessing professional help for personal problems 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 College is that of Middlebury student 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 College has a contract with LifeScope to provide the EFAP. EFAP benefits are only available through LifeScope.

BENEFITS

- 6 free visits per problem per year per Eligible Employee household.
- LifeScope Website: www.lifescopееap.com- A source for articles, tip sheets, videos, health appraisals, wellness assessments, financial calculators and quick reference links.
- 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 College Employee and Family Assistance Program benefits, contact LifeScope at 800-828-6025 or log on to their website at www.lifescopapeap.com.

APPENDIX L

VISION BENEFITS PLAN



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

GROUP VISION CARE POLICY

Group Name **PRESIDENT AND FELLOWS OF MIDDLEBURY COLLEGE**

Policy Number **30022396**

State of Delivery **VERMONT**

Effective Date **JANUARY 1, 2014**

Policy Term **TWENTY-FOUR (24) MONTHS**

Premium Due Date **FIRST DAY OF MONTH**

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

A handwritten signature in black ink, appearing to read 'James M. McGrann', is written above a horizontal line.

James M. McGrann, Secretary

EXHIBIT A

**VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
VSP Choice Plan**

GENERAL

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

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

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

PLAN BENEFITS

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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VISION CARE SERVICES

Eye Examination	Covered in Full*	Up to \$ 45.00*
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Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

*Less any applicable Copayment.

Subsequent regular eye examinations once every **plan year beginning on January 1st.**

VISION CARE MATERIALS

**MEMBER DOCTOR
BENEFIT**

NON-MEMBER PROVIDER BENEFIT

Lenses

Single Vision	Covered in Full*	Up to \$ 30.00*
Bifocal	Covered in Full*	Up to \$ 50.00*
Trifocal	Covered in Full*	Up to \$ 65.00*
Lenticular	Covered in Full*	Up to \$ 100.00*

*Less any applicable Copayment

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

Frames

Covered up to Plan Allowance*	Up to \$ 70.00*
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*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.

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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Professional Fees and Materials - Covered in Full*	Professional Fees and Materials - Up to \$ 210.00*
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ELECTIVE

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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Materials - Up to \$ 130.00 Elective Contact Lens fitting and evaluation** services are covered in full once every other plan year, after a maximum \$60.00 Copayment.	Professional Fees and Materials - Up to \$ 105.00
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*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.

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Supplementary Testing	Covered in Full	Up to \$125.00*
	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 $\pm .50$ 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.

Exhibit B

**VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
VSP Choice Plan**

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.

- \$ 5.61 per month for each eligible Enrollee without dependents.
- \$ 11.19 per month for each eligible Enrollee with one eligible dependent.
- \$ 18.04 per month for each eligible Enrollee with two or more eligible dependents.

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

ADDENDUM

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

GENERAL

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

ELIGIBILITY

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

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

Dependent children are covered up to age 26.

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

PROGRAM DESCRIPTION

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

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

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

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

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

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

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

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

**PLAN BENEFITS
MEMBER DOCTORS**

COVERED SERVICES

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

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

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

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY

VI. ELIGIBILITY FOR COVERAGE

6.01 (b) **Eligible Dependents**, Add the Following:

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

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

APPENDIX M

ABROAD ASSIGNMENT BENEFITS PLAN

AMENDMENT

POLICYHOLDER: MIDDLEBURY COLLEGE

POLICY NUMBER: 02301B

EFFECTIVE DATE OF THIS AMENDMENT: August 1, 2011

ISSUE DATE: July 11, 2011

The page in your policy coded GM5800 3IS1 is replaced by the page attached to this amendment.

The following page attached to this Amendment is added to the policy:

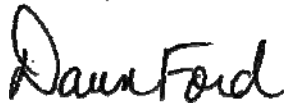
3IS2 V-1

CONNECTICUT GENERAL LIFE INSURANCE COMPANY



Shermona Mapp, Corporate Secretary

BA: Marylouise R. Toro



Registrar

ACCEPTED BY:

Policyholder Representative

Title

Date

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the policy (ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the certificate to "you" or "yours" refers to the Employee.

An Employee in any of the classes shown below may be insured but only for the policy (ies) listed for his Employee Class. The Effective Date shown below is the date on which a policy becomes effective for an Employee Class.

An Employee will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

<u>GROUP POLICY (IES)</u>		<u>EMPLOYEE CLASS</u>	
<u>Certificate</u>		<u>Eligible</u>	<u>Effective</u>
<u>Number</u>	<u>Policy (ies)</u>	<u>Employees</u>	<u>Date</u>
CN001 2-20	Life Insurance Two Times Salary up to \$200,000 02301B	All full-time Expatriate, Third Country National and Select Key Local National Employees working outside the United States.	8-1-11
	Accidental Death And Dismemberment Insurance Two Times Salary up to \$200,000 02301B		
	Medical Expense Insurance Medical Platinum w/ Vision 02301B		
	Prescription Drug Insurance 02301B		
	Dental Insurance Yes - Option 3 02301B		

**GLOBAL HEALTH
ADVANTAGE
2-20 Lives**

GROUP INSURANCE PLAN

CN003 – 01/01/2012
411866
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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*Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152*

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

a Cigna company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

GROUP POLICY(S) — COVERAGE

**COMPREHENSIVE MEDICAL INSURANCE
LIFE INSURANCE (IF APPLICABLE)
ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (IF APPLICABLE)
EMERGENCY EVACUATION OR REPATRIATION BENEFIT (IF APPLICABLE)
TRADITIONAL DENTAL INSURANCE (IF APPLICABLE)
PRESCRIPTION DRUG INSURANCE**

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.



Shermona Mapp, 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.



Patient Protection and Affordable Care Act

The group contract or certificate is amended as stated below.

In the event of a conflict between the provisions of your plan documents and the provisions of this endorsement, the provisions that provide the better benefit shall apply.

Definitions

“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 1) 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; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

“Emergency services” means, with respect to an emergency medical condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

“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.

“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).

“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.

Lifetime Dollar Limits

Any lifetime limit on the aggregate dollar value of essential health benefits is deleted. Any lifetime limits on the dollar value of any essential health benefits are deleted.

Annual Dollar Limits

Any annual limits on the dollar value of any essential health benefits are deleted.

Rescissions

Your coverage may not be rescinded (retroactively terminated) unless: (1) 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 (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Extension of Coverage to Dependents

Dependent children are eligible for coverage up to the age of 26. Any restrictions in the definition of Dependent in your plan document which require a child to be unmarried, a student, financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

Preventive Services

In addition to any other preventive care services described in the plan documents, no deductible, copayment, or coinsurance shall apply to the following Covered Services:

- (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.



Notice of Adverse Determination

In addition to the description provided in your plan documents, a notice of adverse benefit determination will also include information sufficient for you to identify the claim, and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. In the case of a final adverse benefit determination, your notice will include a discussion of the decision.

Right to Appeal

You have the right to appeal any decision or action taken to deny, reduce, or terminate the provision of or payment for health care services covered by your plan or to rescind your coverage. When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, you have the right to have the decision reviewed by an independent review organization not associated with Cigna.

Except where life or health would be seriously jeopardized, you must first exhaust the internal appeal process set forth in your plan documents before your request for an external independent review will be granted. If the plan does not strictly adhere to all internal claim and appeals processes, you can be deemed to have exhausted the internal appeal process.

Your appeal rights are outlined in your plan documents. In addition, before a final internal adverse benefit determination is issued, if applicable, you will be provided, free of charge, any new or additional evidence considered, or rationale relied upon, in sufficient time to allow you the opportunity to respond before the final notice is issued.

Emergency Services

Emergency Services, as defined above, are covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a participating provider. Emergency Services, as defined above, provided by a Non-participating Provider will be covered as if the services were provided by a Participating Provider.

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.cignaenvoy.com or contact customer service at the phone number listed on the back of your ID card.

Pre-Existing Condition Limitations

Any Pre-existing Condition Limitation provision described in the plan document does not apply to anyone who is under 19 years of age.

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Special Plan Provisions

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.

1. 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.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. 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.

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4. 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.

5. 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).
6. 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).
7. 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.

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How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

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.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to Cigna Service Center.

Doctor's Bills and Other Medical or Dental Expenses

The first Medical or Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS:

- BE SURE TO USE YOUR EMPLOYEE ID WHEN



YOU FILE CIGNA CLAIM FORMS, OR WHEN YOU CALL THE CIGNA INTERNATIONAL SERVICE CENTER.

- YOUR EMPLOYEE ID AND ACCOUNT NUMBER ARE BOTH SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Accident and Health Provisions

Claims

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

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Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week.

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 of a participating Employer working outside the United States.

"Expatriate" means an Employee who is working outside his country of citizenship.

"Third Country National" generally means an Employee of the Policyholder who works outside his country of citizenship, and outside the Policyholder'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.

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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 CG 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. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

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.

CG may require evidence of insurability at your expense if you are a Late Entrant. Such requirement will not apply to Medical Insurance.

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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 CG 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.

CG may require evidence of good health at your expense if you are a Late Entrant. Such requirement will not apply to Medical Insurance.

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.

GM6000 EF 2
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Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; Employer contributions toward the other coverage have been terminated; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage. In addition, a Dependent spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Pre-Existing Condition Limitation for Late Entrant (Not applicable to employees and dependents under age 19)

For plans which include a Pre-existing Condition limitation, the one-year waiting period before coverage begins for such conditions, will be increased to 18 months from the date a Late Entrant applies for coverage.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 18 months will apply from date a Late Entrant applies for coverage.

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Life Insurance (If Applicable)

The Schedule

BENEFIT HIGHLIGHTS

For You

Amount of Life Insurance as determined by your Employer

Option 1 -	Flat benefit of \$25,000
Option 2 -	One (1) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$200,000
Option 3 -	Two (2) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$200,000
Option 4 -	One (1) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$50,000
Option 5 -	Two (2) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$400,000

Age Reduction

If you are 65 years old or older, but under age 70, your amount of Life Insurance is reduced to 65% of the amount determined from the above schedule. If you are 70 years old or older, your amount of Life Insurance is reduced to 50% of the amount determined from the above schedule.

Effect of Retirement

If you should leave Active Service due to retirement, your Life Insurance will terminate on your retirement date.

