

BENEFIT HIGHLIGHTS	INTERNATIONAL	U.S. IN-NETWORK	U.S. OUT-OF-NETWORK
Substance Use Disorder			
Inpatient Facility Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Unlimited Maximum per Calendar Year	100%	100%	100%
Outpatient – Office Visits Includes Individual, Family and Group Psychotherapy; Medication Management, etc. Unlimited Maximum per Calendar Year	100%	100%	100%
Outpatient – All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, etc. Unlimited Maximum per Calendar Year	100%	100%	100%

Preferred Provider Medical Benefits

Certification Requirements – U.S. Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

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

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

- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

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

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

Outpatient Certification Requirements – U.S. Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is

performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

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

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

HC-PAC44

11-15

Prior Authorization/Pre-Authorized

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

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

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- partial hospitalization;
- intensive outpatient programs;
- advanced radiological imaging;
- nonemergency ambulance; or
- transplant services.

HC-PRA19

11-15

Covered Expenses

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

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov/):
 - (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
 - (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
 - (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
 - (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for or in connection with mammograms including: a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for asymptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- charges made for or in connection with travel immunization for Employees and Dependents.
- surgical or nonsurgical treatment of TMJ dysfunction.
- charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- charges made for children from birth through age 18 for immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; Haemophilus influenzae B; and hepatitis A.
- charges made for U.S. FDA approved prescription contraceptive drugs and devices and for outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices.
- charges made for Diabetic supplies as recommended in writing or prescribed by a Participating Physician or Other Participating Health Care Professional, including insulin pumps and blood glucose meters.
- scalp hair prostheses worn due to alopecia areata.
- colorectal cancer screening for persons 50 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of

hereditary nonpolyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, provided as determined by the Secretary of Health and Social Services of Delaware after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician. Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is medically necessary in the judgment of the treating Physician.

- hearing aids for Dependent children up to age twenty-four (24).
- nutritional formulas, low protein modified food products, or other medical food consumed or administered enterally (via tube or orally) which are medically necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a Physician.
- the treatment of autism spectrum disorder for the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for CA-125 monitoring of ovarian cancer subsequent to treatment for ovarian cancer. Coverage is not provided for routine screening.

- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.

Clinical Trials

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

- (a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- (b) either
 - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
 - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

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

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
 - be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
 - involve a drug trial that is exempt from having such an investigational new drug application.
- Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:
- services required solely for the provision of the investigational drug, item, device or service;
 - services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
 - services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service;
 - reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications; and
 - routine patient care costs (as defined) for covered persons engaging in clinical trials for treatment of life threatening diseases.

Routine patient care costs do not include:

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

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

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

Genetic Testing

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

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

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

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

Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

Telehealth Services

Charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications

or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

HC-COV446

01-15

V2

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 Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV5

04-10
V1

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 abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program. Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.

- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV481

10-15

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.

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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. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

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

Prostheses/prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
 - rigid and semirigid custom fabricated orthoses;
 - semirigid prefabricated and flexible orthoses; and
 - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
 - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
 - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and

- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and

- myoelectric prostheses peripheral nerve stimulators.

HC-COV9

04-10

V2

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

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

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

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

Multiple outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

The following limitation applies to Chiropractic Care Services:

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

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

HC-COV13

04-10
V2

Alternative Therapies and Non-traditional Medical Services

Charges for Alternative Therapies and Non-traditional medical services limited to \$1,000 per calendar year. Alternative Therapies and Non-traditional medicine include services provided by an Herbalist, or Naturopath, or for Massage Therapy when these services are provided for a covered condition outside the United States in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is medically necessary, cost-effective, and provided in an appropriate setting.

HC-COV235

05-12

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

significant additional improvement as determined by the utilization review Physician.

HC-COV14

04-10
V1

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

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

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

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

Transplant Travel Services (U.S. In-Network Coverage Only)

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized

transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

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

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

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Prescription Drug Benefits (purchased outside the United States)

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician outside the United States, Cigna will provide coverage for those expenses as shown in the Medical Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Coinsurance or Maximums if applicable.

Exclusions:

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by applicable law;

- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription vitamins (other than prenatal vitamins) and dietary supplements;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- anabolic steroids;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the origi

Prescription Drug Benefits

The Schedule

This section describes coverage for Prescriptions obtained inside the United States only.

Prescriptions obtained outside of the United States are covered under the Preferred Provider Medical Benefits section of this certificate.

For You and Your Dependents

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

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Retail Prescription Drugs	The amount you pay for each 30-day supply	The amount you pay for each 30-day supply
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov/) are covered at 100% with no copayment.		
Generic*	\$0 copay	\$25 copay
Brand-Name*	\$25 copay	\$25 copay
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Home Delivery Prescription Drugs	The amount you pay for each 90-day supply	The amount you pay for each 90-day supply
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov/) are covered at 100% with no copayment.		
Generic*	\$0 copay	U.S. In-Network coverage only
Brand-Name*	\$75 copay	U.S. In-Network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

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In the event that you insist on a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the required Copayment identified in the Schedule.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim

system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

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Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule. Please refer to the Schedule for any required Copayments, Coinsurance or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

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Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;

- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- diet pills or appetite suppressants (anorectics);
- anabolic steroids;
- prescription smoking cessation products, unless state or federal law requires coverage of such products;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate.

Other limitations are shown in the Medical "Exclusions" section of your certificate.

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Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment or Coinsurance shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

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Emergency Evacuation (If Applicable)

If you suffer a life-threatening/limb-threatening medical condition, and Cigna, and/or its designee, determines that adequate medical facilities are not available locally, Cigna, or its designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Cigna at the phone number indicated on your identification card to begin this process.

In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of your evacuation to be considered an emergency and requiring emergency evacuation. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Repatriation

Following any covered emergency evacuation, Cigna will pay for one of the following:

- (1) If it is deemed Medically Necessary and appropriate by the Cigna medical director, you will be transferred to your permanent residence via a one-way economy airfare or;
- (2) You will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required, Cigna or its designee will arrange accordingly and such will be covered by Cigna.

Notification

Expenses incurred for your evacuation or repatriation without the approval and authorization of Cigna and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you are expected to require hospitalization in excess of 7 days at the location to which you are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual

chosen by you. If your Dependent Child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

Return of Dependent Children

If Dependent child(ren) are left unattended by virtue of the evacuee's absence alone following a covered evacuation, a one-way economy airfare will be provided to their place of residence.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided by Cigna or its designee for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

General Limitations/ Exclusions for Evacuation Benefits

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna or its designee;
- non emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious injury or harm to you;
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency evacuation or repatriation;
- medical care or services scheduled for member or provider's convenience which are not considered an emergency;
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
- services provided for which no charge is normally made;
- expenses incurred while serving in the armed forces of another country;
- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
- service provided other than those indicated in this certificate;
- injury or sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
- death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action; or
- for claim payments that are illegal under applicable law.

