MIDDLEBURY
HEALTH AND WELFARE BENEFITS PLAN

Summary Plan Description

Effective as of January 1, 2020

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INTRODUCTION

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

This SPD describes benefits available to Eligible Employees. Prior to January 1, 2019 certain retiree benefits were offered under the Plan. Retiree benefits were eliminated under the Plan effective as of December 31, 2018.

I. GENERAL INFORMATION

1.1 Plan Name and Effective Date. The full name of the Plan is the Middlebury Health and Welfare Benefits Plan. This SPD reflects the terms of the Plan in effect as of January 1, 2020, unless otherwise noted.

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

1.3 Employer Information.

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

EIN: 03-0179298

1.4 Plan Year. The Plan Year is generally the period from January 1 through December 31. However, certain benefits offered under the Plan are currently being run on a contract year basis pursuant to the terms of each individual benefit. The Plan's records are kept on a Plan Year basis.

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

Although this SPD references benefits provided by your specific "Employer," the College is responsible for administration of the Plan. As used in this SPD, the term "College" refers to the undergraduate school of the President and Fellows of Middlebury College.

1.6 Agent for Service of Legal Process. The designated agent for service of legal process is the Office of the General Counsel at the following address:

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

Process may also be served upon the Plan Administrator.

1.7 Type of Plan and Eligibility. The Plan is an employee welfare benefit plan, within the meaning of Section 3(1) of ERISA, which offers the benefits described in Section 3.1 to active Eligible Employees (as described in Section 2.1) and their beneficiaries. Eligibility for benefits varies depending upon the type of benefit being provided. As explained in Section 3.2, active Eligible Employees may pay for certain benefits on a pre-tax basis with "Salary Reduction Contributions." Therefore, the Plan is also considered a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended ("Code").

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

1.9 COBRA Continuation Coverage. Under a Federal law referred to as COBRA, you, your covered spouse and dependents, have the right, at your own expense, to continue coverage that otherwise would end for the Group Health Benefits described in 3.1(a), the health care flexible spending account ("Health FSA") benefits described in Section 3.1(b), the employee and family assistance program ("EFAP") benefits described in 3.1(h), and the group health coverage provided under the abroad assignment benefits described in 3.1(i). These rules, which are very important for you, are explained in Article V. You may have other continuation coverage rights under state law. You should contact your Employer's Office of Human Resources for further information.

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

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

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

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

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

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

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

procedures to address any issues of noncompliance with the privacy rules described in this section by its employees or other persons within its control.

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

1.12 **Funding and Type of Administration.** Group Health Benefits under the Plan (other than vision) are self-funded by the Employer, and administered pursuant to a contract the Employer has with CIGNA Health and Life Insurance Company ("CIGNA"). Vision benefits are provided pursuant to a contract the Employer has with Vision Service Plan insurance company. Participants are required to contribute towards the cost of Group Health Benefits, as specified on a schedule maintained by your Employer's Office of Human Resources ("Human Resources").

EFAP benefits under the Plan are provided pursuant to a contract the Employer has with New Directions Behavioral Health, LLC ("New Directions"). Your Employer pays the full cost of coverage for EFAP benefits.

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

Short-term disability benefits under the Plan are self-funded and administered pursuant to a contract the Employer has with UNUM. Your Employer pays the full cost of coverage for short-term disability benefits.

Core life insurance benefits, core accidental death and dismemberment insurance benefits, long-term disability benefits, business travel (abroad) benefits, voluntary life insurance benefits, voluntary accidental death and dismemberment insurance benefits, voluntary group accident insurance benefits, voluntary group critical illness insurance benefits, and voluntary whole life insurance benefits under the Plan are provided pursuant to contracts the Employer has with UNUM. Participants are required to pay the full cost of voluntary life insurance, voluntary accidental death and dismemberment benefits, voluntary group accident insurance benefits, voluntary group critical illness insurance benefits, and voluntary whole life insurance benefits, on an after-tax basis, 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, long-term disability insurance benefits, and business travel (abroad) benefits.

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

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

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

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

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

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

1.15 Subrogation and Reimbursement of Plan Payments. The Plan is designed to pay only covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. However, in order to help a covered person in a time of need, the Plan may advance the payment of covered expenses that may be or become the responsibility of another person, provided the Plan later receives reimbursement for those payments. The Plan's subrogation and reimbursement rights are described in Appendix W. If you have any question regarding these rules, please contact the Plan Administrator.

1.16 Assignment of Benefits. Except as specifically provided in a Summary, a Covered Person may not assign his or her right to receive Plan benefits to a health care provider, unless the Plan Administrator consents in writing to the assignment. Although the Plan may make payment of benefits directly to a health care provider, such payment does not make the provider an assignee or otherwise confer upon the provider any rights under the Plan or ERISA.

II. ELIGIBILITY

2.1 Am I eligible to participate in the Plan?

(a) General requirements.

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

Classification	Authorized Hours Per Year	Appointment Duration
Full-Time	>=1664	on-going
Part-Time – Benefits Eligible	1000-1663	on-going
Time-Limited/Term	>=1,000	>=9 months

On-call, temporary, seasonal, and adjunct employees, as well as part-time employees with authorized hours less than 1,000 per year, are generally not eligible to participate in the Plan.

(2) You will also be eligible if you:

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

(B) are in a **"Grant Funded"** position with the Employer and classified as a "benefits eligible" employee in the records of Human Resources;

(C) have been approved for **"Associate Status"** by the Employer in accordance with procedures that are established by the Employer, from time to time;

(D) are a participant in the Employer's Phased Retirement Program, as described in Appendix S;

(E) are considered a "full-time" employee pursuant to the look-back measurement period method for identifying full-time employees under the Patient Protection and Affordable Care Act ("ACA") as described in the Affordable Care Act Policy For Identifying Full-Time Employees in Appendix V, and have been approved for eligibility for medical benefits by the Employer; or

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

(3) 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 not scheduled to work at least nine months during a year.

(4) 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 Employer.

(5) 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 Employer's business establishments or at some location to which the Employer's business requires you to travel; a regular vacation day, properly scheduled in accordance with the normal practices and policies of the Employer 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 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.