Changes in Amount of Life Insurance

Any change in your amount of Life Insurance due to a change in Basic Earnings will take place on the first day of the month following the date your Basic Earnings change. However, any increase in the amount of Life Insurance is subject to the "Exceptions for Increased Amount of Life Insurance" section.

Any decrease in your amount of Life Insurance due to age will take place on the first day of the month following your birthday.

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.

For Options 2 and 3, if that amount is more than \$100,000, you will be insured for \$100,000 unless you satisfy the Insurability Requirement as of that day. **(Effective 5/1/2011 and after, at your policy's renewal, this provision will no longer apply. In addition for new policies, Effective 5/1/2011 and after, this provision is not applicable.)**



Exceptions For Increased Amount of Life Insurance (Effective 5/1/2011 and after, at your policy's renewal, this provision will no longer apply. In addition for new policies, Effective 5/1/2011 and after, this provision is not applicable.)

If you are not in Active Service on the day your amount of Life Insurance would otherwise be increased for any reason, the increased amount of your Life Insurance will be considered effective after you have returned to Active Service for one full day.

If, at any time, you are insured for \$100,000 or less of Life Insurance and become eligible for an increased amount of Life Insurance that exceeds \$100,000, you will be insured for the increased amount only if you satisfy the Insurability Requirement for such amount. The effective date for such amount will be the date you satisfy the Insurability Requirement for that amount. Any increase in your amount of Life Insurance is subject to the Active Service provision.

Insurability Requirement (Effective 5/1/2011 and after, at your policy's renewal, this provision will no longer apply. In addition for new policies, Effective 5/1/2011 and after, this provision is not applicable.)

You will be considered to have satisfied the Insurability Requirement for an amount of Life Insurance on the date CG accepts you as insurable for that amount. To determine your acceptability for an amount of Life Insurance in excess of \$100,000, CG will require evidence of good health and may require that it be presented at your own expense.



Life Insurance Benefit (If Applicable)

Death Benefit

CG will pay the amount of your Life Insurance when it receives due proof that you died while insured for this benefit. The amount payable is determined from The Schedule and the other terms of the policy.

Total Disability Benefit

If you are Totally Disabled on the date your Life Insurance ceases, CG will pay the amount of that insurance when it receives due proof of your death subject to the terms set forth below. This payment will be in place of all other benefits and options under the policy. The amount payable will be the amount of Life Insurance in force on you when your insurance ceased.

Such payment will be made only if all of the following terms are met:

- you die more than 31 days but less than one year after your insurance ceases.
- on the date your insurance ceased, you had been continuously insured under the policy for a period of time longer than the period of time from that date to the date of your death.
- you were continuously unable to engage in any occupation for wage or profit because of an injury or a sickness from the date your insurance ceased until you died.
- the policy was in force on the date of your death.
- your insurance ceased on or after your 60th birthday and you died before age 65.

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LIF85

Limitations

No benefits are payable under this part if death is the result of declared or undeclared war or any act thereof, riot, civil commotion or police action which occurs in the Employee's country of citizenship.

No benefits are payable for claim payments that are illegal under applicable law.

No benefits are payable for members of the armed forces of any nation while actively engaged in war, except for reservists while temporarily on active duty.

GM6000 LIF218DE

What Your Beneficiary Should Do and Expect if He/She Has a Claim

When your beneficiary is eligible to receive benefits under the Plan, he/she must request a claim form or obtain instructions for submitting his/her claim telephonically or electronically, from the Plan Administrator. All claims he/she submits must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. He/She must complete his/her claim according to directions provided by the Insurance Company. If these forms or instructions are not available, he/she must provide a written statement of proof of loss. After he/she has completed the claim form or written statement, he/she 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.

GM6000 LIF235

The Insurance Company has 90 days from the date it receives his/her claim to determine whether or not benefits are payable to him/her in accordance with the terms and provisions of the Policy. Under special circumstances, the Insurance Company may require more time to review his/her claim. If this should happen, the Insurance Company must notify him/her in writing that its review period has been extended for an additional 90 days. If this extension is made because he/she must furnish additional information, this 90-day period will begin when the additional information is received.

If additional information is required, the Insurance Company must notify your beneficiary, in writing, stating the information needed and explaining why it is needed.

GM6000 LIF236

If the claim is approved, your beneficiary will receive the appropriate benefit from the Insurance Company.

If the claim is denied, in whole or in part, your beneficiary must receive a written notice from the Insurance Company within the 90-day review period (or within 180 days if the review period was extended). The Insurance Company's written notice must include the following information:

- the specific reason(s) the claim was denied.
- specific reference to the Policy provision(s) on which the denial was based.



CIGNA International Expatriate Benefits

- any additional information required for the claim to be reconsidered, and the reason this information is necessary.
- a statement informing your beneficiary of his/her right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

GM6000 LIF237

Appeal Procedure for Denied Claims

Whenever a claim is denied, your beneficiary has the right to appeal the decision. Your beneficiary (or his/her duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days from the date your beneficiary received the denial. If he/she does not make this request within that time, he/she will have waived his/her right to appeal.

Once the request has been received by the Insurance Company, a prompt and complete review of the claim must take place. During the review, your beneficiary (or his/her 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. Your beneficiary may also submit issues and comments that he/she feels might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your beneficiary's request to review the claim and notify your beneficiary of its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must notify your beneficiary, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must notify your beneficiary, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

GM6000 LIF238

Conversion Privilege

When your Life Insurance ceases, you may apply to CG for an individual converted life policy. It will be issued to you if you are Entitled to Convert and if you apply in writing and pay the first premium to CG within 31 days after the date your Life Insurance ceases. Evidence of good health is not needed.

Entitled To Convert

You are Entitled to Convert your Life Insurance only if:

- your insurance ceases because you are no longer in Active Service or no longer eligible for Life Insurance.
- your insurance ceases or is reduced because of retirement or age.
- the policy is canceled for your class of Employees and you have been insured under the policy for at least three years before it is canceled.

The amount of Life Insurance that you are Entitled to Convert will not be more than the amount of group Life Insurance that you lose. If all insurance under the policy is canceled on the class of Employees to which you belong, the amount of insurance under the converted life policy will be the smaller of: (a) the amount of your insurance which ceases less any amount of group life insurance for which you become eligible within 31 days after the insurance ceases; or (b) \$10,000.

The converted policy will be one of CG's current offerings based on its rules for converted life policies. It will be issued at your attained age for the premium that applies to the class of risk to which you then belong. It will take effect on the 32nd day after your Life Insurance ceases. Neither term insurance nor disability benefits are offered under the converted life policy.

Payment During Conversion Period

If you die during the 31 days in which you may convert to an individual life policy, CG will pay to the Beneficiary designated under your group policy, the amount of insurance you could have converted. In this case, no payment will be made under the converted policy.

Extension of Conversion Period

If you are eligible for conversion insurance and are 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. You 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 you by your Employer or mailed to your last known address as reported by your Employer.

If you die during the extended conversion period, but more than 31 days after your coverage under the Policy terminates, Life Insurance Benefits will not be paid under the Policy. If your application for conversion insurance is received by us and the required premium is paid, Life Insurance Benefits will be payable under the conversion insurance.

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GM6000 LI57
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Accidental Death and Dismemberment Insurance (If Applicable)

The Schedule

BENEFIT HIGHLIGHTS

For You

This insurance provides benefits for accidental death or dismemberment. The amount that may be payable is based on your Amount of Principal Sum.

Amount of Principal Sum as determined by your Employer

Option 1 -	Flat benefit of \$25,000
Option 2 -	One (1) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$200,000
Option 3 -	Two (2) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$200,000
Option 4 -	One (1) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$50,000
Option 5 -	Two (2) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$400,000

Age Reduction

If you are 65 years old or older, but under age 70, your amount of Principal Sum is reduced to 65% of the amount determined from the above schedule. If you are 70 years old or older, your amount of Principal Sum is reduced to 50% of the amount determined from the above schedule.

Effect of Retirement

If you should leave Active Service due to retirement, your Accidental Death & Dismemberment Insurance will terminate on your retirement date.

Changes in Amount of Principal Sum

Any change in your amount of Principal Sum due to a change in Basic Earnings will take place on the first day of the month following the date your Basic Earnings change. If you are not in Active Service on that day, the increase in Basic Earnings will be considered effective after you have returned to Active Service for one full day.

Any decrease in your amount of Principle Sum due to age will take place on the first day of the month following your birthday.



Accidental Death and Dismemberment Benefits (If Applicable)

For You

CG will pay the Benefit Amount when it receives due proof that:

- you received an accidental bodily injury while insured for this benefit; and
- as a direct result of that injury, independently of all other causes, you sustained any loss shown in the Table of Losses and Benefits; and
- the loss occurred within 90 days after the date of that injury.

Benefit Amount

The Benefit Amount for each loss will be your amount of Principal Sum determined from The Schedule multiplied by the percentage shown in the Table of Losses and Benefits for that loss. The maximum that will be paid for all losses resulting from injuries you receive in any one accident will be your amount of Principal Sum.

GM6000 DD 1
ADD1

Table of Losses and Benefits

	% of Principal Sum
Loss of Life	100%
Loss of One Hand by Severance at or above the Wrist	50%
Loss of One Foot by Severance at or above the Ankle	50%
Entire and Irrecoverable Loss of Sight in One Eye	50%
Loss of more than one of the above in one Accident	100%

Limitations

Death and Dismemberment Benefits will not be paid for a loss which in any way results from:

- suicide or intentionally self-inflicted injury, while sane or insane.
- sickness, disease, bodily infirmity, or bacterial or viral infection, even if contracted by accident. This exclusion does not apply to bacterial infection that is the natural and foreseeable result of an accidental external cut or wound.
- declared or undeclared war, or an act of war which occurs in the Employee's country of citizenship.

- injuries received by you while operating, learning to operate or acting as a pilot or crew member of an aircraft.

No benefits are payable for claim payments that are illegal under applicable law.

No benefits are payable for members of the armed forces of any nation while actively engaged in war, except for reservists while temporarily on active duty.

GM6000 DD 2
ADD14V1

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 telephonic or electronic 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.

GM6000 ADD66

The Insurance Company has 90 days from the date it receives your claim to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. 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 90 days. If this extension is made because you must furnish additional information, this 90-day period will begin when the additional information is received.

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.