Cigna Vision			
The Schedule			
For You and Your Dependents			
BENEFIT HIGHLIGHTS	INTERNATIONAL	U.S. IN-NETWORK	U.S. OUT-OF-NETWORK
Examinations One Eye Exam every 24 Consecutive months	100%	100%	100%
Lenses & Frames One pair of glasses or contact lenses per 24 Consecutive months Maximum Benefit: \$250	100%	100%	100%

Vision Benefits

For You and Your Dependents

Covered Expenses

Benefits Include:

Examinations – one vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

- Polycarbonate lenses for children under 18 years of age;
- Oversize lenses;
- Rose #1 and #2 solid tints;
- Progressive lenses covered up to bifocal lenses amount.

Frames – One frame – choice of frame covered up to retail plan allowance.

Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year).

Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Charges in excess of the usual and customary charge for the service or materials.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- High Index lenses of any material type.
- Lens treatments or “add-ons”, except rose tints (#1 & #2), and oversize lenses.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related.
- Claims submitted and received in-excess of one year (365 days) from the original Date of Service.

Other Limitations are shown in the Exclusions and General Limitations section.

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Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Magnification or low vision aids.
- Any non-prescription eyeglasses, lenses, or contact lenses.

Cigna Dental Preferred Provider Insurance – Option 1 (If Applicable)

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers.

Deductibles

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

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.

Non-Participating Provider Payment

U.S. Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

BENEFIT HIGHLIGHTS

Classes I, II, III Combined Calendar Year Maximum

\$1,000

Calendar Year Deductible

Individual

\$50 per person

Family Maximum

\$150 per family

Class I

Preventive Care

100% not subject to plan deductible

Class II

Basic Restorative

80% after plan deductible

Class III

Major Restorative

50% after plan deductible

Cigna Dental Preferred Provider Insurance – Option 2 (If Applicable)

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers.

Deductibles

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

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.

Non-Participating Provider Payment

U.S. Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

BENEFIT HIGHLIGHTS

Classes I, II, III Combined Calendar Year Maximum

\$1,500

Class IV Lifetime Maximum

\$1,500

Calendar Year Deductible

Individual

\$50 per person

Family Maximum

\$150 per family

Class I

Preventive Care

100% not subject to plan deductible

Class II

Basic Restorative

80% after plan deductible

Class III

Major Restorative

50% after plan deductible

Class IV

Orthodontia

Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.

50% not subject to plan deductible

Cigna Dental Preferred Provider Insurance – Option 3 (If Applicable)

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.

Non-Participating Provider Payment

U.S. Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

BENEFIT HIGHLIGHTS

Classes I, II, III Combined Calendar Year Maximum	\$1,500
Class IV Lifetime Maximum	\$1,500
Class I	
Preventive Care	100%
Class II	
Basic Restorative	80%
Class III	
Major Restorative	50%
Class IV	
Orthodontia	50%
Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.	

Cigna Dental Preferred Provider Benefits (If Applicable)

Covered Dental Expense

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

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

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service.

Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

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

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

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

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed \$200.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be

considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

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Dental PPO – Participating and Non-Participating Providers

Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the Contracted Fee.

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

The covered person is responsible for the balance of the non-Participating Provider's actual charge.

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Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

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

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 3 calendar years.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

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

Topical application of sealant, per tooth, on a posterior tooth – Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

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Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

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

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

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Class III Services – Major Restorations, Dentures and Bridgework

Crowns

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

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense.

Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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HC-DEN164V1

Class IV Services – Orthodontics (Applicable only if Option 2 or 3 is Elected)

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for Orthodontics during a Dependent child's lifetime will not be more than the Orthodontia Maximum shown in the Schedule.

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Dental Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is

made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;

- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- orthodontic treatment (**Exclusion applies to Option 1 only**);
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- services for which benefits are not payable according to the "General Limitations" section.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared, riot, civil commotion or police action which occurs in the Employee's country of citizenship.
- for claim payments that are illegal under applicable law.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.

- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch. (**Applicable only if Dental is Not Elected**)
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
 - therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
 - consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
 - private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
 - personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
 - artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata.
 - hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section. A hearing aid is any device that amplifies sound.
 - aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of autism.
 - eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 - all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
 - routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 - membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 - genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
 - dental implants for any condition.
 - fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 - blood administration for the purpose of general improvement in physical condition.
 - cosmetics, dietary supplements and health and beauty aids.
 - all nutritional supplements and formulac except for infant formula needed for the treatment of inborn errors of metabolism.
 - medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
 - medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
 - for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
 - telephone, email, and internet consultations.
 - charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- General Limitations**
- No payment will be made for expenses incurred for you or any one of your Dependents:
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
 - to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
 - to the extent that payment is unlawful where the person resides when the expenses are incurred.

- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's Family.

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Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical, dental or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - then, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child;
 - then, the Plan of the parent not having custody of the child, and
 - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

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

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

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

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine",

“Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys’ fees or other representatives’ fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB1

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Payment of Benefits - Medical

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient’s payment on the charge, it is the provider’s responsibility to reimburse the patient. Because of Cigna’s contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to

you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

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

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

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Payment of Benefits – Vision

To Whom Payable

Vision Benefits are payable to you, but are also assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient’s payment on the charge, it is the provider’s responsibility to reimburse the patient. Because of Cigna’s contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal

guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

HC-POB1

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Payment of Benefits – Dental (If Applicable)

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

HC-POB4

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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

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

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

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

HC-TRM1

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Rescissions

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

HC-TRM80

01-11

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums) and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

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

HC-BEX30

04-10

V1

Dental Benefits Extension (If Applicable)

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

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

There is no extension for any Dental Service not shown above.

HC-BEX3

04-10

V1

Federal Requirements

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

HC-FED1

10-10

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

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

HC-FED78

10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4

10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.

- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;
 - termination of employment;
 - reduction in work hours to below the minimum required for eligibility;
 - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
 - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
 - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to

failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

HC-FED43

11-12

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70

12-14

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67

09-14

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11

10-10

Women’s Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12

10-10

Group Plan Coverage Instead of Medicaid

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

HC-FED13

10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of

insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED17

10-10

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

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

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;

- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

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

HC-FED18

10-10

Claim Determination Procedures under ERISA

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of

the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice medical necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity,

experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED79

03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA.

The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
 - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA

continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated

back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse

within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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ERISA Required Information

Please see your Plan Administrator for the following information:

- The name of the Plan;
- The name, address, ZIP code and business telephone number of the sponsor of the Plan;
- Employer Identification Number (EIN);
- Plan Number;
- The name, address and zip code of the person designated as agent for legal process;
- How the cost of the Plan is paid;
- The Plan’s fiscal ending date.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section);
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

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

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a

federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance with Your Questions

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

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4

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When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the

toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer.

For level one appeals, we will respond in writing with a decision within fifteen calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician or Dentist Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician or Dentist Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision.

makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review of Medical Appeals

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Health Care Appeals Program (IHCAP). The IHCAP is conducted by an Independent Utilization Review Organization (IURO) assigned by the State of Delaware. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Utilization Review Organization.

In order to request a referral to an Independent Utilization Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within four months of your receipt of Cigna's level-two appeal review denial. Cigna will then forward the file to the Independent Utilization Review Organization.