(6) 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, the abroad assignment benefits described in Section 3.1(i) of the SPD, and the business travel (abroad) insurance benefits described in Section 3.1(k) 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 eligibility provisions of the Plan will govern, unless the Summary is an insurance contract, in which case the insurance contract will govern.

2.2 Are my spouse. dependent(s), domestic partner or individual with whom I have entered into a civil union eligible for benefits under the Plan? Your spouse and/or dependent(s) may be eligible for coverage under the specific benefit options you select to the extent they satisfy any additional eligibility requirements set forth for that specific benefit. Your spouse is a person who is legally married to you under state law, regardless of your place of domicile. Your domestic partner (as determined by documents maintained and required by Human Resources), and any individual with whom you have entered into a civil union, are eligible for all benefits under the Plan except the Pre-Tax Premium Conversion, Health FSA and the Dependent Care FSA (provided all other eligibility requirements set forth in each specific benefit are satisfied).

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

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

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

For purposes of the medical and dental benefits provided under the Plan, your dependent is generally defined as your child who is less than 26 years old. However, your child who is (i) 26 or more years old, (ii) unmarried, and (iii) primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this Plan, or while covered under a prior plan with no break in coverage, is also eligible for medical and dental coverage under the Plan. If there is a change in the status of your child such that he or she no longer meets the requirements in the previous sentence, you are required to notify Human Resources within 30 days. The Employer may require proof of the continuation of such condition and dependence from time to time, but no more than once a year.

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

(a) For purposes of the pre-tax premium benefits, Health FSA, Dependent Care FSA, Group Health Benefits, long-term disability insurance benefits, core life insurance benefits, core accidental death and dismemberment insurance benefits, voluntary life insurance benefits, and voluntary accidental death and dismemberment insurance 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)(6) are eligible to participate in the Plan immediately upon hire for purposes of the abroad assignment benefits.

(b) For purposes of the voluntary group accident insurance benefits, voluntary group critical illness insurance benefits, and voluntary whole life insurance benefits, you may enroll in the benefits at open enrollment to become effective the first day of the Plan Year.

(c) 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).

(d) For purposes of the EFAP and business travel (abroad) insurance benefits, you can participate immediately upon hire.

(e) If you are enrolled in a high deductible medical plan option offered by the Employer, you are eligible to participate in the health savings account ("HSA"). The HSA is not a welfare benefit plan offered under the Plan, but you may make pre-tax contributions to the HSA and the Employer may make contributions to your HSA, through the Plan's cafeteria plan feature. Please refer to Appendix R for additional information regarding the HSA.

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

2.5 **When must I enroll for benefits?** You will be provided with information about the Plan, and with the election form for electing benefits and entering into a salary reduction agreement.

If you fail to enroll in the Plan by executing and filing an election form with the Plan Administrator 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).

For benefits requiring an affirmative enrollment election by you (see Section 2.3(a)), the 30 day time period begins on the first day of the month following your date of hire. As a limited exception, the 30 day period begins to run on the date of hire for Expatriate Employees.

However, once you satisfy any applicable waiting periods, you are automatically enrolled for EFAP benefits, long-term disability insurance benefits, core life insurance benefits, core accidental death and dismemberment insurance benefits and short-term disability insurance benefits.

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

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

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

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

with whom you have entered into a civil union no longer satisfies the Plan's eligibility requirements (e.g., due to divorce, termination of domestic partner status or loss of dependent child status).

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

2.7 Am I able to convert my sick leave hours to pay for health premium expenses at retirement?

Middlebury offers eligible retirees the opportunity to convert accumulated Sick Leave Reserve ("SLR") or Faculty Leave Reserve ("FLR") amounts to pay for health premium expenses pursuant to the separately administered Middlebury Health Reimbursement Arrangement For Certain Former Middlebury Employees ("Retiree HRA Plan").

If you retire on or after January 1, 2019, you are eligible for a benefit under the Retiree HRA Plan if: (i) you were employed by Middlebury for ten consecutive years following the attainment of age forty-five in a benefits eligible position; or (ii) you were employed as a faculty employee, but resigned from a tenured position to take a part-time position, regardless of your age or years of service.

If you meet the eligibility requirements to participate in the Retiree HRA Plan, your accrued SLR or FLR (if any) will be converted to a dollar value used to fund your HRA account. You and your eligible family members may use the amounts in your HRA account to pay for medical, dental and vision premiums, as described in the Retiree HRA Plan.

There is no cash conversion of SLR or FLR.

You will be provided with additional information regarding the Retiree HRA Plan at the time of your retirement.

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, dental, and vision insurance benefits (collectively, "Group Health Benefits") in accordance with the general terms stated in the attached Appendix C, Appendix D, and Appendix L, respectively, and the remainder of this SPD. Summaries of the different Group Health Benefits have been attached as Appendices C, D, and L 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. (<u>See</u> Section 3.2 below and refer to Appendix R for information regarding Salary Reduction Contributions to the HSA).

(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) Abroad Assignment Benefits.

Your Employer offers abroad assignment benefits in accordance with the terms stated in Appendix Q 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 Q 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.

(j) Phased Retirement Benefits.

Your Employer offers Phased Retirement Program benefits in accordance with the terms stated in Appendix S and the remainder of this SPD. Information regarding the Phased Retirement Program has been attached as Appendix S to this SPD. The

Phased Retirement Program provisions set forth in Appendix S supersede certain otherwise applicable provisions set forth in this SPD.

(k) Business Travel (Abroad) Insurance Benefits.

Your Employer offers business travel (abroad) insurance benefits in accordance with the terms stated in Appendix M and the remainder of this SPD. A summary of the business travel (abroad) insurance 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 benefits, 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.

(l) Voluntary Group Accident Insurance, Voluntary Group Critical Illness Insurance, and Voluntary Whole Life Insurance Benefits.

Your Employer offers voluntary group accident insurance, voluntary group critical illness insurance, and voluntary whole life insurance benefits in accordance with the terms stated in Appendix N, Appendix O, and Appendix P, respectively, and the remainder of this SPD. Summaries of the voluntary group accident insurance, voluntary group critical illness insurance, and voluntary whole life insurance benefits have been attached as Appendix N, Appendix O, and Appendix P, respectively, 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.

