DIGITAL PROSPECTORS

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BENEFITS SPOTLIGHT

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Please find additional benefit information including the detailed Summary of the Plans and Benefits (SBCs) for our plans when logging into the Benefits Connect website, registering your choices, visiting the Company Communication field, and then clicking on Downloadable Forms.

Feel free to contact Human Resources via phone or email at at (603) 772-2700 or hr@digitalprospectors.com with any questions.

CORE BENEFITS:

Digital Prospectors offers three health insurance plan options.

MEDICAL PPO:

PPO – www.cigna.com - (800) CIGNA24

Benefits: 5/1/2018 - 4/30/2019 – PPO: In-Network $20 Office Visit Co-Pay, $100 Emergency Room Co-Pay, $2,000 deductible per member, no more than $6,000 per family per calendar year and 20%coinsurance up to $4,500 per member, no more than $7,000 per family per calendar year. Prescription $15/30/60 (Please refer to Schedule of Benefits and Coverage forms for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays up to $875/mo. If premium is greater than $875, employee pays the difference on an optional pre-tax basis.

MEDICAL PPO WITH H.S.A BENEFIT:

PPO (Health Savings Account [HSA] Option) – www.cigna.com - (800) CIGNA24

Benefits: 5/1/2018 - 4/30/2019 – PPO: In-Network $3000 per individual/$6000 per family Deductible. Co-Insurance – Employee pays 20% up to $2000 per individual/$4000 per family per year. Prescription subject to deductible then $15/35/50 (Please refer to Summary of Benefits and Coverage forms for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays up to $875/mo. If premium is greater than $875, employee pays the difference on an optional pre-tax basis.

MEDICAL HMO:

HMO – www.cigna.com - (800) CIGNA24

Benefits: 5/1/2018 - 4/30/2019 – HMO: In-Network $25/$50 Specialist Office Visit Co-Pays, $250 Emergency Room Co-Pay after deductible, $2,000 deductible per member, no more than $6,000 per family per calendar year. Prescription $15/30/50. (Please refer to Summary of Benefits and Coverage forms for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays up to $875/mo. If premium is greater than $875 , employee pays the difference on an optional pre-tax basis.

DENTAL (ORTHODONTIA OPTION):

Guardian – www.guardiananytime.com - (888) 600-1600

Benefits: Coverage A Preventative & Diagnostic 100%, Coverage B Basic 80% Coverage C Major 50%, $50/50 Deductible, $1,500 Maximum, Child Orthodontia option. (Please see attached Summary of Benefits for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays 100% of employee and dependents' premium.

VISION

Guardian - www.guardiananytime.com - (888) 600-1600

Benefits: $20 copay for Eye Exam every 12 mos., Lenses every 12 mos, Frames every 24 mos. (Please see attached Summary of Benefits for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays 100% of employee and dependents' premium.

SHORT TERM DISABILITY

Guardian – www.guardiananytime.com - (888) 600-1600

Benefits: Elimination Period 8th day accident 8th day sickness duration 26 weeks 60% of covered payroll to maximum of $2000/week. (Please refer to Benefit Summary for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays 100% of employee's premium.

LONG TERM DISABILITY

Guardian – www.guardiananytime.com - (888) 600-1600

Benefits: 90 day elimination period 60% of covered payroll to a maximum of $10,000/monthly (Please refer to Benefit Summary for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays 100% of employee's premium.

VOLUNTARY TERM LIFE

Guardian – www.guardiananytime.com (888) 600-1600

Benefits: Up to $300K for employee, Up to $100K for spouse, Up to $10K for child(ren). (Please refer to Benefit Summary for more details)

Eligibility: First of the month following first day of employment.

Premium: Employee pays 100% of competitive premium rates, post-tax.

GROUP TERM LIFE

Guardian – www.guardiananytime.com - (888) 600-1600

Benefits: Flat $50,000, decreasing after age 70. (Please refer to Benefit Summary for more details)

Eligibility: First of the month following first day of employment.

Premium: Digital Prospectors pays 100% of employee's premium.

RETIREMENT - 401(k)

401(k) Retirement Plan with ADP - www.mykplan.com - (800) 695-7526

Eligibility: Immediate, up to 4% match.