GM6000 ADD67

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 90-day review period (or within 180 days if the review period was extended). The Insurance Company's written notice must include the following information:

- the specific reason(s) the claim was denied.
- specific reference to the Policy provision(s) on which the denial was based.
- any additional information required for your claim to be reconsidered, and the reason this information is necessary.
- a statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

GM6000 ADD68

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 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. During the review, you or your 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. 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. 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. 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.

GM6000 ADD69



Comprehensive Medical Insurance The Schedule

For You and Your Dependents

To receive Comprehensive Medical Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible, Copayment and 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/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and 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.

Maximum Reimbursable Charge

Unless otherwise noted, services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all charges made by providers of such service or supply in the geographic area.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any:

- coinsurance.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- copayments;
- deductibles;
- non-compliance penalties; or
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties; and
- provider charges in excess of the Maximum Reimbursable Charge.

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 that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)



CIGNA International Expatriate Benefits

BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Emergency Evacuation or Repatriation Benefits *Only applicable if elected by your Employer. Please refer to the sticker located inside the front cover of this certificate.	100%*	100%*	100%*
Coinsurance Levels	100% of the Maximum Reimbursable Charge	80% of the Maximum Reimbursable Charge	80% of the Maximum Reimbursable Charge



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Calendar Year Deductible</p> <p>Individual</p> <p>Family Maximum</p> <p>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.</p>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>	<p>\$200 per person</p> <p>\$600 per family</p>
<p>Combined Medical/Pharmacy Calendar Year Deductible</p> <p>Combined Medical/Pharmacy Deductible: includes retail drugs</p>	<p>Not Applicable</p>	<p>Not Applicable</p>	<p>Yes</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Out-of-Pocket-Maximum</p> <p>Individual</p> <p>Family Maximum</p> <p>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%</p>	<p>\$0</p> <p>\$0</p>	<p>\$1,000</p> <p>\$3,000</p>	<p>\$1,000 excluding deductible</p> <p>\$3,000 excluding deductible</p>
<p>Combined Medical/Pharmacy Out-of-Pocket Maximum</p> <p>Combined Medical/Pharmacy Out-of-Pocket: includes retail and mail order drugs</p>	<p>Not Applicable</p>	<p>Yes</p>	<p>Yes</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
Physician's Services			
Physician's Office Visit	100%	80%	80%, after plan deductible
Surgery Performed in the Physician's Office	100%	80%	80%, after plan deductible
Second Opinion Consultants (provided on a voluntary basis)	100%	80%	80%, after plan deductible
Allergy Treatment/Injections/Serum	100%	80%	80%, after plan deductible
Adult Preventive Care Routine Preventive Care for adults ages 18 and over (including immunizations)	100%	100%	100%, not subject to the plan deductible
Child Preventive Care Routine Preventive Care for children through age 17 (including immunizations and developmental screenings)	100%	100%	100%, not subject to the plan deductible
Delaware Mandated Immunizations covered through age 18 (Refer to list under Covered Expenses)	100%	100%	100%, not subject to the plan deductible
Travel Immunizations for Employees and Dependents	100%	100%	100%, not subject to the plan deductible
Prescription Drugs (Purchased outside the United States)	100%	80%	80%, after plan deductible



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Vision Care Benefit</p> <p>One examination per 24 month period</p> <p>One pair of frames or lenses per 24 month period Maximum Benefit: \$250</p>	<p>100%</p> <p>100%</p>	<p>80%</p> <p>100%</p>	<p>Not Covered</p> <p>Not Covered</p>
<p>Hearing Benefit</p> <p>One examination per 24 month period</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>
<p>Hearing Aids For Dependents To Age 24</p> <p>Maximum Benefit: \$1,000 per hearing aid unit necessary for each ear, every three years</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>
<p>Mammograms, PSA, Pap Smear and Colorectal Cancer Screenings</p>	<p>100%</p>	<p>100%</p>	<p>100%, not subject to the plan deductible</p>
<p>Lead Poisoning Screening Tests For Children under age 6</p>	<p>100%</p>	<p>100%</p>	<p>100%, not subject to the plan deductible</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	100% Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate	80% Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate	80%, after plan deductible Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	100%	80%	80%, after plan deductible
Inpatient Hospital Physician's Visits/Consultations	100%	80%	80%, after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	80%	80%, after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	80%	80%, after plan deductible



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
Emergency and Urgent Care Services			
Physician's Office Visit	100%	80%	80%, after plan deductible
Hospital Emergency Room	100%	80%	80%, after plan deductible
Outpatient Professional Services (Radiology, Pathology and ER Physician)	100%	80%	80%, after plan deductible
Urgent Care Facility	100%	80%	80%, after plan deductible
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	100%	80%	80%, after plan deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	100%	80%	80%, after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	100%	80%	80%, after plan deductible
Ambulance	100%	80%	80%, after plan deductible



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Inpatient Services at Other Health Care Facilities</p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Calendar Year Maximum (combined for all facilities listed above): 120 days</p>	100%	80%	80%, after plan deductible
<p>Laboratory and Radiology Services (includes pre-admission testing)</p> <p>Physician's Office</p> <p>Outpatient Hospital Facility</p> <p>Independent X-ray and/or Lab Facility</p>	100%	80%	80%, after plan deductible
<p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	100%	80%	80%, after plan deductible



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Outpatient Short-Term Rehabilitative Therapy</p> <p>Calendar Year Maximum: 60 days for all therapies combined</p> <p>Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p>	100%	80%	80%, after plan deductible
<p>Chiropractic Care Services</p> <p>Office Visit</p> <p>Calendar Year Maximum: 20 days</p>	100%	80%	80%, after plan deductible
<p>TMJ</p> <p>TMJ Treatment</p> <p>Benefit Lifetime Maximum: \$1,000</p>	100%	80%	80%, after plan deductible
<p>Home Health Care</p> <p>Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as medically necessary)</p>	100%	80%	80%, after plan deductible
<p>Hospice</p> <p>Inpatient Services</p> <p>Outpatient Services</p>	100%	80%	80%, after plan deductible



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Bereavement Counseling</p> <p>Services Provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services Provided by Mental Health Professional</p>	<p>100%</p> <p>100%</p> <p>Covered under Mental Health benefit</p>	<p>80%</p> <p>80%</p> <p>Covered under Mental Health benefit</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>Covered under Mental Health benefit</p>
<p>Maternity Care Services</p> <p>Initial Visit to Confirm Pregnancy</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Physician's Office Visits in addition to the global maternity fee when performed by an OB or Specialist</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Abortion</p> <p>Includes elective and non-elective procedures</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p>
<p>Family Planning Services</p> <p>Physician's Office Visit and Counseling</p> <p>Surgical Sterilization Procedure for Vasectomy/ Tubal Ligation (excludes reversals)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Organ Transplant Includes all medically appropriate, non-experimental transplants</p> <p>Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>No charge (only available when using Lifesource facility)</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>No charge (only available when using Lifesource facility)</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>No charge (only available when using Lifesource facility)</p>
<p>Durable Medical Equipment</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>
<p>External Prosthetic Appliances</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>
<p>Scalp Hair Protheses</p> <p>Worn Due to Alopecia Areata</p> <p>Calendar Year Maximum: \$500</p>	<p>100%</p>	<p>100%</p>	<p>100%, not subject to plan deductible</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>Nutritional Evaluation</p> <p>Calendar Year Maximum: 3 visits per person, however the three visit limit will not apply to treatment of diabetes</p> <p>Physician’s Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician’s Services</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p>
<p>Dental Care</p> <p>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</p> <p>Physician’s Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician’s Services</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>	<p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p> <p>80%, after plan deductible</p>
<p>Routine Foot Disorders</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>



BENEFIT HIGHLIGHTS	PLATINUM PLAN	GOLD PLAN	SILVER PLAN
<p>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 abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</p>			
<p>Mental Health & Substance Abuse</p>			
<p>Inpatient Facility</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>
<p>Outpatient (Includes Individual, Group and Intensive Outpatient)</p>			
<p>Physician's Office Visit</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>
<p>Outpatient Facility</p>	<p>100%</p>	<p>80%</p>	<p>80%, after plan deductible</p>



Comprehensive Medical Insurance

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement In The United States

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;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse 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 will not include the first \$300 of Hospital charges made for each separate admission to the Hospital:

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

- 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.

GM6000 PAC1V33

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

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 CG. **Any applicable Coinsurance, Copayments, Deductibles or limits are shown in The Schedule.**

- 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 an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.

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CIGNA International Expatriate Benefits

- 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.
- charges made for visits for Routine Preventive Care of a Dependent child through age 17, including immunizations. Coverage includes developmental screenings at nine, eighteen and thirty months which includes any developmental screening tool favorably mentioned by the American Academy of Pediatrics Committee on Children with Disabilities.
- charges made for Routine Preventive Care for adults ages 18 and over, including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges made for or in connection with travel immunization for Employees and Dependents.
- surgical or nonsurgical treatment of TMJ dysfunction.

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- 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.

GM6000 CM6
FLX108V748

- charges made for or in connection with mammograms including: (a) a baseline mammogram for asymptomatic women at least age 35; (b) 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; (c) an annual mammogram for women age 50 and over; and (d) when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- charges made for CA-125 monitoring of ovarian cancer subsequent to treatment for ovarian cancer. Coverage is not provided for routine screening.
- charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age.
- charges made for 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: (a) diphtheria; (b) hepatitis B; (c) measles; (d) mumps; (e) pertussis; (f) polio; (g) rubella; (h) tetanus; (i) varicella; (j) Haemophilus influenzae B; and (k) hepatitis A.
- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- charges made for scalp hair prostheses worn due to alopecia areata.
- 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.
- nutritional formulas, low protein modified food products, or other medical foods consumed or administered enterally (via tube or orally) which are medically necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a Physician.

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- 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.

GM6000 06BNR10

- charges made for colorectal cancer screening for persons 50 years of age or older to include: (a) a screening with an annual fecal occult blood test (3 specimens); (b) a flexible



sigmoidoscopy every 5 years; (c) a colonoscopy every 10 years; (d) a double contrast barium enema every 5 years; or (e) any combination of the most reliable, medically recognized screening tests available as may be determined by the Delaware Secretary of Health and Social Services. Coverage for persons who are deemed at high risk for colon cancer because of family history of familial adenomatous polyposis or hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease, family history of breast, ovarian, endometrial, colon cancer or polyps, or a background, ethnic or lifestyle, such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk, shall include a screening by colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available as may be determined by the Delaware Secretary of Health and Social Services at a frequency determined by the Physician.