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, long-term disability insurance benefits, and business travel (abroad) 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, voluntary group accident insurance benefits, voluntary group critical illness insurance benefits, and voluntary whole life 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.

You also may elect to make Salary Reduction Contributions to your HSA.

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, voluntary accidental death and dismemberment insurance benefits, voluntary group accident insurance benefits, voluntary group critical illness insurance benefits, and voluntary whole life insurance benefits must be paid with after-tax dollars.

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

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

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 may be made prior to the first day of coverage, but can be made retroactively if made within 30 days from your date of hire. Your election is effective as of the first day of the coverage period, which is the first day of the month following or coincident with your date of hire.

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 **<u>will not</u>** 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).

(c) **Special HSA Rules.** If you are eligible to make contributions to the HSA, you generally may commence Salary Reduction Contributions to the HSA following the date you establish the HSA with the HSA trustee or custodian. Thereafter, you may change your Salary Reduction Contribution election at any time, provided the change is made prospectively and permitted by law. Refer to Appendix R for additional information regarding the HSA.

4.4 May I change an election after the Plan Year has begun? Except with respect to Salary Reduction Contributions to the HSA, 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), AND/OR the requirement to repay claims that were paid on behalf on an individual who did not meet the definition of dependent under the plan AND/OR disciplinary action. These requirements will apply regardless of whether your change in family status involves a spouse, dependent, domestic partner, or individual with whom you have entered into a civil union.

As noted in Section 4.3(c) above, after establishing your HSA, you may change your HSA Salary Reduction Contribution election at any time, provided the change is made prospectively and is permitted by law. Refer to Appendix R for additional information regarding the HSA.

Please note: For purposes of the Health and Dependent Care FSAs, no election changes will be allowed unless there is at least one payroll period remaining in the Period of Coverage. Further, your pay during the payroll period must be in a sufficient amount to cover your election.

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

In addition, a 60-day special enrollment period applies for the health benefits provided under the Plan if you or a dependent (including your spouse) loses Medicaid or State

Children's Health Insurance Program coverage, or if you or a dependent becomes eligible for assistance from the State to purchase coverage under the Plan.

The "Special Enrollment" provisions will also allow you to make changes to your election of benefits to cover your domestic partner or individual with whom you have entered into a civil union, to the extent allowed by law.

Changes In Family Status: You may change an election during a Period of Coverage due to one of the following changes in family status, provided the election change is consistent with the change in family status:

(i) A change in legal marital status;

(ii) A change in number of dependents (or number of qualifying dependents for the Dependent Care FSA);

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

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

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

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

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

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

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

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

<u>Please note</u>: **In the event you notify the Employer of an individual's tax dependent status, such individual will be treated as your tax dependent on a prospective basis, unless HIPAA Special Enrollment rules apply.**

V. COBRA HEALTH CONTINUATION COVERAGE

5.1. When will my participation in the Plan terminate?

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

Generally, your participation in the Plan will end on the earlier of the date on which the Plan terminates, you cease to be an Eligible Employee, or you fail to pay any required premiums. However, under federal law, continued health coverage may be available for you, your spouse and dependents ("Qualified Beneficiaries") at your (or their) own expense. These legal rights are known as "COBRA" rights and apply to group health plans. The following benefits provided under the Plan are subject to COBRA: the Group Health Benefits described in 3.1(a), the health care flexible spending account ("Health FSA") benefits described in Section 3.1(b), the employee and family assistance program ("EFAP") benefits described in 3.1(h), and the group health coverage provided under the abroad assignment benefits described in 3.1(i).

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

<u>**Note**</u>: 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.

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. <u>**Please note**</u> 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;

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

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

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

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

2. Following those sixty (60) days, if you satisfied the requirements to be eligible for retiree benefits under the separately administered Middlebury Health Reimbursement Arrangement For Certain Former Middlebury Employees ("Retiree HRA Plan") at the time of your death, then any accumulated Sick Leave Reserve ("SLR") and Faculty Leave Reserve ("FLR") will be converted to a survivor benefit pursuant to the terms of the Retiree HRA Plan.

   If you did not satisfy the requirements to be eligible to participate in the Retiree HRA Plan at the time of your death, any accumulated SLR and FLR will be converted to a dollar amount. The Employer will pay 100% of the COBRA premium to continue the medical and dental insurance coverage until the dollar amount is exhausted.

   The dollar amount will be determined by taking the monthly premium cost for single coverage for the health benefits the survivors were enrolled in at the time of the employee's death (medical, dental and/or vision). The aggregate of these amounts is referred to as the "Total Monthly Premium."

   A COBRA Multiplier is then determined by dividing the Total Monthly Premium by 173.33 (the monthly equivalent of a 40 hour work week).

The deceased employee's accrued unused SLR or FLR is then multiplied by the COBRA Multiplier to determine the dollar amount that will be used to pay for COBRA coverage.

If the survivor's COBRA benefit is exhausted prior to the end of the maximum COBRA period, qualified beneficiaries will be able to continue COBRA coverage if they pay the applicable COBRA premium described in subsection 5.3(f) above, and otherwise maintain eligibility for COBRA coverage.

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

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

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

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

VI. CLAIMS AND APPEAL PROCEDURES

6.1 Where do I find information on filing a claim for benefits? The claims procedures applicable to the Plan are summarized below. However, the claims procedures for benefits offered under an insurance policy are generally established by the insurance company, and the Summaries for a governing self-insured benefit may also provide for separate claims procedures. See the relevant Summaries for the details of claims procedures applicable to particular benefits. Special rules apply to medical benefit claims offered under a group health plan coverage option that is not a grandfathered plan under the Patient Protection and Affordable Care Act of 2010. This summary of the claims procedures will refer to those coverage options as "Non-Grandfathered" coverage options.

The procedures described below apply unless a Summary provides different procedures that are compliant with applicable law.