PTO

Digital Prospectors' employees typically receive 10 holidays (6 holidays upfront [New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas], plus 4 floating holidays accrued annually). In addition, employees typically accrue 15 days of Paid Time Off (inclusive of vacation, sick and bereavement time) to equal a total of 5 weeks paid time off annually.

BENCH TIME

Digital Prospectors' employees typically accrue up to five days (40 hours) of paid bench time per year to be used for situations such as the time in-between assignments, weather condition that results in the client closing (snow days, tornadoes, hurricanes etc) or jury duty.

PRICING:

Digital Prospectors pays the first $875/mo of each employee's health insurance premium, and any additional premium will be covered on an optional pre-tax basis by the employee each pay period. Following are the employee cost details for each plan:

PPO - Employee premium contribution taken out per paycheck (26 annual paychecks)

Single: $0.00
Parent/Child(ren): $167.58
Couple: $162.24
Family: $466.02

PPO with H.S.A option - Employee premium contribution taken out per paycheck (26 annual paychecks)

Single: $0.00
Parent/Child(ren): $80.26
Couple: $75.72
Family: $333.08

HMO - Employee premium contribution taken out per paycheck (26 annual paychecks)

Single: $0.00
Parent/Child(ren): $205.05
Couple: $199.35
Family: $523.06

SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Digital Prospectors Corporation
Open Access Plus

General Services	In-Network	Out-of-Network
Physician office visit – Primary Care Physician (PCP)/Specialist	You pay $20 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%
Cigna Telehealth Connection Services • Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)	You pay $20 per visit copay, then plan pays 100%	Not Covered
Urgent care visit • All services including Lab & X-ray	You pay $50 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%
Preventive Care	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%
Preventive Services	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%
Immunizations	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%
Coinsurance	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Calendar year deductible • Benefits for an individual within a family are paid once the individual deductible has been met. • In-network and out-of-network expenses do not cross accumulate. • Copays always apply before plan deductible and coinsurance.	Individual: $2,000 Family: $6,000	Individual: $3,000 Family: $9,000
Out-of-pocket annual maximum • Medical copays apply towards the out-of-pocket maximums • Medical deductibles apply towards the out-of-pocket maximums • Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums • This plan includes a combined Medical/Pharmacy out-of-pocket maximum.	Individual: $6,500 Family: $13,000	Individual: $6,500 Family: $13,000
Lifetime maximum	Unlimited Per individual	

General Services	In-Network	Out-of-Network
Out-of-network annual maximum		Unlimited Per individual
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	You pay $100 per visit copay (waived if admitted), then plan pays 100%	
Ambulance	After the in-network plan deductible is met, You pay 20% Plan pays 80%	
Office surgery – PCP/Specialist	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Other office services – laboratory	After the plan deductible is met, You pay 20% Plan pays 80%	Covered same as plan's Physician's Office Services
Other office services – radiology	After the plan deductible is met, You pay 20% Plan pays 80%	Covered same as plan's Physician's Office Services
Outpatient lab	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient radiology	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Independent lab	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Durable medical equipment • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%

Benefits	In-Network	Out-of-Network
Hospital Services		
Inpatient hospital services	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient hospital services	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%

Benefits	In-Network	Out-of-Network
Outpatient professional services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Skilled nursing facility care • 60 days per calendar year maximum	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Hospice care	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Home health care • 60 visits per calendar year maximum • The limit is not applicable to mental health and substance use disorder conditions.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Mental Health and Substance Use Disorder		
Inpatient mental health • Includes Residential Treatment	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient mental health – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	You pay $20 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient mental health – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Inpatient substance use disorder • Includes Residential Treatment	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient substance use disorder – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	You pay $20 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient substance use disorder – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Therapy Services		
Outpatient physical therapy • 30 visits per calendar year • Limits are not applicable to mental health conditions	Covered same as plan's Physician Office Visit – Specialist	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient speech therapy, hearing therapy and occupational therapy • 60 visits per calendar year • Limits are not applicable to mental health conditions for speech and occupational therapies	Covered same as plan's Physician Office Visit – Specialist	After the plan deductible is met, You pay 40% Plan pays 60%