- hearing aids for Dependent children up to age 24.

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Clinical Trials

- charges made for routine Patient Services associated with clinical trials for treatment of life-threatening diseases approved and sponsored by the federal government. In addition, the following criteria must be met:
 - the clinical trial is listed on the National Institutes of Health web site www.clinicaltrials.gov as being sponsored by the federal government.
 - the subject or purpose of the trial must be the evaluation of an item or service that falls within the covered benefits of the policy and is not specifically excluded from coverage.
 - the trial must not be designed exclusively to test toxicity or disease pathophysiology.
 - the trial must have therapeutic intent.
 - trials of therapeutic interventions must enroll the patients with diagnosed disease.
 - the principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes.
 - the trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
 - the trial does not unjustifiably duplicate existing studies.
 - the trial is in compliance with federal regulations relating to the protection of human subjects.
 - the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol."

- the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine Patient Services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself.
- services or supplies listed herein as Exclusions or Limitations.
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs).
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

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

GM6000 05BPT1 V10 (2)

- 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 contract year for both pre- and postgenetic 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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Home Health Services

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

Home Health Services are provided only if CG 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. 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.

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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;

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- 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.

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Mental Health and Substance Abuse 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 Abuse 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 Abuse.

Inpatient Mental Health Services are 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 Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

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.

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Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) 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 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.

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. 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.

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Inpatient Substance Abuse 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 Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Abuse 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 Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) 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 Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse 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 Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. 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.

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V78

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG 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 Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- 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.

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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 CG 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.

GM6000 06BNR5

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; and
- 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.

GM6000 05BPT5

Short-Term Rehabilitative Therapy

- 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.

The following limitations apply to short-term rehabilitative therapy:

- to be covered all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- services are not covered if they are custodial, instructional, educational or developmental in nature.
- 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 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 recurrences or to maintain the patient's current status.

GM6000 06BNR8 (2)

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 are specifically excluded from chiropractic care services:

- to be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative therapy services do not include therapy designed to acquire levels of function that has not been previously achieved prior to the Injury or Sickness;
- services are not covered if they are considered custodial, instructional, developmental or educational in nature;
- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;
- 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 preventive treatment consisting of routine, long-term or Non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- vitamin therapy.

GM6000
05BPT9
06BNR6

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/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.
- 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

- 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: (a) evaluation, (b) candidacy, (c) transplant event, or (d) 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.

GM6000 05BPT7 V13

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) 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: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) 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.

GM6000 05BPT2 V2

Prescription Drug Benefits (purchased outside the U.S.)

- charges made for Prescription Drugs and Related Supplies, subject to the Deductibles, Coinsurance and Limits shown in the Medical Schedule, except that the following Prescription Drugs, by way of example, but not of limitation are excluded:
 - drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication;
 - any drugs that are labeled as experimental or investigational;
 - Food and Drug Administration (FDA) approved prescription 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, and fluoride products;
- prescription 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;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products; or
- any non-prescription drugs.

GM6000 INDEM14



Prescription Drug Insurance Platinum Plan Schedule

This section describes coverage for Prescriptions obtained inside the United States only.

Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Insurance section of this certificate.

For You and Your Dependents

This plan provides Prescription Drug Insurance for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion is the Copayment and Coinsurance. **There is no Deductible.**

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.

Copayments

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Copayments are in addition to any Coinsurance.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Prescription Drugs – per 30 day prescription order or refill		
Generic*	\$ 0 Copayment	\$25 Copayment
Brand-Name *	\$25 Copayment	\$25 Copayment
Mail-Order Drugs – per 90 day prescription order or refill		
Generic *	\$ 0 Copayment	In-network coverage only
Brand-Name*	\$75 Copayment	In-network coverage only

* Designated as per generally-accepted industry sources and adopted by CG



Prescription Drug Insurance Gold Plan Schedule

This section describes coverage for Prescriptions obtained inside the United States only.

Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Insurance section of this certificate.

For You and Your Dependents

This plan provides Prescription Drug Insurance for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion is the Coinsurance. **There is no deductible.**

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.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Prescription Drugs – per 30 day prescription order or refill Generic* Brand-Name *	10% coinsurance 30% coinsurance	30% coinsurance 30% coinsurance
Mail-Order Drugs – per 90 day prescription order or refill Generic * Brand-Name*	10% coinsurance 30% coinsurance	In-network coverage only In-network coverage only

* Designated as per generally-accepted industry sources and adopted by CG



Prescription Drug Insurance Silver Plan Schedule

This section describes coverage for Prescriptions obtained inside the United States only.

Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Insurance section of this certificate.

For You and Your Dependents

This plan provides Prescription Drug Insurance for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion is the Deductible and 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.

Deductibles

Deductibles are also expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Prescription Drugs – per 30 day prescription order or refill		
Generic*	10% coinsurance	30% coinsurance, subject to plan deductible
Brand-Name *	30% coinsurance	30% coinsurance, subject to plan deductible
Mail-Order Drugs – per 90 day prescription order or refill		
Generic *	10% coinsurance	In-network coverage only
Brand-Name*	30% coinsurance	In-network coverage only

* Designated as per generally-accepted industry sources and adopted by CG



Prescription Drug Insurance For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Insurance, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CG 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.

Limitations

Each Prescription Order or refill shall be limited to:

- a dosage and/or dispensing limit as determined by the Pharmaceuticals & Therapeutics Committee.

GM6000 PHARM91
GM6000 PHARM85 PHARM122

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

GM6000 PHARM92 PHARM124
GM6000 PHARM93
GM6000 PHARM87

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;

- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;
- 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 and non-prescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- dietary supplements, and fluoride 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;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- 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.

Other limitations are shown in the Medical "Exclusions" section.

GM6000 PHARM88 PHARM104V16
GM6000 PHARM89
GM6000 PHARM105



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, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a Non-Participating Retail Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form in order to be reimbursed for the amount payable by the plan. You may get the required claim forms at www.cignaenvoy.com or from your Benefit Plan Administrator.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your Benefits Kit for details, or contact member services for assistance.

GM6000 PHARM94 V17 (M)



Emergency Evacuation or Repatriation Benefits (If Applicable)

Notification

International SOS, acting as CG's evacuation coordinator, must approve any evacuation or repatriation.

If you need an emergency evacuation or repatriation as the result of an Injury or Sickness, International SOS or CG must be notified by the end of the first scheduled workday after the Injury or Sickness.

Expenses incurred for your evacuation or repatriation without the approval and authorization of International SOS will not be considered Covered Expenses (See General Limitations/Exclusions for Evacuation Benefits.)

GM6000 NOT32 V2

Covered Expenses

If you suffer an Injury or sudden, life-threatening Illness, and International SOS determines that adequate medical facilities are not available locally, International SOS will arrange for an emergency evacuation or repatriation to the nearest facility capable of providing adequate care. Although International SOS will be providing the service, to access International SOS, you must call the Cigna Service Center at 1-800-441-2668 (Inside the U.S. and Canada) or outside the U.S. and Canada call collect at 1-302-797-3100.

In making their determinations, they 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. Transportation will be provided by private medically equipped aircraft, helicopter, commercial airline, train or ambulance. All evacuations or repatriations are carried out under the medical authorization or intervention of International SOS.

Following an approved medical evacuation, CG will pay, based on recommendation of International SOS, for one of the following:

- if it is deemed Medically Necessary, you will be transferred to your permanent residence via a one-way economy airfare. If your transportation needs to be medically supervised, a qualified medical attendant will escort you; or
- a one-way economy airfare will be provided to return to the point of evacuation or original work location.

Emergency Family Travel Arrangements and Confinement Visitation

If family members need to join you when you are evacuated, and subsequently hospitalized, emergency travel arrangements for your family members will be coordinated. The costs of the travel services, however, are the responsibility of you or your family members.

If you require hospitalization in excess of 7 days at the location to which you were 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.

GM6000 COM445V1

Return of Dependent Children

If Dependent children are left unattended as a result of your Injury or Sickness, a one-way economy airfare will be provided to their place of residence. Furthermore, the accompaniment of a qualified attendant will be provided at no charge, if required.

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 for organizing and obtaining the necessary clearances for the repatriation of mortal remains.

Return of Traveling Companion

If you are hospitalized or evacuated, and a traveling companion's air ticket is no longer usable, a one-way economy airfare will be provided to the original point of departure.

GM6000 COM446 V1

General Limitations/ Exclusions for Evacuation Benefits

No payment will be made for charges for:

- services rendered without the authorization or intervention of International SOS;
- nonemergency, 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;
- 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;



**General Limitations/ Exclusions for Evacuation Benefits
(continued)**

- 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.

GM6000 GEN309DE M



Traditional Dental Insurance – Option 1 (If Applicable) The Schedule

For You and Your Dependents

To receive Comprehensive Dental Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.

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 separate from and 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.

Maximum Reimbursable Charge

Unless otherwise noted, 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 made by providers of such service or supply in the geographic area.

BENEFIT HIGHLIGHTS

Classes I, II, III Calendar Year Maximum	\$ 1,000
Calendar Year Deductible Individual Family Maximum	\$ 50 per person \$150 per family
Class I Preventive Care	100%
Class II Basic Restorative	80% after plan deductible
Class III Major Restorative	50% after plan deductible



Traditional Dental Insurance – Option 2 (If Applicable)

The Schedule

For You and Your Dependents

To receive Comprehensive Dental Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.

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 separate from and 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.

Maximum Reimbursable Charge

Unless otherwise noted, 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 made by providers of such service or supply in the geographic area.

BENEFIT HIGHLIGHTS

Classes I, II, III 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%
Class II	
Basic Restorative	80% after plan deductible
Class III	
Major Restorative	50% after plan deductible
Class IV	
Orthodontia	50%
Class IV Orthodontia applies only to a Dependent Child less than 19 years of age	



Traditional Dental Insurance – Option 3 (If Applicable)

The Schedule

For You and Your Dependents

To receive Comprehensive Dental Insurance, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Coinsurance. **There is no Deductible.**

Coinsurance

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

Maximum Reimbursable Charge

Unless otherwise noted, 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 made by providers of such service or supply in the geographic area.