6.2 **How do I file a claim for benefits?** Unless otherwise provided under the applicable Summaries, the Plan Administrator provides forms for filing claims under the Plan. Read the instructions on the forms carefully and be sure to complete them in their entirety. You have the right to be represented by an attorney or other person of your choice in connection with your claim for benefits, but such representation is not required. The Plan Administrator will require you to provide satisfactory evidence that a person who identifies himself/herself as your representative has in fact been properly authorized to represent you, except that any health care professional familiar with your medical condition may represent you in connection with an urgent care claim.

6.3 **Who determines my benefits?** Unless otherwise provided under an applicable Summary, the Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Plan Administrator or the decision-maker designated by the applicable Summary, by resolution of the Plan Administrator or by the Employer has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the Plan that the Plan Administrator or designated decision-maker in its sole discretion determines you are entitled to receive.

6.4 **What will the Plan Administrator (or designated decisionmaker) do when it makes a decision regarding a benefits claim?** If any claim for benefits under the Plan is wholly or partially denied, you will receive notice in writing (or in a permissible electronic format) of such denial within a reasonable period of time. Notice will generally be provided not later than 90 days after the claim was filed, unless circumstances beyond the control of the Plan require an extension of time for processing, in which case the Plan Administrator (or designated decisionmaker) may extend the decision deadline, but not beyond 180 days after the claim was filed. If an extension is required, you will be so notified within the original 90-day period. Any notice of extension issued in connection with a claim for benefits will explain the reason for the extension and identify the date on which the Plan Administrator (or designated decisionmaker) expects to render a decision.

In some cases, the Plan Administrator is required to provide you with a decision within a shorter time period, as explained below:

(a) If the claim is a claim for urgent care with respect to a group health benefit, you will receive notice of any benefit determination as soon as possible, taking into account the medical exigencies, but in all events within 72 hours after receipt of the claim by the Plan Administrator (or designated decisionmaker). If you fail to provide sufficient information to enable the Plan Administrator (or designated decisionmaker) to make a benefit determination, the Plan Administrator (or designated decisionmaker) shall inform you of the specific information necessary as soon as possible (but not later than 24 hours after receipt of the claim by the Plan Administrator (or designated decisionmaker)) and shall give you a reasonable

period of time (but not less than 48 hours) to provide the information. You will then be notified of the Plan Administrator's (or designated decisionmaker) benefit determination as soon as possible, but not later than 48 hours after the earlier of the Plan Administrator's (or designated decisionmaker) receipt of the specified information or the expiration of the period you were given to provide the specified information.

(b) If the claim is a claim for the extension of concurrent care group health benefits (i.e., an ongoing course of treatment) and qualifies as an urgent care claim, the Plan Administrator (or designated decisionmaker) will notify you of any benefit determination as soon as possible, taking into account the medical exigencies (but in all events within 24 hours after receipt of the claim), so long as the claim is made within 24 hours prior to the expiration of the prescribed period of time or number of concurrent care treatments.

(c) In the event of an adverse benefit determination involving concurrent care group health benefits, the Plan Administrator (or designated decisionmaker) will notify you at a time sufficiently in advance of the intended reduction or termination of such benefits to enable you to appeal the adverse benefit determination and obtain a benefit determination on review prior to the effective date of the reduction or termination.

(d) In the event of a claim involving group health benefits (other than claims governed by items (a) through (c) above) as to which the terms of an applicable Summary require you to obtain approval from the Plan Administrator (or designated decisionmaker) *before* services are rendered or expenses incurred ("pre-service approval"), the Plan Administrator (or designated decisionmaker) will notify you of any benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless circumstances beyond the control of the Plan require an extension of time for processing. If an extension is required, you will be so notified within the original 15-day period and a decision shall be rendered as soon as possible, but not later than 30 days after the Plan Administrator's (or designated decisionmaker) receipt of the claim. If an extension is necessary because you failed to provide sufficient information for a decision to be made, the notice of extension will identify the necessary information and you will be afforded at least 45 days from receipt of the notice to provide the information.

(e) In the event of a claim involving group health benefits (other than claims governed by items (a) through (d) above) as to which the Plan Administrator's (or designated decisionmaker) approval is not required prior to the provision of services, the Plan Administrator (or designated decisionmaker) will notify you of an adverse benefit determination within a reasonable period of time, but not later than 30 days following receipt of the claim, unless circumstances beyond the control of the Plan require an extension of time for processing. If an extension is required, you will be so notified within the original 30-day period and a decision shall be rendered as soon as possible, but not later than 45 days after receipt of the claim. If an extension is necessary because you failed to provide sufficient information for a

decision to be made, the notice of extension shall identify the necessary information and you will be afforded at least 45 days from receipt of the notice to provide the information.

(f) In the event of a claim involving disability benefits, the Plan Administrator (or designated decisionmaker) will notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim, unless circumstances beyond the control of the Plan require an extension of time for processing. If an extension is required, you will be so notified within the original 45-day period and a decision shall be rendered as soon as possible, but not later than 75 days after receipt of the claim or, if the Plan Administrator (or designated decisionmaker) determines that a second extension is necessary and notifies you of this decision, not later than 105 days after receipt of the claim. Any notice of extension will explain the standard under which your entitlement to benefits will be determined and identify the remaining unresolved issues. If an extension is necessary because you failed to provide sufficient information for a decision to be made, the notice of extension will identify the necessary information and you will be afforded at least 45 days from receipt of the notice to provide the information.

Commencement of benefit payments constitutes notice of claim approval to the extent of the amount paid. Generally, any notice of denial shall be provided in writing (or in a permissible electronic format). However, in order to ensure the most rapid possible response, a notice involving a denial of a claim for urgent care group health benefits may be provided orally so long as a written (or electronic) notice is provided within 3 days. A notice of denial will set forth the following information:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

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

(4) An explanation that a full and fair review of the decision denying the claim may be requested by you or your authorized representative by filing a written request for such review with the Plan Administrator (or designated decisionmaker) within 60 days (or 180 days, in the case of denials involving group health or disability benefits) after receipt of the original notice of denial;

(5) A statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is denied on review; and

(6) In the event of a claim involving group health or disability benefits:

(a) If an internal rule or other similar criterion was relied upon in reaching the adverse benefit determination, a recitation of such rule

or a statement that such a rule was relied upon and that a copy of the rule will be provided free of charge upon request;

(b) If the adverse benefit determination is based on a "medical necessity," "experimental treatment" or similar exclusion, an explanation of the scientific or clinical basis for the determination or a statement that such an explanation will be provided free of charge upon request;

(c) In the event of a claim involving urgent care group health benefits, a description of the expedited procedures available for appeal of the denial, including a statement that a request for appeal may be made orally or in writing.