Benefits	In-Network	Out-of-Network
Chiropractic services • 12 visits per calendar year	Covered same as plan's Physician Office Visit – Specialist	After the plan deductible is met, You pay 40% Plan pays 60%
Acupuncture	Not Covered	Not Covered
Additional Services		
Medical Specialty Drugs Inpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Outpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
PPACA Women's Health • Includes surgical services, such as tubal ligation (excludes reversals) • Contraceptive devices are included.	Plan pays 100%, no copay,no deductible	Varies based on place of service
Family planning • Includes surgical services, such as vasectomy (excludes reversals) • Includes infertility testing for diagnosis only	Varies based on place of service	Varies based on place of service
Infertility	Not Covered	Not Covered
Abortion • Includes non-elective procedures and elective procedures	Varies based on place of service	Varies based on place of service
TMJ	Not Covered	Not Covered
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum $10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility)	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60% Transplant Maximums: Heart - $150,000 Liver - $230,000 Bone Marrow - $130,000 Kidney - $80,000 Pancreas - $50,000 Kidney/Pancreas - $80,000 Heart/Lung - $185,000 Lung - $185,000

Benefits	In-Network	Out-of-Network
Out-of-area services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for out of area • Out-of-network deductible and out-of-pocket maximums apply	For all other services You pay 20% Plan pays 80% after the out of network deductible is met	

Pharmacy	In-Network
Cost Share and Supply	
Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.	**Retail (per 30-day supply):** Generic: You pay $15 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $60 **Retail (per 90-day supply):** Generic: You pay $45 Preferred Brand: You pay $90 Non-Preferred Brand: You pay $180 **Home Delivery (per 90-day supply):** Generic: You pay $38 Preferred Brand: You pay $75 Non-Preferred Brand: You pay $150

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

Drugs Covered

Prescription Drug List:
Your Cigna Performance Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectable drugs, but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Prescription smoking cessation drugs are covered.

Pharmacy Program Information
Pharmacy Clinical Management and Prior Authorization • Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician. • Prior authorization is required on specialty medications and quantity limits may apply.
Pharmacy Cost Management Program **Step Therapy:** Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved. • Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.
Clinical Outcome Programs: • Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

Additional Information

Selection of a Primary Care Provider- Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Out of Pocket Maximum

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards the out-of-pocket maximums
- Medical deductibles apply towards the out-of-pocket maximums

Plan Coverage for Out-of-Network Providers

- The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or at 110% of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or supply or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

Complete Care Management

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, a $250 penalty will be applied.

General Notice of Preexisting Condition Exclusion

- Not applicable

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former 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.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Exclusions

What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list)

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services
- Treatment of TMJ disorders and craniofacial muscle disorders

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

EHB State: NH

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2,000**/individual or **$6,000**/family For out-of-network providers: **$3,000**/individual or **$9,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, office visits, prescription drugs, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network and out-of-network providers **$6,500**/individual or **$13,000**/family. Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-866-494-2111** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply	40% coinsurance	None
	Specialist visit	$20 copay/visit Deductible does not apply	40% coinsurance	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **Deductible does not apply	40% coinsurance/visit 40% coinsurance/other services 40% coinsurance/ immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance at an outpatient facility 20% coinsurance in the office	40% coinsurance at an outpatient facility 40% coinsurance in the office	$250 penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail 30 days), $45 copay/prescription (retail 90 days); $38 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail 30 days), $90 copay/prescription (retail 90 days); $75 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$60 copay/prescription (retail 30 days), $180 copay/prescription (retail 90 days); $150 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
If you need immediate medical attention	Emergency room care	$100 copay/visit Deductible does not apply	$100 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay/visit Deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	40% coinsurance/office visit 40% coinsurance/all other services	$250 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	$250 penalty for no precertification. Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$20 copay/visit for Physical, Speech, Hearing & Occupational therapy** $20 copay/visit for Chiropractic services** **Deductible does not apply	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic services	$250 penalty for failure to precertify speech therapy. Coverage is limited to an annual max of 30 visits for Physical therapy and 60 visits for Speech, Hearing & Occupational therapy and 12 visits annual max for Chiropractic services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	$250 penalty for no precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
	Hospice services	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered		None
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (12 visits)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$40
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,150**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$130
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$660
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$860**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP 5-2018 **Ben Ver:** 11 **Plan ID:** 7477639