The Independent Utilization Review Organization will render an opinion and provide written notice of its decision to the Participant or his/her authorized representative, the carrier and the Delaware Insurance Department within 45 calendar days of its receipt of the appeal. When requested and when the Participant suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition, the review shall be completed within 72 hours of the IURO's receipt of the appeal with immediate notification. The IURO will provide written confirmation of its decision to the Participant or his/her authorized representative, the carrier, and the Delaware Insurance Department within 2 calendar days after the immediate notification.

Claim Appeal to the State of Delaware

You have the right to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (302) 674-7310. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. You may also wish to submit a complaint by sending an email to the Delaware Insurance Department at consumer@state.de.us, or by using the complaint form, found at <http://www.delawareinsurance.gov/complaint/complaintform.pdf> and faxing the complaint to (302) 739-6278.

All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline,

protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for U.S. In-Network Services or within three years after proof of claim is required under the Plan for U.S. Out-of-Network and International services.

HC-APL235

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1

04-10
V1

Bed and Board

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

HC-DFS2

04-10
V2

Certification

The term Certification means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

HC-DFS476

04-10
V1

Charges

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

HC-DFS3

04-10
V1

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to

specific joints to restore motion, reduce pain and improve function.

HC-DFS55

04-10
V1

Contracted Fee - Cigna Dental Preferred Provider

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

HC-DFS123

04-10
V1

Custodial Services

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

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

HC-DFS4

04-10

Dentist

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

HC-DFS125

04-10
V3

Dependent

Dependents are:

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

Proof of the child's condition and dependence must be submitted to the Plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the Plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild.

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

Anyone who is eligible as an Employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

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

HC-DFS673

07-14
V1

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS394

11-10

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a

hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

HC-DFS393

11-10

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7

04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8

04-10
V1

Essential Health Benefits

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

HC-DFS411

01-11

Expense Incurred

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

HC-DFS10

04-10
V1

Free-Standing Surgical Facility

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

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

HC-DFS11

04-10

V1

Hospice Care Program

The term Hospice Care Program means:

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

HC-DFS11

04-10

V1

Hospice Care Services

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

HC-DFS12

04-10

V1

Hospice Facility

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

- primarily provides care for Terminally Ill patients;

- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53

04-10

V1

Hospital

The term Hospital means:

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

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

HC-DFS806

10-15

Hospital Confinement or Confined in a Hospital

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

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

HC-DFS807

10-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12

04-10

V1

Maximum Reimbursable Charge – Dental

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

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

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

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

HC-DFS752

07-14
V5

Maximum Reimbursable Charge - Medical

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

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

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

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

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

HC-DFS13

04-10
V8

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16

04-10
V1

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

HC-DFS19

04-10
V1

Medicare

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

HC-DFS17

04-10
V1

Necessary Services and Supplies

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

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

HC-DFS21

04-10
V1

Nurse

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

HC-DFS22

04-10
V1

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

HC-DFS70

04-10
V1

Optician

The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

HC-DFS71

04-10
V1

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

HC-DFS72

04-10
V1

Other Health Care Facility/Other Health Professional

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

HC-DFS23

04-10
V1

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

HC-DFS60

04-10
V1

Participating Provider

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

HC-DFS45

04-10
V1

Participating Provider - Cigna Dental Preferred Provider

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

The providers qualifying as Participating Providers may change from time to time.

HC-DFS136

04-10
V1

Patient Protection and Affordable Care Act of 2010 ("PPACA")

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

HC-DFS412

01-11

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61

04-10
V1

Physician

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

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

HC-DFS25

04-10
V1

Prescription Drug

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

HC-DFS63

04-10
V1

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

HC-DFS64

04-10
V1

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

HC-DFS65

04-10
V1

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57

04-10
V1

Psychologist

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

HC-DFS26

04-10
V1

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68

04-10
V1

Review Organization

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

HC-DFS808

10-15

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50

04-10

V1

Skilled Nursing Facility

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

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31

04-10

V1

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

HC-DFS413

01-11

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54

04-10

V1

Urgent Care

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

therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

HC-DFS34

04-10

V1

Vision Provider

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

HC-DFS73

04-10

V1

**GROUP LIFE
INSURANCE CERTIFICATE**

GLOBAL HEALTH ADVANTAGE

IMPORTANT NOTICES

The group policy is issued in the state of Delaware and will be governed by its laws.

FOREWORD

Life insurance provides individuals and their families with financial protection. The Life Insurance Benefit described in this booklet will help secure your family's financial security in the event of your death.

The need for life insurance protection depends on individual circumstances and financial situations. This valuable coverage should add an extra dimension to your personal insurance portfolio.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

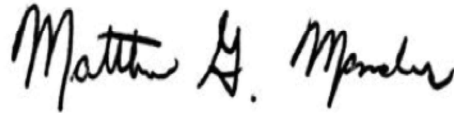
**GROUP INSURANCE
CERTIFICATE**

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your employer. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your employer or Cigna.

A handwritten signature in black ink that reads "Matthew G. Manders". The signature is written in a cursive, flowing style.

Matthew G. Manders, President

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SCHEDULE OF BENEFITS

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active, Full-time Expatriate, Third Country National and Select Key Local National Employees of a participating Employer regularly working a minimum of 30 hours per week outside the United States.

Your Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

If you were hired on or before the Policy Effective Date:
No Waiting Period

If you were hired after the Policy Effective Date:
No Waiting Period

LIFE INSURANCE BENEFITS

Employee Benefits

Option 1 -	Flat benefit of \$25,000
Option 2 -	One (1) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$200,000
Option 3 -	Two (2) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$200,000
Option 4 -	One (1) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$50,000
Option 5 -	Two (2) times your annual Basic Earnings (rounded to the next higher \$1,000) up to a Maximum Amount of \$400,000
Initial Amount of Life Insurance For Options 2, 3, 4 and 5, your amount of Life Insurance on the day you become insured is based on your age and annual Basic Earnings on that day.	

Age Based Reductions

If you are age 65 or older, your Life Insurance Benefits are payable as follows:

Age 65 to 69	65% of Life Insurance Benefits
Age 70 and over	50% of Life Insurance Benefits

ACCIDENT INSURANCE BENEFITS

Employee Benefits

Amount of Insurance

Same as Life Insurance Benefits

Age Based Reductions

Accident Insurance Benefits will reduce the same as Life Insurance Benefits

TL-004774

WHO IS ELIGIBLE

Classes of Eligible Persons

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.

EMPLOYEE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.

TL-004710.CGHB

WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

An Employee who is required to contribute toward the cost of this insurance may elect insurance for himself only by authorizing payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

If an enrollment form is received more than 31 days after an individual is eligible to elect coverage, this insurance will be effective on the date the Insurance Company agrees in writing to insure that eligible person.

If you are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

TL-004712

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service; and
6. for an Employee, the date the Employer cancels participation under the Policy.

TL-004714

WHEN COVERAGE CONTINUES

Extended Death Benefit

If an Employee is under age 60 and his or her Active Service ends due to Disability and he or she is Disabled on the date his or her Life Insurance Benefits ends, the Insurance Company will continue his or her Life Insurance Benefits as shown in the Schedule of Benefits until the earlier of the following dates.