(7) To the extent required by law, in the event of a claim for a medical benefit under a Non-Grandfathered coverage option:

(a) the date of service, name of the health care provider, and claim amount;

(b) the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim;

(c) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

(d) a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and external review processes.

6.5 What do I do if my claim is denied? For claims which do not involve group health or disability benefits, you have 60 days after the earlier of: (i) your receipt of the written (or electronic) notice of denial; or (ii) the expiration of the 90-day original claims review period, plus any extension of which you received notice, to file a request for review. For group health and disability benefits, you have 180 days after the earlier of: (i) your receipt of the written (or electronic) notice of denial; or (ii) the expiration of the applicable original claims review period, plus any extension of which you received notice. Requests for review must be in writing, except that requests for review of a denial involving an urgent care claim may be made orally.

For claims which do not involve group health or disability benefits, the Plan Administrator (or designated decisionmaker) then has 60 days to act on your request for review and deliver a decision in writing (or in a permissible electronic format) to you, unless there are special circumstances, in which case you will be informed that extra time is required and notified of the final decision within 120 days. The notice of extension will specify the reasons why an extension was necessary and identify the date on which the Plan Administrator (or designated decisionmaker) expects to render a decision. If the denied

claim was a claim for disability or group health care benefits, the Plan Administrator (or designated decisionmaker) will appoint someone other than the initial decision-maker to review your claim on appeal, and that person will provide you with a written (or electronic) decision within the relevant time period described below:

(1) You will be notified of the decision in an appeal involving urgent care group health benefit claims as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after the Plan Administrator's (or designated decisionmaker) receipt of your request for review.

(2) You will be notified of the decision in an appeal involving group health benefits (other than urgent care claims) as to which the terms of the Summaries require pre-service approval by the Plan Administrator (or designated decisionmaker) within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

(3) You will be notified of the decision in an appeal involving group health benefits (other than urgent care claims) as to which the Plan Administrator's (or designated decisionmaker) pre-service approval is not required within a reasonable period of time, but not later than 60 days after receipt of your request for review.

(4) You will be notified of the decision in an appeal involving disability benefits not later than 45 days after receipt of the request for review, unless circumstances beyond the control of the Plan require an extension of time for processing. If an extension is required, you will be so notified within the original decision period and a decision shall be rendered as soon as possible, but not later than 90 days after receipt of the request for review. The notice of extension will explain the reasons for the extension and identify the date by which the Plan Administrator (or designated decisionmaker) expects to make a decision.

The appeal process will afford you a full and fair opportunity for review. You and your authorized representatives shall be permitted reasonable access to pertinent documents and other relevant information and upon request shall receive copies of such items, free of charge. The review shall take into account all comments, documents, records and other information submitted regardless of whether such information was submitted prior to the initial determination.

In the case of group health and disability benefits, if an appeal involves an adverse benefit decision that was based in whole or in part on a medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the relevant field of medicine. Additionally, the group health and disability benefit appeal procedures require the identification of any medical or vocational expert whose opinion was obtained on behalf of the Plan in connection with the adverse benefit determination, whether or not that expert's advice was relied upon, and state that no health care professional engaged for purposes of a consultation during the appeal process shall be an individual who was consulted in connection with the adverse benefit determination under appeal or a subordinate of such individual.

In the case of a claim for a medical benefit under a Non-Grandfathered coverage option, if the Plan Administrator (or designated decisionmaker) considers, relies upon or

generates new or additional evidence in the process of considering your claim, such evidence will be provided to you as soon as possible in advance of the date by which the Plan Administrator (or designated decisionmaker) is required to provide notice of its final decision on appeal. In addition, if the Plan Administrator (or designated decisionmaker) intends to deny your appeal in whole or part based on a new or additional rationale, the Plan Administrator (or designated decisionmaker) will provide you with the rationale as soon as possible in advance of the date by which the Plan Administrator (or designated decisionmaker) is required to provide notice of its final decision on appeal.

Commencement of benefit payments constitutes notice of claim approval to the extent of the amount paid. Any notice of denial shall be provided in writing (or in a permissible electronic format) and shall set forth the following information:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents and other information relevant to your claim for benefits;

(4) A statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is denied on review; and

(5) In the event of a claim involving group health or disability benefits:

  (a) If an internal rule or other similar criterion was relied upon in reaching the adverse benefit determination, a recitation of such rule or a statement that such a rule was relied upon and that a copy will be provided free of charge upon request;

  (b) If the adverse benefit determination is based on a "medical necessity," "experimental treatment" or similar exclusion, an explanation of the scientific or clinical basis for the determination or a statement that such an explanation will be provided free of charge upon request;

  (c) A statement that "You and 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."

6. To the extent required by law, in the event of a claim for a medical benefit under a Non-Grandfathered coverage option:

  (a) the date of service, name of the health care provider, and claim amount;

  (b) the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim;

  (c) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning; and

(d) a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and external review processes.

You must exhaust all your remedies under this claims procedure (or the applicable claims procedure under a Summary) before you will be entitled to file suit to obtain benefits from the Plan. Since claims must be filed in accordance with Plan and Summary procedures and those procedures may require advance approval, it is very important that you review the rules governing different types of claims *before* you incur expenses. Although the Plan Administrator (or designated decisionmaker) will attempt to notify you or your authorized representative within five days (or 24 hours in the case of a claim involving urgent care group health benefits) if it is aware that you have failed to follow proper pre-service approval procedures (provided you have directed your claim to a person or department accustomed to handling benefits matters and have provided the name of the claimant and identified the treatment, service or product for which approval is requested), the Plan Administrator (or designated decisionmaker) may not be aware of such a failure in time to notify you. Ultimately, it is your responsibility to be familiar with the Plan and Summary claims procedures and ensure that your claims are submitted in a timely fashion.