BENEFIT HIGHLIGHTS

Classes I, II, III Calendar Year Maximum	\$ 1,500
Class IV Lifetime Maximum	\$ 1,500
Class I Preventive Care	100%
Class II Basic Restorative	80%
Class III Major Restorative	50%
Class IV Orthodontia Class IV Orthodontia applies only to a Dependent Child less than 19 years of age	50%



Traditional Dental Insurance (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; and
- 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.

GM6000 DEN160

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, CG 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 CG’s dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

CG will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, CG 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 \$500 - \$1,000).

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.

GM6000 DEN161

Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes insured is 50% of the amount payable for the replacement of teeth that are extracted after a person has dental coverage.

This payment limitation no longer applies after 24 months of continuous coverage.

GM6000 DEN165

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule;
- no benefits are payable for Class III or Class IV Dental Services if a covered person is a Late Entrant for Dental Insurance; and
- after a person has been continuously insured for 12 months, this limit no longer applies.

GM6000 DEN172 (M)

Covered Services

The following section lists covered dental services. CG 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 CG.

GM6000 DEN166V2

Payment for a covered service is the Maximum Reimbursable Charge 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 provider’s actual charge.

GM6000 DES425



CIGNA International Expatriate Benefits

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 – Only one per person, including panoramic film, in any 3 calendar years.

Bitewing X-rays – Only 2 charges per person per calendar year.

Panoramic (Panorex) X-ray – Only one per person in any 3 calendar years.

Prophylaxis (Cleaning) – Only 2 per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.

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

Topical application of sealant, per tooth, on a posterior tooth – Only one treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

GM6000 DES297V5

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 CG, 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 CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

GM6000 DES298V7

Class III Services - Major Restorations, Dentures and Bridgework

High Noble Metal (gold) or 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.

Crowns

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Fixed or 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)

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



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if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GM6000 DES302V5

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 for a Dependent child less than 19 years of age during his lifetime will not be more than the Orthodontia Maximum shown in the Schedule.

GM6000 DES462

Dental 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: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) 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: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) 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;

GM6000 DEN183

- 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 services or supplies (**Exclusion applies to Option 1 only**);
- orthodontic services or supplies for any person other than a Dependent child less than 19 years of age (**Limitation applies to Option 2 and 3 Plans**);
- 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;
- services for which benefits are not payable according to the "General Limitations" section.

GM6000 DEN186



Exclusions, Expenses Not Covered and General Limitations

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

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary;
- 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;
- 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;
- 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 abuse 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 of this plan; or

- the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section 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 or to treat psychological symptomatology or psychosocial complaints related to one's appearance;
- regardless of clinical indication for macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupuncture; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions;
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery;
- for 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 and female voluntary sterilization procedures;



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- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery;
- 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), anorgasmia, 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, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to 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 or mental retardation;
- 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, dentures and wigs other than for scalp hair prostheses worn due to alopecia areata;
- hearing aids, except as covered under this plan;
- 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;
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery. **(Exclusion applies to Silver Plan only)**
- charges made for or in connection with eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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;
- 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, e-mail and Internet consultations and telemedicine with the exception of Cigna's "My Consult" program with the eCleveland Clinic, or as specifically authorized by Cigna International;
- massage therapy;



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- 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;
- charges made by any covered provider who is a member of your family or your Dependent's family;
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

GM6000 05BPT14 V143
GM6000 05BPT105
GM6000 06BNR2V42
GM6000 07BNR10

Pre-Existing Condition Limitations For Late Entrants Only

(Not applicable to employees and dependents under age 19)

No payment in excess of \$2,500 will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous 18-month period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-Existing Condition Limitation

Pregnancy and genetic information with no related treatment will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition Limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition Limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

GM6000 CM10 INDEM82 V3

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. 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 or dental treatment:

- (1) 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.
- (2) Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
- (3) 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.

GM6000 COB11

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



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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 semi-private room, the difference in cost between a private and semi-private 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.

GM6000 COB12

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:

- (1) 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;
- (2) 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;
- (3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - (a) 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;
 - (b) then, the Plan of the parent with custody of the child;
 - (c) then, the Plan of the spouse of the parent with custody of the child;
 - (d) then, the Plan of the parent not having custody of the child; and
 - (e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

- (4) 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;
- (5) 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;
- (6) 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



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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 during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

GM6000 COB14

Recovery of Excess Benefits

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

CG 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

CG, 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.

GM6000 COB15

Medicare Eligibles

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

a) a former Employee who is eligible for

Medicare and whose insurance is continued for any reason as provided in this plan;

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

GM6000 MEL23 V4

CG 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.

GM6000 MEL45 V5

Expenses For Which A Third Party May Be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights;
2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
 - a. the amount actually paid for such Covered Expenses by CG; or
 - b. the amount you actually receive from the third party for such Covered Expenses;

at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

GM6000 CCP7
CCL7

Payment of Benefits – Life Benefits (If Applicable)

To Whom Payable

Any benefits for loss of your life will be paid to your named Beneficiary.

Any amount of your loss of life benefits for which there is no

designated or surviving Beneficiary will be paid at CG's option, to any of your following living relatives: spouse, child or children, mother, father, brothers or sisters, or the executors or administrators of your estate. CG will also have the right to make payment in such manner, if it is not able, within what it considers a reasonable period of time to locate your Beneficiary.

All dismemberment benefits that are payable will be paid to you.

If you die while dismemberment benefits remain unpaid, CG may, at its option, make direct payment to any of your following living relatives: spouse, child or children, mother, father, brothers or sisters, or to the executors or administrators of your estate.

If any person to whom benefits are payable is a minor, or in CG's opinion, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support. Payment in this event will be made in monthly installments of not more than \$500.

Payment in the manner described above will release CG from all liability to the extent of any payment made.

GM6000 POB 8
PMT25

Time of Payment

All benefits will be paid by CG when it receives due proof of loss.

Life Payment

After your death, your amount of Life Insurance will be paid to your Beneficiary in one sum.

If your Beneficiary dies prior to such payment, your amount of Life Insurance will be paid in one sum pursuant to the terms of the order of the appropriate Probate Court.

Beneficiary Designation

Beneficiary

When you become insured, you should name someone as your Beneficiary to receive your loss of life benefit. Your Beneficiary designation will be filed with CG, or if agreed to in advance by CG, with the Policyholder.

Change of Beneficiary

You may change your Beneficiary at any time, by completing a form satisfactory to CG and signed by you. No change will take effect until this form is received by CG (or by the Policyholder if CG has agreed to this in advance). When the form is received, the change will take effect as of the date on the form. If you die before the form is received, CG will not



be liable for any payment it has already made.

Consent of Beneficiary

Your Beneficiary's consent will not be required to change the Beneficiary or to effect any other changes.

GM6000 POB 9V-11
GM6000 POB 10
PMT90V6

Payment of Benefits – Medical Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, 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, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

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

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

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

Calculation of Covered Expenses

CG, 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.

GM6000 TRM366

Payment of Benefits – Dental Benefits (If Applicable)

To Whom Payable

All Dental Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, 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, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

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

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

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

GM6000 POB12
PMT135V185

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)



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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 (For Life, Medical, and Dental Insurance If Applicable)

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 the insurance.

GM6000 TRM23V3

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.

GM6000 TRM62

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.

GM6000 BEX182 V11

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.

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BEX131V7



Federal Requirements

The following pages explain your rights and responsibilities under this plan of benefits pursuant to United States federal laws and regulations. Some states may have similar requirements. If a similar applicable provision appears elsewhere in this booklet, the provision which provides the better benefit will apply. Generally speaking, the following mandates are only applicable if you are a United States citizen or permanent U.S. resident. They generally and/or specifically may not apply to non-U.S. citizens or residents, nonresident aliens, nonresident aliens with no U.S. sourced income, or other foreign nationals.

FDRL1

Qualified Medical Child Support Order (QMCSO)

A. 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.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

B. 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:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. 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;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. 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.

C. 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.

FDRL2

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 adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **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



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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: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) 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 (c) 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.

FDRL3

V4

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.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition Limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4

V3

Coverage of Students on Medically Necessary Leave of Absence

(Applies to Students Age 26 or Over When Covered Under This Plan)

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a Medically Necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- a) the date that is one year after the first day of the Medically Necessary leave of absence; or
- b) the date on which coverage would otherwise terminate under the terms of the plan.



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The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the Medically Necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is Medically Necessary.

A “Medically Necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is Medically Necessary; and (3) causes the child to lose student status under the terms of the plan.

FDRL80

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 F.

B. Change of Status

A change in status is defined as:

- (a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- (b) change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- (c) 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;
- (d) changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for

coverage;

- (e) change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
- (f) 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: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL5

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance 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.

FDRL6

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.

FDRL8

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.

FDRL51

Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)

(Not Applicable To Anyone Under 19)

A federal law known as the Health Insurance Portability & Accountability Act (HIPAA) establishes requirements for Pre-existing Condition Limitation provisions in health plans. The following is an explanation of the requirements and limitations under this law.

A. Pre-Existing Condition Limitation

Under HIPAA, a Pre-existing Condition Limitation is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective

date of coverage under the plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. A Pre-existing Condition Limitation is permitted under group health plans, provided it is applied only to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or a shorter period as applies under the plan) ending on the enrollment date. Plan provisions may vary. Please refer to the section entitled “Exclusions, Expenses Not Covered and General Limitations” for the specific Pre-existing Condition Limitation provision which applies under this Plan, if any.

B. Exceptions to Pre-Existing Condition Limitation

Pregnancy and genetic information with no related treatment will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition Limitation if such child was covered under any creditable coverage within 30 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days or more elapse between coverage under the prior creditable coverage and coverage under this Plan.

C. Credit for Coverage Under Prior Plan

If you and/or your Dependent(s) were previously covered under a plan which qualifies as Creditable Coverage, CG will reduce any Pre-existing Condition Limitation period under this policy by the number of days of prior Creditable Coverage you had under the prior plan(s). However, credit is available only if you notify the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 63 days elapsed between coverage under any two plans.