1. The date you are no longer Disabled.
2. 12 months after the date your Life Insurance Benefits would otherwise end.

Amount of Insurance

If the Employee dies during the period his or her Life Insurance Benefits are continued, the Insurance Company will pay the Life Insurance Benefit in effect on the day before he or she became Disabled. However, the Life Insurance Benefit payable will be subject to the provisions of the Policy that may reduce or terminate coverage on account of age, retirement or a change in eligible class.

TL-008770

“Disability”/“Disabled” means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under the Employer’s plan.

“Regular Occupation” means the occupation you routinely perform at the time the Disability begins. We will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

TL-009745

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

If an Insured dies, we will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

TL-004730

Conversion Privilege for Life Insurance Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:

1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy; or
4. reduction in insurance based on attained age.

The Insured may apply for any type of life insurance the Insurance Company offers to persons of the same age in the amount applied for, except the Insured may not:

1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than \$10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if the Insured has been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:

1. submit an application to the Insurance Company; and
2. pay the required premium.

Evidence of insurability is not required.

WHAT IS COVERED

LIFE INSURANCE BENEFITS (Continued)

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by the Insurance Company and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:

1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
 - a. the Insured's application for conversion insurance has been received by the Insurance Company; and
 - b. the required premium has been paid.

Prior Conversion Limitation

If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

**WHAT IS NOT COVERED
LIFE EXCLUSIONS**

No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured's country of citizenship.

No benefits are payable for an insured on full-time active duty for more than 30 days in the Armed Forces of any nation. (If the Insured sends proof of service, the Insurance Company will refund any premiums paid for coverage during this time. Reserve or National Guard active duty or training are not excluded unless it extends beyond 31 days.)

No benefits are payable for claim payments that are illegal under applicable law.

TL-004752.CGHB

ACCIDENT INSURANCE BENEFITS

If you are an Employee and insured under the Policy for Accident Insurance on the date of an Accident, we will pay the Accident Insurance Benefits for a loss shown in the Schedule of Losses. If more than one loss results from the same Accident, we will pay only the largest Benefit Amount to which you are entitled. The loss must be a result of bodily Injuries caused directly, and from no other causes, by an Accident, and must occur within 365 days of the Accident.

Schedule of Losses	Benefit Amount
Life, or Two Members	100%
One Member	50%
Thumb and Index Finger of the Same Hand	25%

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

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

TL-004754

WHAT IS NOT COVERED

ACCIDENT EXCLUSIONS

The Insurance Company will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following.

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri, this applies only while sane).
2. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor. (Accidental ingestion of a poisonous substance is not excluded.)
3. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)
4. While an Insured in on full-time active duty for more than 30 days in any Armed Forces. (If the Insured sends proof of service, the Insurance Company will refund any premiums paid for coverage during this time. Reserve or National Guard active duty or training are not excluded unless it extends beyond 31 days.)
5. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured is flying, is learning to fly, or is part of the crew of; a military aircraft, other than transport aircraft flown by the U.S. Air Mobility Command (AMC) or a similar air transport service of another country; an aircraft owned or leased by or for the Employer, its subsidiaries or affiliates, or the Insured or a member of his or her household; an aircraft that does not have a valid FAA normal or transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.
6. Commission of a felony.
7. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured's country of citizenship.
8. No benefits are payable for claim payments that are illegal under applicable law.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Claim Forms

When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

CLAIM PROVISIONS

(Continued)

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Change of Beneficiary

You may change your beneficiary at any time by giving written notice to the Employer or to us. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or us. When this form is received, it will take effect as of the date of the form. If you die before the form is received, we will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

CLAIM PROVISIONS
(Continued)

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship

You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

TL-004724

ADMINISTRATIVE PROVISIONS

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Reinstatement of Insurance

Your coverage may be reinstated without satisfying the Insurability Requirement, if your insurance ends because you are on an unpaid leave of absence and you apply for Reinstatement within 31 days of your return to Active Service.

After your insurance ends, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met.

1. The Policy is still in force.
2. You are eligible under the Policy.
3. You send us a written request for reinstatement and a new enrollment form.
4. The required premium is paid.
5. The Insurability Requirement, if applicable, is satisfied.

TL-004722

GENERAL PROVISIONS

Incontestability

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age

If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Assignment of Benefits

We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

GENERAL PROVISIONS **(Continued)**

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

TL-004728

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident

The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

Active Service

If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation

Annual Compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.

Employee

For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer

The Employer who has subscribed to the Policyholder and for the benefit of whose Employees this policy has been issued. The Employer, named as the Subscriber on the front of this Policy, includes any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

DEFINITIONS (Continued)

Full-time

Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

Injury

Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

Insurability Requirement

An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

Insurance Company

The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date.

Sickness

The term Sickness means a physical or mental illness.

TL-004708

**SUPPLEMENTAL INFORMATION
for**

Employee Benefits Plan

**required by the Employee Retirement
Income Security Act of 1974**

As a Plan participant in your Company's Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

Please see your Plan administrator for the following information:

- The Plan is established and maintained by the Plan Sponsor.
- The Employer Identification Number (EIN)
- The Plan Number
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- How the Plan of Benefits is financed.
- The date of the end of the Plan Fiscal Year.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOUR BENEFICIARY SHOULD DO AND EXPECT IF HE/SHE HAS A CLAIM

When your beneficiary is eligible to receive benefits under the Plan, a request must be made for a claim form or to obtain instructions for submitting a claim telephonically or electronically, from the Plan Administrator. All claims submitted must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. A claim must be completed according to directions provided by the Insurance Company. If these forms or instructions are not available, a written statement of proof of loss must be provided. After a claim form or written statement has been completed, it must be submitted to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

Review of Claims for Benefits

The Insurance Company has 45 days from the date it receives a claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. If this should happen, the Insurance Company must provide notice in writing that its review period has been extended for up to two more 30 day periods (in the case of a claim for disability benefits); or 90 days more (in the case of any other benefit). If this extension is made because additional information must be furnished, these extension periods will begin when the additional information is received. The requested information must be furnished within 45 days.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the Insured of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit.

If the claim is denied, in whole or in part, the Insurance Company will provide written notice within the review period. The Insurance Company's written notice will include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for the claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit: identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement regarding the right to appeal the decision, and an explanation of the appeal procedure, including a statement of the right to bring a civil action under Section 502(a) of ERISA if the appeal is denied.

APPEAL PROCEDURE FOR DENIED CLAIMS

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

01/2016



APPENDIX R

HEALTH SAVINGS ACCOUNT

Health Savings Account (HSA)

An HSA is trust or custodial account that qualifies as a “health savings account” under the Internal Revenue Code. Very generally, if you have high deductible health plan coverage under the Plan and meet other Code requirements, you can make pre-tax or deductible contributions to an HSA and then take distributions from the account tax-free to pay for qualifying medical expenses incurred after the establishment of the account by you, your spouse, or qualifying dependents. You also may take distributions for other purposes, subject to income tax and, in certain cases, penalties. Funds in an HSA are not subject to forfeiture and remain available for distribution to you even you no longer are eligible to contribute to the account, and for distribution after your death to your estate or beneficiary.

Your HSA is a personal tax vehicle and is not part of the Plan and is not subject to ERISA.