In addition, if your medical coverage is terminated retroactively for a reason other than your failure to timely pay required contributions toward the cost of coverage (called a Rescission), you have a right to appeal that decision as if it is a denied claim for group health benefits. You will have 180 days from the date you receive the notice of Rescission to appeal the Rescission.

In the event your claim for a medical benefit under a Non-Grandfathered coverage option is denied on appeal, you may be able to request an external review of your claim. Your request for external review must be filed in accordance with the instructions contained in your appeal denial notice.

6.6 What additional rules regarding disability claims apply to the Plan?

Effective for disability claims filed on or after April 1, 2018:

(1) Independence and Impartiality. The Plan will ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

(2) Content of Benefit Determination. The notification of the benefit determination will contain the following (in addition to any other required language specified in this Article):

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the termination, 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;

(c) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(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 a document, record, or other information is relevant to a claim for benefits shall be determined by reference to the ERISA regulations.

The notification shall be provided in a culturally and linguistically appropriate manner, in accordance with the requirements of the applicable regulations.

(3) The Plan will provide a claimant with a reasonable opportunity for a full and fair review of a disability benefits claim and adverse benefit determination, in accordance with the following rules (in addition to the other applicable requirements of this Section that apply to disability benefit claims):

(a) Claimants shall be provided with the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(b) Claimants shall be provided with, 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 a

document, record, or other information is relevant shall be determined by reference to the ERISA regulations);

(c) The 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 benefit determination;

(d) Claimants will have at least 180 days following receipt of notification of an adverse benefit determination within which to appeal the determination;

(e) The review will not afford deference to the initial adverse benefit determination that is conduction by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(f) In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(g) The identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination will be provided to the claimant, without regard to whether the advice was relied upon in making the benefit determination;

(h) The health care professional engaged for purposes of consultation shall be an individual who is neither the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(i) Before the Plan can issue an adverse benefit determination on review, the Plan Administrator (or claims administrator) shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and

(j) Before the Plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the Plan Administrator (or claims administrator) shall provide the claimant, free of charge with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to responded prior to that date.

(4) Timing of Notification of Benefit Determination on Review. The Plan Administrator (or claims administrator) shall notify a claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review by the Plan, unless the Plan Administrator (or claims administrator) determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator (or claims administrator) determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the determination on review.

(5) Content of Notification of Benefit Determination On Review. The notification of the benefit determination on review will contain the following (in addition to any other required language specified in this Article):

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts who advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 change upon request; and

(c) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

The notification of an adverse benefit determination on review shall be provided in a culturally and linguistically appropriate manner, in accordance with the requirements of the ERISA regulations.

(6) Contractual Limitations Period. The content of the benefit notification on review will describe any applicable contractual limitation period that applies to the claimant's right to bring an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim.

(7) Deemed Exhaustion of Administrative Remedies. If the Plan fails to strictly adhere to all of the requirements of this Section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the Plan and entitled to pursue any available remedies under Section 502(a) of ERISA unless the violations of the claims procedures by the Plan are *de minimis* and (i) do not cause, and are not likely to cause, prejudice or harm the claimant, (ii) the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan, and (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and claimant and was not part of a pattern or practice of violations. The claimant may request a written explanation of a Plan's violation of the claims procedures. The Plan shall provide such explanation within 10 days of the request. The description shall include a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

(8) Adverse Benefit Determination Definition. With respect to disability benefit claims, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

VII. ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

This includes the ability to:

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part,

you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

VIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

Group health plans and health insurers may not deny eligibility to enroll, renew or continue coverage in a plan, in order to avoid providing the above-described coverage provided by the law. Further, the law prohibits (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similarly benefits. Contact the Plan Administrator if you have questions.

IX. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

X. WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

XI. MEDICARE

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

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

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

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

Medicare Carve Out Provisions

Medicare Carve Out applies to Participants who are: (i) no longer actively employed due to disability (during the time they remain on the Plan); or (ii) COBRA Qualified Beneficiaries, and Medicare is the primary payer, to the extent permitted under federal law. Carve out complements Medicare by providing payment for expenses not paid by Medicare Payment is determined by the design of the medical insurance coverage.

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

XII. MENTAL HEALTH PARITY ACT

The Mental Health Parity Act requires certain group health plans to provide equal treatment of mental health and substance use disorder benefits in parity with medical/surgical benefits. This generally means that:

(a) Financial requirements and treatment limits applicable to mental health and substance use disorder benefits be no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, copays, coins, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);

(b) Out-of-Network benefits provided for medical/surgical also must be available for mental health and substance use disorder benefits; and

(c) Criteria for medical necessity and reason for claim denials must be made available.

The Summaries for the welfare benefit plans that are subject to this law will provide an explanation of the covered and excluded benefits.

XIII. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

GINA prohibits the Employer and the Plan from:

(a) Using genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;

(b) Adjusting your premium and contribution amounts on basis of genetic information;

(c) Requesting or requiring you or a family member to undergo a genetic testing;

(d) Requesting, requiring or purchasing genetic information for underwriting purposes; or

(e) Requesting, requiring or purchasing genetic information about an individual prior to or in connection with an individual's enrollment under the plan.

GINA also makes it illegal for the Employer to discriminate against you with respect to your compensation or the terms, conditions or privileges of employment on the basis of your genetic information and from collecting such data (except as otherwise permitted for certain wellness programs of the Employer).

XIV. MICHELLE'S LAW

Michelle's Law prohibits a group health plan from terminating coverage for a dependent student who takes a medically necessary leave of absence. Generally, coverage must continue for a dependent that otherwise would lose coverage under the group health plan for failing to maintain full-time enrollment status in a post-secondary institution because the dependent requires a medically necessary leave of absence. If you would like more information on Michelle's Law, please contact Human Resources.

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

The actual dollar amount of the required premiums for the coverage elected each Plan Year will be communicated to Participants during the annual Open Enrollment Period before the Plan Year begins. In addition, Plan changes may require contribution rate changes during the Plan Year which will be communicated to Participants periodically. These communications are hereby incorporated by reference and made a part of this Plan.