If you and/or your Dependent enrolled or re-enrolled in COBRA continuation coverage or state continuation coverage under the extended election period allowed in the American Recovery and Reinvestment Act of 2009 (“ARRA”), this lapse in coverage will be disregarded for the purposes of determining Creditable Coverage.

D. Certificate of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition Limitation period. You should submit proof of prior coverage with your enrollment material. A certificate of prior Creditable Coverage, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, Cigna, P.O. Box 15050, Wilmington, DE 19850. You should contact the Plan Administrator or a Cigna Customer Service Representative if assistance is needed to obtain proof of prior



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Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition Limitation period.

E. Creditable Coverage

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; A health plan for certain members of the uniformed armed services and their dependents, including the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; The Federal Employees Health Benefits Program; A public health plan established by a State, the U.S. government, or a foreign country; The Peace Corps Act; Or a State Children's Health Insurance Program.

F. Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any Pre-existing Condition Limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

FDRL.81

Requirements of Medical Leave Act of 1993 (FMLA)

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) 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, where applicable:

A. 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; 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.

B. 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, 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 or the requirements of any Pre-existing Condition Limitation 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.

FDRL.13

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.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

B. 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



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expiration of USERRA and you are re-employed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) 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 Pre-existing Condition Limitation (PCL) or 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.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

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.

FDRL58

Claim Determination Procedures Under ERISA

The following complies with federal law. Provisions of the 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 either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice Medical Necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations 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 Medically Necessary, 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, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, CG 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 CG's control, CG 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 CG within 45 days after receiving the notice. The determination period will be suspended on the date CG 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 (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. CG 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, CG 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 CG within 48 hours after receiving the notice. CG 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 CG's procedures for requesting a required preservice Medical Necessity determination, CG 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 Medical Necessity 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 Medical Necessity 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, CG will notify you or your representative of the determination within 24 hours after receiving the request.



Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, CG 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 CG's control, CG 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 CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG 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 within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and 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: (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 description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) 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; (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 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; and (7) 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.

FDRL77

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.



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The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, 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 below titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

FDRL20

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:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. 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.

FDRL21

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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

FDRL22

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



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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:
 - (a) 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;
 - (b) 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
 - (c) 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.

FDRL23

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



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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.

FDRL24

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;
- your child ceases to qualify as a Dependent under the Plan; or
- 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.

FDRL25

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment

assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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.

FDRL26

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



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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.

FDRL27

Discretionary Authority

The Plan Administrator delegates to CG 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 CG 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. 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 of all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. 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 last day of the calendar month in which you leave Active Service;
- 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:

FDRL28

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 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 this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group



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health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 you 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.

FDRL29

Enforce Your Rights

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.

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.

FDRL59



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.

GM6000 NOT90

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; and "Physician reviewers" are licensed Physicians or licensed Dentists depending on the care, treatment or service under review.

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 Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please write to us at the following address:

Cigna
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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

CG 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. 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 our toll-free number or write to us at the address above.

GM6000 APL330

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.

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 non-authorization of an admission or continuing inpatient Hospital stay. CG'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.

GM6000 APL758

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.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician or Dentist reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician or Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee 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. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee 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 non-authorization of an admission or continuing inpatient Hospital stay. CG'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.

GM6000 APL759

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary 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. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. 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 180 days of your receipt of CG's level-two appeal review denial. CG will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Physician or Dentist reviewer, the review shall be completed within 3 days.

The Independent Review Program is a voluntary program arranged by CG.

Appeal to the State of Delaware

You have the right to appeal a claim denial for medical reasons or 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@deins.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.

GM6000 APL760

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) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) 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); (5) 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.

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



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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 CG 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.

GM6000 APL334



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.

DFS1

Basic Earnings

The term Basic Earnings means the Employee's rate of pay reported by the Employer. It does not include overtime, bonus, additional compensation or pay for more than 40 hours in a week.

DFS210

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.

DFS14

Civil Union

Civil Union is a legal union between two adults of the same sex.

DFS2196

Coinsurance

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

DFS17

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: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dentist

The term Dentist means a person practicing dentistry or oral surgery 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 Dental Services described in the policy.

DFS24

Dependent

Dependents are:

- your lawful spouse; or
- your Civil Union Partner; and
- any child of yours who is
 - less than 26 years old;
 - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you.

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

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

DFS511



Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

DFS1533

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.

DFS1427

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Expense Incurred

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

DFS60

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.

DFS682

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.

DFS70

Hospice Care Services

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

DFS599

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 CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72



Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) 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: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) 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.

DFS1693

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 Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

DFS1815

Injury

The term Injury means an accidental bodily injury.

DFS147

Maximum Reimbursable Charge

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 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 CG.

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 CG. Additional information about how CG determines the Maximum Reimbursable Charge is available upon request.

DFS1997

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.

DFS192

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.

DFS1813

Medicare

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

DFS149

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



CIGNA International Expatriate Benefits

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.

DFS151

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."

DFS155

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.

DFS156

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.

DFS157

Other Health Care Facility

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.

DFS1686

Other Health Professional

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.

DFS1685

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which CG has contracted to provide mail-order prescription services to insureds.

DFS1937

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.

DFS1910

Pharmacy

The term Pharmacy means a retail pharmacy, or a mail-order pharmacy.

DFS1934

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.

DFS164

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) 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.

DFS1708



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.

DFS1711

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.

DFS170

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.

DFS1710

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG 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 abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Sickness - For Medical Insurance

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

DFS187

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: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

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.

DFS197

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 CG, 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.

DFS1534

Small Group Long Term Disability Insurance

250911

Printed in U.S.A.

These materials are being made available electronically for your convenience. In addition to the electronic version, CIGNA International has provided original printed and 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 International.

Home Office: P.O. Box 15050
Wilmington, Delaware 19850

CIGNA WORLDWIDE INSURANCE COMPANY
GROUP LONG TERM DISABILITY INSURANCE
CERTIFICATE

CIGNA Worldwide Insurance Company (referred to as "we", "our" and "us") welcomes your Employer as a client. This is your certificate of coverage as long as you are eligible for insurance and you become and remain insured.

A few words about this certificate of coverage. . .

It is written in plain English. But a few terms and provisions are written as required by insurance law. Please read it carefully. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to us. We will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.

Please refer to the sticker located inside the front 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.



David S. Scheibe, President

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SECTION I – PLAN OUTLINE

CLASSES TO BE COVERED

Class 1 – All full-time Expatriate, Third Country National and Select Key Local National Employees of a participating Employer working outside the United States as reported by the policyholder.

"Expatriate" means an employee of the Policyholder who works outside his country of citizenship.

"Third Country National" generally means an employee of the Policyholder who works outside his country of citizenship, and outside the Policyholder'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 operations.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

AMOUNT OF INSURANCE

- a. 60% (benefit percentage) of basic monthly earnings, not to exceed the maximum monthly benefit, less other income benefits.
- b. The maximum monthly benefit is \$5,000.
- c. The minimum monthly benefit is \$50.

MAXIMUM BENEFIT PERIOD

Accident – Sickness – To Age 65 with Reducing Benefit Duration

<u>Age At Disability</u>	<u>Benefit Duration</u>
Less than 60	To Age 65
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and older	12 Months

ELIMINATION PERIOD

Option I – 90 Days

Option II – 180 Days

MINIMUM REQUIREMENT FOR ACTIVE EMPLOYMENT

30 regularly scheduled hours per week

WAITING PERIOD

None

CONTRIBUTIONS

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.

PDC-LTD-85-3.0 ED. 11-88 REV. 8-93



SECTION II - TERMS YOU SHOULD KNOW

Many terms used in your certificate of coverage have special meanings. A list of these terms and meanings follow:

ACTIVE EMPLOYMENT means you must be working:

1. for your employer on a full-time active basis and paid regular earnings;
2. at least the minimum number of hours shown in the Plan Outline;
3. at your employer's usual place of business; or
4. at a location to which your employer's business requires you to travel.

BASIC MONTHLY EARNINGS or PRE-DISABILITY

EARNINGS means your monthly rate of earnings from your employer in effect immediately prior to the date total disability begins. Basic monthly earnings include all earnings before any reductions. It does not include commissions, bonuses, overtime pay and extra compensation.

BENEFIT DURATION SCHEDULE means the amount of time for which benefits are payable under the policy as shown in the Plan Outline.

COMPANY means CIGNA Worldwide Insurance Company.

DISABILITY BENEFIT when used with the term Retirement Plan, means money which:

1. is payable under a Retirement Plan due to disability as defined in the plan; and
2. does not reduce the amount of money which would have been paid as retirement benefits under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit as defined in this certificate of coverage.)

ELIGIBILITY DATE means the date you become eligible for insurance after completing the Waiting Period shown in the Plan Outline.

ELIMINATION PERIOD means a period of consecutive days of total disability for which no benefit is payable. The Elimination Period is shown on the sticker located inside the front cover of this certificate and begins on the first day of total disability.

ELIMINATION PERIOD – 90 DAYS

NOTE: If you return to work for 7 or less days during the Elimination Period and cannot continue, we will count only those days you are totally disabled to satisfy the Elimination Period.

ELIMINATION PERIOD – 180 DAYS

NOTE: If you return to work for 14 or less days during the Elimination Period and cannot continue, we will count only those days you are totally disabled to satisfy the Elimination Period.

PDC-LTD-85-4.0 ED. 11-88 REV. 9-93

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

EMPLOYER'S RETIREMENT PLAN is deemed to include any retirement plan:

1. which is part of any federal, state, county, municipal or association retirement system; or
2. for which you are eligible as a result of employment with your employer or for which you are eligible from a union retirement plan.

EVIDENCE OF INSURABILITY means a statement or proof of your medical history upon which we will determine your acceptance for insurance.

GROSS MONTHLY BENEFIT means your Monthly Benefit before any reduction for other income benefits and earnings.

HOME OFFICE means CIGNA Worldwide Insurance Company, P.O. Box 15050 Wilmington, Delaware 19850.

INJURY means bodily injury resulting directly from an accident and independently of all other causes. The Injury must occur and disability must begin while you are insured under the policy.

Exception: Any disability which begins more than 60 days after an injury will be considered a sickness for the purpose of determining benefits under the policy.

MONTHLY BENEFIT means the amount we will pay you when you are disabled. The Monthly Benefit is payable in United States Dollars.



OWN OCCUPATION - See definition of Total Disability or Totally Disabled.