Establishing Your HSA

For administrative convenience, the Employer has chosen to make HSA contributions for eligible employees by direct deposit to HSAs established at HealthEquity. HealthEquity is an authorized HSA trustee. You will be provided with information regarding how to establish your HSA with HealthEquity if you enroll in a high deductible health plan.

You may establish an HSA with a trustee or custodian other than HealthEquity. However, if you do so, you must independently fund such contributions. The Employer will only remit pre-tax salary reduction contributions elected by you and the Employer’s contribution (if any) to HealthEquity.

Establishing an HSA, including providing any required information to the HSA trustee or custodian, is solely your responsibility. The Employer cannot establish an HSA on your behalf.

You are responsible for managing your HSA, including choosing how your HSA funds are invested and following the rules that HealthEquity and the Internal Revenue Service impose on your contributions. Your HSA trustee or custodian may offer options for your HSA account balance. The Employer has not reviewed these options and does not endorse or recommend any options. You should consult a tax advisor or financial consultant to determine what, if any, investments are appropriate for you.

If you elect to fund your HSA through Salary Reduction Contributions, you must establish your HSA prior to the effective date of your Salary Reduction Contribution election. If the establishment of your HSA is delayed until more than 30 days after the effective date of your Salary Reduction Contribution election, the Employer will refund to you as a taxable distribution the amount of any Salary Reduction Contributions previously withheld from your pay that could not be contributed to the HSA due to the delay in establishing the account.

Additionally, in order to be eligible for an Employer Contribution to your HSA, you must establish your HSA by the last day of the Plan Year in which the contribution is scheduled to be made. If you fail to establish your HSA prior to your termination of employment date, you are not eligible to receive the Employer Contribution.

Who is Eligible to Contribute to an HSA

You can contribute to an HSA if you have high deductible coverage under the Plan and are not covered by any health coverage that is considered disqualifying coverage under Code rules. Disqualifying coverage includes the following:

- Coverage under another health insurance contract or health benefit plan, including family coverage under your spouse's employer's health plan (unless the other coverage is a limited type permitted under Code rules).
- Coverage under a general-purpose health care flexible spending account or general-purpose health reimbursement arrangement (either under a plan offered by your Employer or under your spouse's employer's plan). Accordingly, you may not contribute to a general purpose health care flexible spending account under this Plan while you are otherwise HSA eligible. You may, however, contribute to a limited purpose health care flexible spending account (only for dental and vision care). In addition, you may have coverage under a health reimbursement arrangement, if it is compatible with an HSA pursuant to IRS rules (e.g., a suspended health reimbursement arrangement).
- Medicaid coverage
- Enrollment in Medicare Part A or B (note that you are automatically enrolled in Medicare Part A if you are age 65 or older and receiving Social Security benefits).
- TRICARE coverage
- Certain coverage from the U.S. Department of Veteran's Affairs or the Indian Health Service.

Additionally, you are not eligible to contribute to the HSA if you can be claimed as a dependent on another individual's tax return.

Additional details regarding HSA eligibility can be found in IRS Publication 969.

Employer Contributions To Your HSA

You will receive an HSA contribution in an amount that will be determined annually by the Employer and communicated to you ("Employer Contribution"). The amount of the Employer Contribution will depend on whether you have self-only coverage or family coverage under the high deductible health plan you enroll in. The Employer Contribution will be made bi-annually in February and August (actual dates will vary by year, depending on the payroll cycle) and will be based on your enrollment status as of the contribution date (i.e., if you change status following a contribution date your contribution will not be modified until the next contribution date). In order to be eligible for the contribution, you must be an active employee on the date the Employer Contribution is made.

The Employer's Contribution will cease if you cease to meet the Plan's eligibility requirements, or if the Employer determines, in its sole discretion, that an HSA contribution will no longer be made.

HSA Limits

The Internal Revenue Service imposes a limit on health savings account contributions. Both your contributions and any Employer Contribution made for you will count against the limit.

For 2020, the Internal Revenue Service limits on health savings account contributions are:

- Single HDHP coverage \$3,550
- Family HDHP coverage \$7,100
- Catch-up (age 55 or older) \$1,000 (additional)

The Internal Revenue Service changes these amounts each year to reflect cost of living adjustments.

The limits apply on a calendar year basis. They are reduced proportionately for the months you are not HSA eligible. (Eligibility is determined monthly, but special rules may apply if you are considered an eligible individual on the first day of the last month of your tax year. See IRS Publication 969 for details.)

As described above, you may make HSA contributions through pre-tax payroll deduction. You may also contribute directly to your HSA (subject to the Internal Revenue Service limits) by depositing or transferring funds to the trustee or custodian of your account.

For a highly-compensated employee, the Employer may limit the amount of contributions that you may make through payroll deduction, but you may still make contributions by depositing or transferring funds to the trustee or custodian of your account.

Other Rules

- Qualified Medical Expenses. Qualified medical expenses are those expenses that generally would qualify for the medical and dental expenses deduction (See IRS Publication 502). Eligible Expenses do not include:
 - Expenses incurred before you establish your HSA.
 - Expenses incurred by a child who you do not claim as a tax dependent (a limited exception exists for certain children not claimed by you as a dependent – see IRS Publication 969 for details). Note that pursuant to this exclusion, it is possible that medical expenses incurred by a child who is enrolled as a dependent under your high deductible health plan (which generally provides coverage to children up to age 26 regardless of dependent status) may not be eligible for reimbursement under the HSA.
 - Expenses incurred by your eligible domestic partner, unless the domestic partner is your tax dependent (or the domestic partner satisfies the limited exception for non-dependents, as described in IRS Publication 969).
- FSA Rollovers. If you were enrolled in the Employer's general purpose health flexible spending account in the year prior to the year in which you first elect to enroll in a high deductible health plan option under the Plan, any unused amounts under the general purpose health flexible spending account (up to the maximum rollover amount) will be carried over to a limited purpose health flexible spending account (only for dental and vision care). You may still seek reimbursement for medical expenses incurred in the prior year from the general purpose health flexible spending account up to the end of the run-out period (March 31st).
- Taxation of HSA Contributions. Contributions to an HSA are not taxed for federal income tax purposes. Most states also treat HSA contributions as tax-free. However, certain states,

including California, treat HSA contributions as taxable for state tax purposes. You should consult your financial advisor regarding the tax consequences of your HSA.

Additional Information about HSAs

You should review the documents establishing your HSA and contact the trustee or custodian of your account for information about the operation and investment of the account, how to obtain distributions from your account, and the expenses that may be charged against your account. You may not rely on this summary plan description or other information from the Employer for tax advice regarding your HSA. The tax rules are complicated, and failure to follow them may result in tax penalties. You should consult your own tax adviser and IRS Publication 969 for information about:

- Whether you are eligible to contribute to an HSA.
- The amount of deductible or pre-tax contributions you may make to an HSA, and how a partial calendar year of eligibility will affect that amount, and the deadline for making contributions for a calendar year.
- What and whose medical expenses you can pay from your HSA on a tax free basis.
- What tax penalties apply if contributions to your account exceed the limit, or if you take distributions from the account that are not eligible for tax free treatment.