II. HEALTH FSA PLAN

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

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

III. DEPENDENT CARE FSA PLAN

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

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

IV. CORE LIFE INSURANCE PLAN BENEFITS

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

V. VOLUNTARY LIFE INSURANCE PLAN BENEFITS

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

VI. LONG-TERM DISABILITY PLAN BENEFITS

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

VII. SHORT-TERM DISABILITY PLAN BENEFITS

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

VIII. EMPLOYEE AND FAMILY ASSISTANCE PROGRAM BENEFITS

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

IX. PRE-TAX PREMIUM BENEFITS

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

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. ABROAD ASSIGNMENT BENEFITS

Expatriate Employees may elect abroad assignment benefits, in accordance with Appendix Q. 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.

XI. PHASED RETIREMENT BENEFITS

Eligible Employees may participate in the Phased Retirement Program, in accordance with Appendix S.

XII. BUSINESS TRAVEL (ABROAD) INSURANCE PLAN BENEFITS

Eligible Employees are automatically enrolled in the business travel (abroad) insurance Plan benefits, in accordance with Appendix M. The Employer pays the entire cost of coverage.

XIII. VOLUNTARY GROUP ACCIDENT INSURANCE PLAN BENEFITS

Eligible Employees may elect Voluntary Group Accident Insurance Plan benefit coverage, in accordance with Appendix N, at full cost to the Eligible Employee.

XIV. VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE PLAN BENEFITS

Eligible Employees may elect Voluntary Group Critical Illness Insurance Plan benefit coverage, in accordance with Appendix O, at full cost to the Eligible Employee.

XV. VOLUNTARY WHOLE LIFE INSURANCE PLAN BENEFITS

Eligible Employees may elect Voluntary Whole Life Insurance Plan benefit coverage, in accordance with Appendix P, at full cost to the Eligible Employee.

APPENDIX C-1

MEDICAL PLAN OPTION 1: PPO

Middlebury

PREFERRED PROVIDER MEDICAL
BENEFITS

EFFECTIVE DATE: January 1, 2020

ASO6a
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This document printed in May, 2020 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Important Information

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

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

HC-NOT89

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

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

Services Available in Conjunction With Your Medical Plan

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

HC-SPP44 04-17

Case Management

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

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

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

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

HC-SPP2 04-10
V1

Additional Programs

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

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

HC-SPP3 04-10 V1

Care Management and Care Coordination Services

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

HC-SPP27 06-15 V1

Important Notices

Direct Access to Obstetricians and Gynecologists

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

HC-NOT5 01-11

Important Information

Rebates and Other Payments

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

Coupons, Incentives and Other Communications

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

HC-IMP258 01-19

Discrimination is Against the Law

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

Cigna:

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

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

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

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic - برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

HC-NOT97 07-17

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NQTLs) include:

- Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- Prescription drug formulary design;
- Network admission standards;
- Methods for determining in-network and out-of-network provider reimbursement rates;
- Step therapy a/k/a fail-first requirements; and
- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of your plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g. employers) and covered persons by accessing the appropriate link below:

Employers (Plan Administrators): https://cignaaccess.cigna.com/secure/app/ca/centralRepo - Log in, select Resources and Training, then select the NQTL document.

Covered Persons: www.cigna.com\sp

To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage (whether or not your plan includes pharmacy coverage).

HC-NOT113 01-20

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

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

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

Cigna

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM25 01-11
V11

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

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

First of the month coincident with or next following your employment, or your classification as an Eligible Employee.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

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

Dependent Insurance

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

Effective Date of Dependent Insurance

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

Your Dependents will be insured only if you are insured.

Late Entrant Limit

Your Employer will not allow you to enroll for medical insurance until the next open enrollment period.

Exception for Newborns

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

HC-ELG274 M 01-19

Preferred Provider Medical Benefits

The Schedule

For You and Your Dependents

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

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

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Deductibles

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

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

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

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

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

- Coinsurance.
- Plan Deductible.