PHYSICIAN means a person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. is legally qualified as a medical practitioner and required to be recognized under the policy for insurance purposes according to the insurance statutes/regulations of the governing jurisdiction; and
3. is not an employee or his spouse, daughter, son, father, mother, sister or brother.

PDC-LTD-85-5.0 ED. 11-88 REV. 12-93

PRE-DISABILITY EARNINGS - See definition of Basic Monthly Earnings.

RETIREMENT BENEFIT when used with the term Retirement Plan, means money which:

1. is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
2. does not represent contributions made by you (payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received); and
3. is payable upon:
 - a. early or normal retirement; or
 - b. disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

RETIREMENT PLAN means a plan, which provides your retirement benefits and which, is not funded wholly by your contributions. The term shall not include: a 401(k), profit-sharing plan, thrift plan, informal salary continuation plan, individual retirement account (IRA), tax sheltered annuity (TSA), stock ownership plan, or a non-qualified plan of deferred compensation.

SICKNESS means illness, disease, pregnancy or complications of pregnancy. The sickness must begin while you are insured under the policy.

TIME EFFECTIVE means an effective date will start at 12:01 A.M. A termination date will end at 12:00 midnight. Each of these times is Standard Time in the place where the policy is

delivered. Insurance under the policy will start and end at these times.

WAITING PERIOD as shown on the Plan Outline means the continuous length of time you must serve in an eligible class to reach your eligibility date.

PDC-LTD-85-5.0a ED. 11-88 REV. 9-93

TOTAL DISABILITY or TOTALLY DISABLED means during the Elimination Period and the next 24 months of disability you are:

1. unable to perform all of the material and substantial duties of your occupation on a full-time basis because of a disability:
 - a. caused by injury or sickness;
 - b. that started while you are insured under this plan; and
2. after 24 months of benefits have been paid, you are unable to perform with reasonable continuity all of the material and substantial duties of your own or any other occupation for which you are or become reasonably fitted by training, education, experience, age and physical and mental capacity.

If you are employed as a pilot, co-pilot or a crew member of an aircraft:

"Total disability" or "totally disabled" means because of injury or sickness you cannot perform the material duties of any gainful occupation for which you are or become reasonably fitted by training, education or experience. The loss of a pilot's license for any reason does not, in itself, constitute total disability.

PDC-LTD-85-6.0 ED. 11-88 REV. 8-93



SECTION III - ENROLLMENT AND DATE INSURANCE STARTS

WHEN CAN YOU ENROLL?

You can enroll if you are:

1. in Active Employment with your Employer; and
2. in a class eligible for insurance.

WHAT IS YOUR ELIGIBILITY DATE?

If you are in an eligible class as shown on the Plan Outline, you will be eligible for insurance on the later of:

1. the policy effective date; or
2. the day after you complete the Waiting Period.

WHEN DOES INSURANCE START?

Insurance will start at 12:01 A.M. on the day determined as follows, but only if you enroll for insurance with us through your employer on a form satisfactory to us.

If you do not contribute toward the plan's cost, your insurance will start on your eligibility date.

If you do contribute toward the plan's cost, your insurance will start on the latest of these dates:

- a. on your eligibility date if you make written application for insurance on or before the 31st day after your eligibility date.
- b. The date we give approval. If you:
 - i. make written application for insurance more than 31 days after your eligibility date; or
 - ii. terminated your insurance while still eligible.

In the case of i. and ii. above, you must submit, at your expense, an application and evidence of insurability to us for approval.

But, no initial, increased or additional insurance will apply to you if you are not in active employment because of a disability on the date such insurance otherwise would become effective. Such insurance will start for you on the day you return to full-time active employment.

If you enter another eligible class, you will not be eligible for any additional benefits until you have completed a 30-day waiting period, and have been actively at work one full day in the new class.



SECTION IV - BENEFITS

PARTIAL DISABILITY or PARTIALLY DISABLED

means as a result of the Sickness or Injury which caused total disability, you are:

1. able to perform one or more, but not all, of the material and substantial duties of your own or any other occupation on a full-time or a part-time basis; or
2. able to perform all of the material and substantial duties of your own or any other occupation on a part-time basis.

To qualify for a partial disability benefit you must be earning less than 80% of your pre-disability income at the time partial disability employment begins.

PARTIAL DISABILITY

When proof is received that you are partially disabled from a sickness or injury following a period of total disability for which benefits were payable, the Company will pay a partial disability benefit if you:

1. are partially disabled within 31 days of the date your total disability benefits cease; and
2. give to the Company upon request, and at your expense, proof of continued:
 - a. partial disability; and
 - b. regular attendance of a physician.

PARTIAL DISABILITY MONTHLY BENEFIT

To figure the amount of monthly benefit:

1. Multiply your pre-disability income by the benefit percentage shown in the Plan Outline.
2. Take the lesser of:
 - a. the amount determined in step (1) above; or
 - b. 100% of your pre-disability income less other income benefits, shown on the following page; or
 - c. the maximum monthly benefit shown in the Plan Outline.

The partial disability benefit will never be less than the minimum monthly benefit shown in the Plan Outline.

PDC-LTD-85-8.1 ED. 11-88 REV. 8-90

PROOF OF DISABILITY

WHEN DO DISABILITY BENEFITS BECOME PAYABLE?

We will pay your benefit a month after the end of the elimination period when we have proof that you:

1. are disabled due to sickness or injury; and

2. require the regular attendance of a physician.

WHAT CONDITIONS MUST BE MET FOR BENEFIT PAYMENTS TO CONTINUE?

We will pay you as long as you remain disabled and require the regular attendance of a physician. But we will not pay a benefit any greater than your amount of insurance or any longer than the maximum benefit period shown in the Plan Outline.

Also, you must give us proof of these facts at your own expense, when we ask for it.

HOW IS THE BENEFIT FIGURED?

To figure the amount of your monthly benefit:

1. Multiply your basic monthly earnings by the benefit percentage shown in the Plan Outline.
2. Take the lesser of:
 - a. the amount figured in step (1) above;
 - b. the maximum monthly benefit shown in the Plan Outline; and then
3. Deduct other income benefits, shown on the next page from this amount.

This is the total disability benefit which you may receive.

Your monthly benefit will never be less than the minimum benefit shown in your Plan Outline.

PDC-LTD-85-8.3 ED. 11-88 REV. 8-93

WHAT ARE "OTHER INCOME BENEFITS"?

Other income benefits mean those benefits shown below:

1. The amount of temporary and/or permanent benefits/awards for which you are eligible under:
 - a. workers' compensation law;
 - b. occupational disease law;
 - c. any other act or law of like intent.
2. The amount of any disability income benefits which you are eligible to receive under any compulsory benefit act or law.
3. The amount of any disability income benefits which you are eligible to receive under:
 - a. any other group insurance plan of your employer; or
 - b. any governmental retirement system as a result of your job with your employer.
4. The amount of benefits from your employer's retirement plan you:
 - a. receive as disability benefits;
 - b. voluntarily elect to receive as Retirement Benefits; and/or



- c. receive as Retirement Benefits when you reach the greater of age 62 or normal retirement age, as defined in the Employer's Retirement Plan.

As used here, "receive" does not include any amount rolled over or transferred to any eligible retirement plan as that term is defined in Section 402 of the Internal Revenue Code of 1986 and any future amendments to Section 402 which affect the definition of an eligible retirement plan.

- 5. The amount of disability or retirement benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, or any similar government plan or act, as follows:

- a. disability or unreduced Retirement Benefits for which:
 - i) you are eligible; and
 - ii) your spouse, child or children are eligible because of your disability; or
 - iii) your spouse, child or children are eligible because of your eligibility for unreduced retirement benefits; or
- b. reduced Retirement Benefits received by:
 - (i) you; and
 - (ii) your spouse, child or children because of your receipt of the reduced retirement benefits.

- 6. The amount of earnings you receive from any sick leave or formal salary continuation plan paid by your employer.
- 7. The amount of earnings you earn or receive from any form of employment.

These other income benefits, except Retirement Benefits, must be payable as a result of the same disability for which we pay a benefit.

PDC-LTD-85-9.1 ED. 11-88 REV. 12-93

WHAT HAPPENS IF YOU RECEIVE INCREASES IN THESE OTHER INCOME BENEFITS?

After the first deduction for each of the other income benefits, we will not further reduce your monthly benefit due to any cost of living increases payable under these other income benefits. This provision does not apply to increases received from any form of employment.

WHAT IF YOU RECEIVE A LUMP SUM PAYMENT?

We will prorate other income benefits which are paid in a lump sum on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over your expected lifetime. In each case, the amount to be prorated will be calculated by an actuary, based on a morbidity table, with interest, or a mortality table, with interest, depending on the source of the lump sum.

WHEN DOES THE DISABILITY MONTHLY BENEFIT CEASE?

Your monthly benefit will cease on the earliest of:

1. the date you are no longer disabled; or
2. the date you die; or
3. the end of your maximum benefit period; or
4. the date your current earnings exceed 80% of your pre-disability earnings.

NOTE: Because your current earnings may fluctuate, we may average your earnings over three (3) consecutive months rather than immediately terminating your benefit once 80% of your pre-disability earnings has been reached.

WHEN WILL THE BENEFIT PERIOD BE EXTENDED?

The maximum benefit period is shown in the Plan Outline. However, benefits will be extended beyond the end of the maximum benefit period if you are disabled and have attained the age specified in the benefit duration schedule and have not received twelve monthly benefit payments. In this event, the benefit period will be extended during the continuance of disability until twelve monthly payments have been paid.

PDC-LTD-85-10.0 ED. 11-88 REV. 8-93

RECURRENT DISABILITY

WHAT HAPPENS IF YOU TRY TO RETURN TO WORK AND BECOME DISABLED AGAIN?

RECURRENT DISABILITY means a disability which is related or due to the same cause(s) as a prior disability for which you received a monthly benefit.

We will treat a recurrent disability as a continuation of the original disability if, after receiving disability benefits under this plan, you:

1. return to your regular occupation on a full-time basis for less than six months; and
2. perform all the material duties of your occupation.

To qualify for a recurrent disability benefit, you must experience more than a 20% loss of pre-disability earnings.

Benefit payments will be subject to the terms of this plan for the original disability.