The Employer does not guarantee the tax consequences of contributions to your health savings account or distributions from that account. The Employer does, however, strongly recommend that you keep receipts and records for the medical expenses you pay (or for which you obtain reimbursement) from your health savings account. You will need these receipts and records to prove to the Internal Revenue Service that payments from your account should not be taxed. You will be responsible for reporting contributions made to your HSA and for reporting distributions from your HSA.

APPENDIX S

PHASED RETIREMENT POLICY

Eligibility

The employee must meet all of the following:

- 1) Currently be a full-time benefits-eligible faculty or staff employee, or be a faculty member currently on Associate Status; AND
- 2) Currently be at least age 59.5; AND
- 3) Have worked for a minimum of ten years past the age of 45 in a benefits-eligible status; AND
- 4) Receive VP approval in writing.

Work/Retirement Commitment

Eligible employee must agree to a reduced work schedule of between .5 and .6 full-time equivalent (FTE) for a maximum of 36 months, and then retire fully from employment.

Pay and Benefits

During the phased retirement (part-time work) period:

- the employee receives pro-rated salary;
- retirement plan contributions and CTO accrual (if applicable) are based on actual, pro-rated FTE/pay;
- for retirements on or after January 1, 2019, the employee's life and disability benefits will be based on the employee's pro-rated salary level,
- health and welfare benefits are maintained:
 - the employee pays for medical insurance at the reduced salary level (resulting in a significant premium savings), and
 - the employee has the ability to begin withdrawing funds from his/her Core and/or Voluntary Retirement Plans, while still working part-time.

Note: for Phased Retirements that began prior to January 1, 2019 the employee's life and disability benefits continued at the (higher) pre-Phased Retirement salary level.

Agreement

In order to take advantage of this program, the employee and the Employer must enter into an irrevocable Phased Retirement Agreement under which the employee consents to reduce to a specific work schedule of between .5 and .6 FTE, as well as establish a specific retirement date, which retirement date can be no more than 36 months in the future. It is important to note that while the employee can request a Phased Retirement Agreement, the decision as to whether or not to approve such a request lies with the area Vice President, as does, in the case of an approval, the specific retirement date and the duration of employment.

Staff employees who are interested in learning more about Phased Retirement should contact the Human Resources Department; faculty employees are encouraged to contact the Dean of the Faculty's Office.

APPENDIX T

COORDINATION OF BENEFITS (COB)

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

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

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

1. Non-Dependent/Dependent – Any plan under which the covered person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan under which the covered person is covered as a dependent of the employee will pay second.
2. Dependent Child/Parents Not Separated or Divorced – If a dependent child is covered under the plans of both the child's parents, and the parents are not separated or divorced (regardless of whether they were ever married), the plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the plan which has covered a parent for the longest period of time will pay benefits before the plan of the other parent.
3. Dependent Child/Separated or Divorced Parents – Where a dependent child is covered under the plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child's health care costs:
 - a) the plan under which the child is covered as a dependent of the custodial parent will pay first;
 - b) the plan under which the child is covered as a dependent of the custodial parent's spouse will pay second; and
 - c) the plan under which the child is covered as a dependent of the noncustodial parent will pay third.
4. Active/Inactive Employee – Any plan under which the covered person is covered as an active employee (or as that employee's dependent) will pay first. Any plan under which the covered person is covered as a laid off or retired employee (or as that

employee's dependent) will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

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

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

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

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

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

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

APPENDIX U

NONDISCRIMINATION NOTICE

Discrimination is Against the Law

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

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - 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 Ellen Usilton in Human Resources at 802-443-5565 or (eusilton@middlebury.edu).

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

The President and Fellows of Middlebury College

Attn: Ellen Usilton

Human Resources

152 Maple Street

Suite 203

Middlebury, VT 05753

Phone: 802-443-5565

Fax: 802-443-2058

www.eusilton@middlebury.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ellen Usilton in Human Resources (eusilton@middlebury.edu) is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

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

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

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

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

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

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-802-443-5465.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-802-443-5465.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-802-443-5465.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-802-443-5465

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-802-443-5465.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم قم هاتف الصم والبك-

1-802-443-5465

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-802-443-5465

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-802-443-5465.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-802-443-5465.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-802-443-5465) まで、お電話にてご連絡ください。

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-802-443-5465.

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (1-802-443-5465 تماس بگیرید.

ਪਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-802-443-5465 ‘ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្បួង គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-802-443-5465។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-802-443-5465.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-802-443-5465 पर कॉल करें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-802-443-5465

APPENDIX V

AFFORDABLE CARE ACT POLICY FOR IDENTIFICATION OF FULL-TIME EMPLOYEES

- 1.1 Purpose.** The Employer is adopting this Policy for purposes of identifying Full-Time Employees pursuant to the look-back measurement method set forth in the employer shared responsibility provisions of the Patient Protection and Affordable Care Act of 2010 (“Affordable Care Act”).
- 1.2 Relationship between Full-Time Status and Eligibility.** An Employee who does not otherwise satisfy the eligibility requirements of Section 2.1(a), but who is determined to be a Full-Time Employee with respect to a given period of time, may be approved for eligibility for medical benefits under the Plan for such period for purposes of complying with the Employer Shared Responsibility requirements of the Affordable Care Act, as set forth in Code Section 4980H(a). Eligibility shall be determined in a nondiscriminatory manner and communicated to an Employee in advance of the Employee’s eligibility period.
- 1.3 Modification.** This Policy may be modified or amended in the same manner as the Plan.
- 1.4 Election to Use Look-Back Measurement.** The Employer elects to use the Look-Back Measurement Method with respect to all Employees for purposes of identifying those Employees who are Full-Time Employees.
- 1.5 Election of Standard Measurement Period.** The Standard Measurement Period is a 12-month period beginning November 1 each year and ending the following October 31.
- 1.6 Election of Standard Stability Period.** The Standard Stability Period is the 12-month period beginning January 1 each year and ending the following December 31. The same Standard Stability Period applies with respect to Employees who are determined to be Full-Time Employees during the Standard Measurement Period and Employees who are determined not to be Full-Time Employees during the Standard Measurement Period.
- 1.7 Election of Standard Administrative Period.** The Standard Administrative Period is the 61-day period beginning on November 1 each year and ending December 31 of that year.
- 1.8 Election of Initial Measurement Period.** With respect to a New Employee who is a Part-Time Employee, Variable-Hour Employee, or Seasonal Employee, the Initial Measurement Period is the 12-month period beginning on the first day of the calendar month following the Employee’s Start Date.
- 1.9 Election of Initial Stability Period.** With respect to a New Employee who is a Part-Time Employee, Variable-Hour Employee, or Seasonal Employee, except as provided in Section 1.14(b)(iv), the Initial Stability Period is the 12-month period beginning on the first day of the second calendar month after the end of the Initial Measurement Period.
- 1.10 Election of Initial Administrative Period.** With respect to a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the Initial Administrative Period means all periods of time between the Employee’s Start Date and the beginning of the Employee’s Initial Stability Period other than the Employee’s Initial Measurement Period.