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

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

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

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

Multiple Surgical Reduction

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

Preferred Provider Medical Benefits
The Schedule

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greatest of the following, not to exceed the provider's billed charges: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays	80%	80% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance. **Note:** Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.	Not Applicable	200%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$300 per person	$300 per person
Family Maximum	$900 per family	$900 per family
Family Maximum Calculation **Individual Calculation:** 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.		
Out-of-Pocket Maximum		
Individual	$1,100 per person	$1,100 per person
Family Maximum	$3,300 per family	$3,300 per family
Family Maximum Calculation **Individual Calculation:** 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%.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist.		
Surgery Performed in the Physician's Office		
Primary Care Physician	80%	80%
Specialty Care Physician	80%	80%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	80%	80%
Specialty Care Physician	80%	80%
Medical Telehealth		
Primary Care Physician	80%	In-Network coverage only
Specialty Care Physician	80%	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Routine Preventive Care - all ages		
Primary Care Physician's Office Visit	100%	100%
Specialty Care Physician's Office Visit	100%	100%
Immunizations - all ages (includes travel immunizations)		
Primary Care Physician's Office Visit	100%	100%
Specialty Care Physician's Office Visit	100%	100%
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	100%	100%
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Inpatient Hospital - Facility Services	Plan deductible, then 80%	Plan deductible, then 80%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Surgeon		
Radiologist, Pathologist, Anesthesiologist		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 80%	Plan deductible, then 80%
Urgent Care Services		
Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.	80%	80%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit	80%	80%
Emergency Services		
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan deductible, then 80%	Plan deductible, then 80%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	Plan deductible, then 80%	Plan deductible, then 80%
Ambulance	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined	Plan deductible, then 80%	Plan deductible, then 80%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory Services		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Outpatient Hospital Facility	Plan deductible, then 80%	Plan deductible, then 80%
Independent Lab Facility	Plan deductible, then 80%	Plan deductible, then 80%
Radiology Services		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Outpatient Hospital Facility	Plan deductible, then 80%	Plan deductible, then 80%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Therapy Services and Chiropractic Services		
Calendar Year Maximum: Unlimited		
Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors) Massage Therapy		
Primary Care Physician's Office Visit	80%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	80%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Home Health Care		
Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	Plan deductible, then 80%	Plan deductible, then 80%
Hospice		
Inpatient Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Services (same coinsurance level as Home Health Care)	Plan deductible, then 80%	Plan deductible, then 80%
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient	Plan deductible, then 80%	Plan deductible, then 80%
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceuticals		
Physician's Office	80%	80%
Home Care	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.		
Gene Therapy Product	Covered same as Medical Pharmaceuticals	Not Covered
Inpatient Facility	Plan deductible, then 80%	Not Covered
Outpatient Facility	Plan deductible, then 80%	Not Covered
Inpatient Professional Services	Plan deductible, then 80%	Not Covered
Outpatient Professional Services	Plan deductible, then 80%	Not Covered
Travel Maximum: $10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy		
Note: OB/GYN providers will be considered either as a PCP or Specialist.		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan deductible, then 80%	Plan deductible, then 80%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Delivery - Facility (Inpatient Hospital, Birthing Center)	Plan deductible, then 80%	Plan deductible, then 80%
Abortion		
Includes elective and non-elective procedures		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.		
Primary Care Physician	100%	100%
Specialty Care Physician	100%	100%
Surgical Sterilization Procedures for Tubal Ligation		
Primary Care Physician's Office Visit	100%	100%
Specialty Care Physician's Office Visit	100%	100%
Inpatient Facility	100%	100%
Outpatient Facility	100%	100%
Inpatient Professional Services	100%	100%
Outpatient Professional Services	100%	100%
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Primary Care Physician	80%	80%
Specialty Care Physician	80%	80%
Surgical Sterilization Procedures for Vasectomy		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Services Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)		
Primary Care Physician	80%	80%
Specialty Care Physician	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Lifetime Maximum: $15,000 per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	100% at LifeSOURCE center, otherwise plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	100% at LifeSOURCE center, otherwise, plan deductible, then 80%	Plan deductible, then 80%
Lifetime Travel Maximum: $10,000 per transplant	100% (only available when using LifeSOURCE facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Breast Feeding Equipment and Supplies	100%	100%
Note: Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.		
External Prosthetic Appliances	Plan deductible, then 80%	Plan deductible, then 80%
Calendar Year Maximum: Unlimited		
Hearing Aids	Plan deductible, then 80%	Plan deductible, then 80%
Lifetime Maximum: $2,500		
Nutritional Evaluation		
Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of mental health and substance use disorder conditions.		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Genetic Counseling		
Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Primary Care Physician's Office Visit	80%	80%
Specialty Care Physician's Office Visit	80%	80%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 80%
Wigs Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 80%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health		
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	80%	80%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	80%	80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 80%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	80%	80%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	80%	80%

Preferred Provider Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 72 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 be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 72 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 not include:

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

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

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

HC-PAC73 M 01-19

Prior Authorization/Pre-Authorized

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

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

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- non-emergency ambulance.

HC-PRA41 01-19

Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services; and
- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.

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

Covered Expenses – Mental Health and Substance Use Disorder

- behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

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

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

- involve a drug trial that is exempt from having such an investigational new drug application.

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

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

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

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

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

Genetic Testing

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

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

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing.

Nutritional Evaluation and Counseling

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 non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

HC-COV731 01-19

Orthognathic Surgery

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

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

HC-COV3 04-10
V1

Home Health Services

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

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting.

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

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

HC-COV863 01-20

Hospice Care Services

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

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

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent; in daily living.

HC-COV6 04-10
V1

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the

psychological and social functional disturbances that are a result of subacute Mental Health conditions.

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

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

Outpatient Mental Health Services

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

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

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

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

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

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

HC-COV481 12-15

Durable Medical Equipment

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

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

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8 04-10
V2

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.

External prosthetic appliances and devices 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:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial 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:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot 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 required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older;
- no more than once every 12 months for persons 18 years of age and under;
- replacement due to a surgical alteration or revision of the impacted 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.

HC-COV732 01-19

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); services of an embryologist; and the reversal of male and female voluntary sterilization.

  Infertility is defined as:

  - the inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse;
  - the inability of opposite-sex partners to achieve conception after six months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;

- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period; and
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time, when the female partner trying to conceive is age 35 or older.

This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

HC-COV734 M 01-19

Outpatient Therapy Services

Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- Charges for therapy services are covered when provided as part of a program of treatment.

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Chiropractic Care Services

- Charges 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. For these services you have direct access to qualified chiropractic Physicians.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called "rehabilitative"):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Illness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called "habilitative"):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Illness or Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy;
- treatment of dyslexia;
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status;
- charges for Chiropractic Care not provided in an office setting; or
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.

HC-COV864 01-20

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

HC-COV631 12-17

Transplant Services

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

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

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

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

Transplant Travel Services

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

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

alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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

HC-COV482 12-15

Medical Pharmaceuticals

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

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

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

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

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

HC-COV526 10-16

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a

participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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Prescription Drug Benefits
The Schedule

For You and Your Dependents

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

Copayments (Copay)

Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.

Out-of-Pocket Expenses

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

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Out-of-Pocket Maximum		
Individual	$600 per person	Not Applicable
Family	$1800 per family	Not Applicable
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Designated Pharmacy or home delivery Pharmacy.		
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Note: Infertility medications have a $4,000 Lifetime maximum All contraceptives are covered at No charge		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Tier 1		
Generic Drugs on the Prescription Drug List	No charge after $10 Copay	In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $25 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $40 Copay	In-network coverage only
Note: Infertility medications have a $4,000 Lifetime maximum All contraceptives are covered at No charge		
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $50 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $80 Copay	In-network coverage only
Note: Infertility medications have a $4,000 Lifetime maximum All contraceptives are covered at No charge		
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay	In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $50 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $80 Copay	In-network coverage only

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

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

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

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Employer's plan is managed by the Cigna Business Decision Team. Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

HC-PHR278 01-19

Limitations

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

Prior Authorization Requirements

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

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

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

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

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

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

Step Therapy

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

Supply Limits

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

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

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

Specialty Prescription Drug Products

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

Designated Pharmacies

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

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on Prescription Drug List upon its market entry. The Business Decision Team will use reasonable efforts to make a decision for a New Prescription Drug