If you return to your regular occupation on a full-time basis for six months or more, a recurrent disability will be treated as a new period of disability and you must complete another elimination period.

If you become eligible for coverage under any other group long term disability policy, this recurrent disability section will cease to apply to you.



WAIVER OF PREMIUM

DO PREMIUMS HAVE TO BE PAID WHILE YOU ARE RECEIVING BENEFITS?

No, while you are receiving benefits, premiums do not have to be paid. However, if coverage is to be continued, premium payments may be resumed following a period during which they were waived.

PDC-LTD-85-11.0 ED. 11-88

THREE MONTH SURVIVOR BENEFIT

WHAT HAPPENS TO YOUR BENEFIT IF YOU DIE?

We will pay a lump sum benefit to your eligible survivor when we receive proof that you died:

1. after disability had continued for 180 or more consecutive days; and
2. while receiving a monthly benefit.

The lump sum benefit will be an amount equal to three times your last gross monthly benefit.

ELIGIBLE SURVIVOR means your spouse, if living, otherwise your children under age 19.

If payment becomes due to your children, payment will be made to:

1. the children; or
2. a person named by us to receive payments on the children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

GROSS MONTHLY BENEFIT means your benefit amount before any reduction for income benefits and earnings.

If there are no eligible survivors, payment will be made to your estate.

PDC-LTD-85-12.1 ED. 11-88 REV. 1-94

MENTAL ILLNESS LIMITATION

ARE BENEFITS LIMITED FOR MENTAL ILLNESS?

Benefits for disability due to mental illness will not exceed 24 months of monthly benefit payments unless you meet one of these situations:

1. You are in a hospital or institution at the end of the 24 month period. We will pay the monthly benefit during the confinement.

If you are still disabled when discharged, we will pay the monthly benefit for a recovery period of up to 90 days.

If you become reconfined during the recovery period for at least 14 days in a row, we will pay benefits for the confinement and another recovery period up to 90 more days.

2. You continue to be disabled and become confined:
 - a. after the 24 month period; and
 - b. for at least 14 days in a row.

We will pay the monthly benefit during the confinement. We will not pay the monthly benefit beyond the maximum benefit period.

HOSPITAL or INSTITUTION means a facility licensed to provide care and treatment for the condition causing your disability.

MENTAL ILLNESS means a disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as:

1. schizophrenia;
2. depression;
3. manic depressive or bipolar illness;
4. anxiety;
5. personality disorders;
6. adjustment disorders;

or other conditions usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

This limitation does not apply to dementia, if due to:

1. stroke;
2. trauma;
3. viral infection;
4. Alzheimer's disease;

or other conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs or other similar modalities.

PDC-LTD-85-12.4 ED. 11-88 REV. 12-93

GENERAL EXCLUSIONS

WHAT DISABILITIES ARE NOT COVERED?

We will not cover any disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries;
3. active participation in a riot;



4. your committing of or attempting to commit a felonious act.

PARTICIPATION shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

RIOT shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or consequence of such disorder.

PDC-LTD-85-13.0 ED. 11-88 REV. 12-89

PRE-EXISTING CONDITION EXCLUSION

ARE THERE ANY OTHER DISABILITIES NOT COVERED?

Yes, we will not cover any disability:

1. which is caused or contributed to by, or results from a pre-existing condition; and
2. which begins in the first 24 months after your effective date, unless you have had no treatment of the condition for 6 consecutive months after your effective date.

TREATMENT means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

PRE-EXISTING CONDITION means a diagnosed sickness or injury for which you received treatment within 12 months prior to your effective date.

PDC-LTD-85-14.3 ED. 1-88



SECTION V - TERMINATION PROVISIONS

WHEN DOES YOUR INSURANCE TERMINATE?

You will cease to be insured at 12:00 midnight on the earliest of the following dates:

1. the date the plan terminates but without prejudice to any claim originating prior to the time of termination;
2. the date you are no longer in an eligible class;
3. the date your class is no longer included for insurance;
4. the last day for which you made any required employee contribution;
5. the date employment terminates. Cessation of active employment will be deemed termination of employment, except;
 - a. your insurance will be continued if you are absent due to disability during:
 - (i) the elimination period; and
 - (ii) the period during which premium is being waived.
 - b. your employer may choose to continue your insurance by paying the required premium, subject to the following:
 - (i) insurance may be continued during a family or medical leave of absence, but not beyond the end of the approved leave of absence period;
 - (ii) insurance may continue if you are temporarily laid off or given any other leave of absence, but not beyond the end of the month following the month the layoff or leave of absence begins.
 - (iii) the employer must act so as not to discriminate unfairly among employees in similar situations.
6. the date you cease active work due to a labor dispute, including any strike, work slowdown or lockout.

The insurer reserves the right to review and terminate all classes insured under this plan if any class(es) cease(s) to be covered.



SECTION VI - GENERAL INFORMATION

NOTICE AND PROOF OF CLAIM

WHEN MUST WE BE NOTIFIED OF A CLAIM?

You must give us written notice of claim within 30 days of the date disability starts. If that is not possible, you must notify us as soon as you can.

When we receive your written notice of claim, we will send you our claim forms. If you do not receive the forms within 15 days after you sent the notice, you can send written proof of claim without waiting for the form.

WHEN DOES PROOF OF CLAIM HAVE TO BE GIVEN?

You must give us proof of claim no later than 90 days after the end of the elimination period.

Failure to furnish such proof within such time shall not invalidate nor reduce your claim if it was not reasonably possible to furnish such proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

You must give us proof of continued disability and regular attendance of a physician within 30 days of the date we request the proof.

The proof must cover:

1. the date disability started;
2. the cause of disability; and
3. the degree of disability.

WHAT ARE OUR EXAMINATION RIGHTS?

We, at our expense, have the right and opportunity to have you examined by a physician or vocational expert of our choice to determine the extent of any sickness or injury for which you have made a claim. This right may be used as often as reasonably required.

CAN LEGAL PROCEEDINGS BE STARTED AT ANY TIME?

No, you or your authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; or
2. more than 3 years after the time proof of claim is required.

HOW ARE CHANGES MADE TO THE POLICY?

The policy may be changed in whole or in part. Only an officer or a registrar of the Company may approve a change. The approval must be in writing and endorsed on or attached to the policy.

PDC-LTD-85-17.0 ED. 11-88 REV. 5-94

WHEN ARE CLAIMS PAID?

When we receive satisfactory proof of claim, benefits payable under the plan will be monthly during any period for which we are liable. Any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

WHO ARE CLAIMS PAID TO?

All benefits are payable to you. But if a benefit is payable to your estate, or if you are a minor, or you are not competent, we have the right to pay up to \$1,000 to any of your relatives whom we consider entitled to the benefit. If we pay benefits in good faith to a relative, we will not have to pay such benefits again. No benefits are payable for payments that are illegal under applicable law.

Your monthly benefits for this plan will be paid on a prorata basis. The rate will be 1/30 per day for any period of disability that does not extend through a full month.

WHAT HAPPENS IF YOUR CLAIM IS OVERPAID?

If Long Term Disability benefits have been overpaid on your claim, you will be required to reimburse CWW within 60 days, or CWW has the right to reduce future benefits until reimbursement is made. CWW also has the right to recover such overpayments from your estate.

DOES THIS COVERAGE AFFECT WORKERS' COMPENSATION?

This plan is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

HOW CAN STATEMENTS MADE IN ANY APPLICATION FOR THIS INSURANCE BE USED?

In the absence of fraud, all statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim unless a copy of your signed statement has been given to you.



WHAT HAPPENS IF YOUR AGE IS MISSTATED?

If your age has been misstated, an equitable adjustment will be made in the premium. If the amount of your benefit is dependent upon your age, as shown in the Benefit Duration Schedule, the amount of your benefit will be the amount you would have been entitled to if your correct age were known.

NOTE: A refund of premium will not be made for a period more than twelve months before the date the Company is advised of the error.

WHAT AUTHORITY DOES THE COMPANY HAVE IN MAKING A BENEFITS DETERMINATION?

In making any benefits determination under the policy, the Company shall have the discretionary authority both to determine your eligibility for benefits and to construe the terms of the policy.

PDC-LTD-85-18.0 ED. 11-88 REV. 6-93

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 the service of legal process;
- How the cost of the Plan is paid;
- The Plan's fiscal ending date.

The office designated to consider the appeal of denied claims is:

CIGNA International Service Center
P.O. Box 15050
Wilmington, DE 19850
USA

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 names, title and address, is available upon request from 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 CWW 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 CWW 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. 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 of all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. 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;
- 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.

CLAIM REVIEW PROCEDURE

You may get claim forms and guidance for filing claims from the Plan Administrator or from the CIGNA International Service Center. If a claim is denied, you will be given the reason for denial in writing. You, or a person in your behalf, may ask the CIGNA International Service Center for a review of the denied claim in writing within 60 days of receipt of the denial notice. This written request for review should state the reasons why you feel your claim should not have been denied. It should include any additional documents (medical or dental records, etc.) which you feel support your claim. You may also ask additional questions or make comments and you may review pertinent documents. In normal cases, you will receive the final decision within 60 days of the date of your request for review is received. In special cases requiring a delay, you will receive notice of the final decision no later than 120 days after your request for review is received.

The Plan is handled by the Plan Administrator with benefits as set forth in the group insurance policies issued by CWW.

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 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 this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 you 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.

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.

ENFORCE YOUR RIGHTS

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.

CWW will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this certificate are fully guaranteed by CWW.

This certificate is issued by:

CIGNA Worldwide Insurance Company
P.O. Box 15050
Wilmington, DE 19850

DISABILITY

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 telephonic or electronic 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 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. If this extension is made because you must furnish additional information, these 30-day 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 45-day review period (or within 75 or 105 days if the review period was extended). 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. 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, as outlined below.

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 180 days 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 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. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 45 days from the date it receives your request to review your claim and to notify you of its decision. 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 45 days. 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.

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
- *full-time* health and welfare benefits are maintained:
 - the employee pays the (lower) full-time rate for medical insurance at the reduced salary level (resulting in a significant premium savings), and
 - the employee pays the lower FT dental and vision rate, and
 - the employee's life and disability benefits continue at the (higher) pre-Phased Retirement salary level, and
 - 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 College 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.

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.

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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.