1.11 Election to Apply Rule on Midyear Change to Part-Time Status. The special rule in Treas. Reg. §54.4980H-3(f)(2) regarding certain Full-Time Employees changing employment status in the middle of a stability period applies. Therefore, in the case of a Full-Time Employee to whom this section applies, the Employee ceases to be a Full-Time Employee on the last day of the third calendar month after the change in employment status described in this section. This section applies to a Full-Time Employee if:

- (a) The Employer has offered the Employee minimum value coverage continuously during the period beginning on the first day of the calendar month following the Employee's initial three full calendar months of employment and ending on the last day of the calendar month in which the change in employment status described in this section occurs;
- (b) The Employee has a change in employment status to a position or status in which the Employee would not have reasonably been expected to be a Full-Time Employee if the Employee had begun employment in that position or status; and
- (c) The Employee actually is credited with less than 130 Hours of Service for each of the three full calendar months following such change in employment status.

1.12 Taking Special Unpaid Leave Into Account. For purposes of determining an Employee's average Hours of Service during a Measurement Period, the average Hours of Service for that Measurement Period are determined by computing the average after excluding any periods of Special Unpaid Leave during that Measurement Period and by using that average as the average for the entire Measurement Period.

1.13 Ongoing Employees:

- (a) *Employees Determined to Be Full-Time.* An Ongoing Employee who is determined to be a Full-Time Employee during a Standard Measurement Period will be considered a Full-Time Employee for each calendar month during the Standard Stability Period associated with that Standard Measurement Period, except to the extent the special rule in Section 1.11 of this Policy applies.
- (b) *Employees Determined Not to Be Full-Time.* An Ongoing Employee who is determined not to be a Full-Time Employee during a Standard Measurement Period will not be considered a Full-Time Employee for any calendar month during the Standard Stability Period associated with that Standard Measurement Period.

1.14 New Employees:

- (a) *New Full-Time Employees.* A New Employee who is reasonably expected at his or her Start Date to be a Full-Time Employee (and is not a Seasonal Employee) is considered a Full-Time Employee beginning on the Employee's Start Date.
 - i. *Factors for Determining Full-Time Status.* Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee who is not a Seasonal Employee is reasonably expected at his or her Start Date to be a Full-Time Employee:

- A. Whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee.
 - B. The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods.
 - C. Whether the job was advertised or otherwise communicated to the Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average 30 or more Hours of Service per week or less than 30 Hours of Service per week.
- ii. *Transition to Ongoing Employee.* Once a New Employee who is a Full-Time Employee has been employed for an entire Standard Measurement Period, the Employee becomes an Ongoing Employee, and the Employee's status as a Full-Time Employee is governed by the provisions of this Policy regarding Ongoing Employees.
- (b) *New Non-Full-Time Employees.* A New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is not initially considered a Full-Time Employee and will have Hours of Service measured over an Initial Measurement Period and be treated as follows:
 - i. *Full-Time After Initial Measurement Period.* If a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is determined to be a Full-Time Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will be considered a Full-Time Employee for each calendar month during the Employee's Initial Stability Period.
 - ii. *Not Full-Time After Initial Measurement Period.* If a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is determined not to be a Full-Time Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will not be considered a Full-Time Employee during the Employee's Initial Stability Period, except to the extent provided under the provisions of this Policy regarding Ongoing Employees.
 - iii. *Change in Status During the Initial Measurement Period.* Notwithstanding the foregoing, if a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee experiences a change in employment status before the end of the Employee's Initial Measurement Period such that if the Employee had begun employment in that new status the Employee would have reasonably been expected to be a Full-Time Employee (and not a Seasonal Employee or Variable-Hour Employee), the Employee will be considered a Full-Time Employee beginning on the first day of the calendar month after the change in the Employee's employment status or, if earlier, at the beginning of

the Employee's Initial Stability Period, if the Employee is determined to be a Full-Time Employee during the Employee's Initial Measurement Period.

- iv. *Transition to Ongoing Employee.* Once a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee has been employed for an entire Standard Measurement Period, the Employee becomes an Ongoing Employee, and the Employee's status as a Full-Time Employee is governed by the provisions of this Policy regarding Ongoing Employees, but subject to the following:

- A. *Full-Time During the Initial Measurement Period but Not the First Standard Measurement Period.* If the Employee is determined not to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will continue to be considered a Full-Time Employee for each calendar month during the Initial Stability Period, if the Employee was determined to be a Full-Time Employee during the Employee's Initial Measurement Period.
- B. *Full-Time During the First Standard Measurement Period but Not During the Initial Measurement Period.* If the Employee is determined to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will be considered a Full-Time Employee for each calendar month during the entire Standard Stability Period associated with the Employee's first Standard Measurement Period, even though that Standard Stability Period may overlap an Initial Stability Period associated with an Initial Measurement Period during which the Employee was determined not to be a Full-Time Employee.
- C. *Full-Time During Both the Initial Measurement Period and the First Standard Measurement Period.* If the Employee is considered a Full-Time Employee during both the Employee's Initial Stability Period and the Employee's first Standard Stability Period, the Employee will be considered a Full-Time Employee during any period between the end of the Initial Stability Period and the beginning of the Employee's first Standard Stability Period.

- 1.15 Rehired Employees.** An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer or any member of the Controlled or Affiliated Group for a period of at least 26 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding Period of Employment. For purposes of applying these rehire rules, the duration of the Period of Employment immediately preceding a period during which an Employee was not credited with any Hours of Service is determined after application to that Period of Employment of the rules on Special Unpaid Leave, if and to the extent those rules are applicable.

1.16 Definitions. For purposes of this Policy, the following terms have the following meanings:

- (a) “Administrative Period” means a Standard Administrative Period or an Initial Administrative Period.
- (b) “Code” means the Internal Revenue Code of 1986, as amended.
- (c) “Controlled or Affiliated Group” means the group of organizations consisting of the Plan Sponsor and any other organization that is part of a controlled group or affiliated service group with the Plan Sponsor within the meaning of Code §414(b), (c), (m), or (o).
- (d) “Eligible Employee” has the meaning set forth in the SPD.
- (e) “Employee” has the meaning set forth in the SPD.
- (f) “Employer” has the meaning set forth in the SPD.
- (g) “Full-Time Employee” means an Employee of the Employer who is credited with an average of at least 30 Hours of Service per week during a Measurement Period. For this purpose, 130 Hours of Service in a calendar month is treated as the monthly equivalent of at least 30 Hours of Service per week.
- (h) “Hour of Service” means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR §2530.200b-2(a)).
 - i. The term “Hour of Service” does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code §§861 through 863 and the regulations thereunder.
 - ii. An Hour of Service for one organization is treated as an Hour of Service for all other organizations that are part of the same Controlled or Affiliated Group for all periods during which those organizations are part of the same Controlled or Affiliated Group.
 - iii. Hours of Service for all Employees are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due.
- (i) “Initial Administrative Period” means, with respect to a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the period described in Section 1.10 of this Policy.
- (j) “Initial Measurement Period” means, with respect to a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the period described in Section 1.8 of this Policy.

- (k) “Initial Stability Period” means, with respect to a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the period described in Section 1.9 of this Policy.
- (l) “Look-Back Measurement Method” means the method of identifying full-time employees for purposes of Code §4980H that is described in Treas. Reg. §54.4980H-3(d), as amended or supplemented.
- (m) “Measurement Period” means an Initial Measurement Period or a Standard Measurement Period.
- (n) “New Employee” means an Employee who has been employed for less than one complete Standard Measurement Period.
- (o) “Ongoing Employee” means an Employee who has been employed for at least one complete Standard Measurement Period.
- (p) “Part-Time Employee” means a New Employee whom the Employer reasonably expects to be employed on average less than 30 Hours of Service per week during the Employee’s Initial Measurement Period, based on the facts and circumstances at the Employee’s Start Date. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Part-Time Employee:
 - i. Whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee.
 - ii. The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 hours of service per week during recent Measurement Periods.
 - iii. Whether the job was advertised or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average 30 (or more) Hours of Service per week or less than 30 Hours of Service per week.

The anticipated length of the Employee’s Period of Employment shall not be considered.

- (q) “Period of Employment” means the period of time beginning on the first date for which an Employee is credited with an Hour of Service for an Employer or any member of the Controlled or Affiliated Group and ending on the last date on which the Employee is credited with an Hour of Service for that Employer or any member of the Controlled or Affiliated Group, both dates inclusive. An Employee may have one or more Periods of Employment with the same Employer.
- (r) “Plan” means the Middlebury Health and Welfare Benefits Plan.
- (s) “Policy” means this “Affordable Care Act Policy for Identifying Full-Time Employees,” as amended and in effect from time to time.

- (t) “Seasonal Employee” means a New Employee who is hired into a position for which the customary annual employment is six months or less, occurring at approximately the same time each year.
- (u) “Special Unpaid Leave” means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.
- (v) “Stability Period” means either a Standard Stability Period or an Initial Stability Period.
- (w) “Standard Administrative Period” means the period described in Section 1.7 of this Policy.
- (x) “Standard Measurement Period” means the period described in Section 1.5 of this Policy.
- (y) “Standard Stability Period” means the period described in Section 1.6 of this Policy.
- (z) “Start Date” means the first date on which an Employee is credited with an Hour of Service with the Employer or a member of the Controlled or Affiliated Group.
- (aa) “Variable-Hour Employee” means a New Employee if, based on the facts and circumstances at the Employee’s Start Date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the Initial Measurement Period because the Employee’s hours are variable or otherwise uncertain. For purposes of determining whether an Employee is a Variable-Hour Employee, the Employer may not take into account the likelihood that the Employee may terminate employment before the end of the Initial Measurement Period. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Variable-Hour Employee:
 - i. Whether the Employee is replacing an Employee who was a Full-Time Employee or a Variable-Hour Employee.
 - ii. The extent to which the Hours of Service of employees in the same or comparable positions have actually varied above and below an average of 30 hours of service per week during recent Measurement Periods.
 - iii. Whether the job was advertised or otherwise communicated to the new Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 30 hours of service per week, average less than 30 hours of service per week, or might vary above and below an average of 30 hours of service per week.

1.17 Terms Defined in the Plan. Capitalized terms not specifically defined in this Policy have the meanings set forth in the SPD.

APPENDIX W

SUBROGATION AND REIMBURSEMENT OF PAYMENTS MADE BY PLAN

- 1.1 Scope.** With respect to any welfare benefits that provide group health benefits, the Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may advance the payment of covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”). Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person (and any person or entity acting on behalf of a covered person, including a covered person’s attorney) is subject to, and agrees to, the terms and conditions set forth in this Appendix with respect to the amount of covered expenses paid by the Plan.

This subrogation and reimbursement rules of this Appendix W shall apply to the extent the applicable Plan materials described in Article III do not describe the Plan’s subrogation and reimbursement rights or to the extent the provisions contained in the Plan materials provide subrogation and/or reimbursement provisions that are less beneficial to the Plan than the rules set forth in this Appendix W.

- 1.2 Assignment of Rights (Subrogation).** The covered person automatically assigns to the Plan any rights the covered person his heirs, guardians, executors, agents or other representatives may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment (i) applies on a first-dollar basis (*i.e.*, has priority over other rights to such funds), (ii) applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial claim or recovery, (iii) applies regardless of how such funds, claims, or recoveries are classified or characterized by the courts or any other entity, and (iv) even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. In cases where the Plan pursues the collection of a claim (*e.g.*, by suing a third party), the costs of collection incurred by the Plan shall be considered as part of the claim. By this assignment, the Plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
- 1.3 Equitable Lien and Other Equitable Remedies (Reimbursement).** If payments are made by the Plan and the covered person receives a settlement or is otherwise compensated by a third party (including his or her own insurance company) as a result of illness or injury of the covered person, the covered person is required to reimburse the Plan for the Reimbursable Payments advanced from the Plan. Moreover, the Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. Such an equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment

by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any and all money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's right of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. Thus, the Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

This and any other provisions of the Plan concerning subrogation, equitable liens, and other equitable remedies are intended to supersede the applicability of the federal common law doctrines, including, but not limited to, general unjust enrichment, comparative fault, and what are commonly referred to as the "make whole" rule and the "common fund" rule, in accordance with the United States Supreme Court's decisions in U.S. Airways, Inc. v. McCutchen, 133 S. Ct. 1537 (2013) and Sereboff v. Mid-Atlantic Medical Services, Inc., 547 U.S. 356 (2006).

- 1.4 Assisting in Plan's Subrogation and Reimbursement Activities.** Regardless of whether a reimbursement agreement is required by the Plan or signed by the covered person, by accepting benefits under the Plan, the covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (i) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement, (ii) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (iii) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement, or other rights within 30 days of receipt by the covered person, and (iv) promptly provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plan's rights.
- 1.5 Consequences of Failure to Follow Terms and Conditions.** Failure by a covered person to follow the terms and conditions set forth in this Appendix may result, at the discretion of the Plan Administrator, in termination of participation or a reduction from future benefit payments (whether anticipated or unanticipated) available to the covered person (and any of his or her beneficiaries enrolled in the Plan) under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan. If a covered person fails to reimburse the Plan for all Reimbursable Payments, out of any recovery or reimbursement received, the covered person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such Reimbursable Payments from the covered person, in addition to the unpaid portion of the Reimbursable Payments. The aggregate amount of Reimbursable Payments recovered by a covered person from a third party shall be considered plan assets that must be repaid to the Plan, and the covered person shall be considered a fiduciary with respect to same, such that the covered person's failure to repay such funds to the Plan shall be considered a fiduciary breach, subject to the Plan's right of relief under Sections 409(a) and

502(a)(2) of ERISA. Finally, by participating in the Plan and accepting advanced benefits under this Plan, each covered person acknowledges the Plan has a contractual right to pursue all Reimbursable Payments which shall not be preempted by ERISA.

- 1.6 Application of Provisions Where Covered Person is a Minor.** If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to the provisions of this Appendix regardless of state law and/or whether the minor's representative has access or control of any recovery funds.
- 1.7 Application of Provisions Where Covered Person is Deceased.** If the injury or condition giving rise to subrogation involves wrongful death of a covered person, this condition applies to the parent, guardian, executor, agent or other personal representative of the covered person's estate.