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Digital Prospectors Corporation
HDHP Open Access Plus

General Services	In-Network	Out-of-Network
Physician office visit – Primary Care Physician (PCP)/Specialist	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Cigna Telehealth Connection Services • Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)	After the plan deductible is met, You pay 20% Plan pays 80%	Not Covered
Urgent care visit • All services including Lab & X-ray	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Preventive Care	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%
Preventive Services	Plan pays 100%, no copay, no deductible	Lab & X-Ray: Plan pays 100%, no copay, no deductible All other services: After the plan deductible is met, You pay 40% Plan pays 60%
Immunizations	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%
Coinsurance	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Calendar year deductible • Entire Family deductible must be met before benefits will be paid. • In-network and out-of-network expenses do not cross accumulate. • Plan deductible always applies before any copay or coinsurance. • This plan includes a combined Medical/Pharmacy deductible.	Individual: $3,000 Family: $6,000	Individual: $6,000 Family: $12,000

General Services	In-Network	Out-of-Network
Out-of-pocket annual maximum • Medical copays apply towards the out-of-pocket maximums • Medical deductibles apply towards the out-of-pocket maximums • Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums • This plan includes a combined Medical/Pharmacy out-of-pocket maximum.	Individual: $5,000 Individual – In a Family: $6,550 Family: $10,000	Individual: $10,000 Individual – In a Family: $13,100 Family: $20,000
Lifetime maximum	Unlimited Per individual	
Out-of-network annual maximum		Unlimited Per individual
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	After the plan deductible is met, You pay 20% Plan pays 80%	
Ambulance	After the in-network plan deductible is met, You pay 20% Plan pays 80%	
Office surgery – PCP/Specialist	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Other office services – laboratory	After the plan deductible is met, You pay 20% Plan pays 80%	Covered same as plan's Physician's Office Services
Other office services – radiology	After the plan deductible is met, You pay 20% Plan pays 80%	Covered same as plan's Physician's Office Services
Outpatient lab	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient radiology	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Independent lab	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Durable medical equipment • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 40% Plan pays 60%

Benefits	In-Network	Out-of-Network
Hospital Services		
Inpatient hospital services	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient hospital services	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient professional services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Skilled nursing facility care • 60 days per calendar year maximum	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Hospice care	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Home health care • 60 visits per calendar year maximum • The limit is not applicable to mental health and substance use disorder conditions.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Mental Health and Substance Use Disorder		
Inpatient mental health • Includes Residential Treatment	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient mental health – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient mental health – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Inpatient substance use disorder • Includes Residential Treatment	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient substance use disorder – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient substance use disorder – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Therapy Services		

Benefits	In-Network	Out-of-Network
Outpatient physical therapy • 30 visits per calendar year • Limits are not applicable to mental health conditions	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient speech therapy, hearing therapy and occupational therapy • 60 visits per calendar year • Limits are not applicable to mental health conditions for speech and occupational therapies	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Chiropractic services • 12 visits per calendar year	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Acupuncture	Not Covered	Not Covered
Additional Services		
Medical Specialty Drugs Inpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Outpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
PPACA Women's Health • Includes surgical services, such as tubal ligation (excludes reversals) • Contraceptive devices are included.	Plan pays 100%, no copay,no deductible	Varies based on place of service
Family planning • Includes surgical services, such as vasectomy (excludes reversals) • Includes infertility testing for diagnosis only	Varies based on place of service	Varies based on place of service
Infertility	Not Covered	Not Covered
Abortion • Includes non-elective procedures and elective procedures	Varies based on place of service	Varies based on place of service
TMJ	Not Covered	Not Covered

Benefits	In-Network	Out-of-Network
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum $10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility)	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60% Transplant Maximums: Heart - $150,000 Liver - $230,000 Bone Marrow - $130,000 Kidney - $80,000 Pancreas - $50,000 Kidney/Pancreas - $80,000 Heart/Lung - $185,000 Lung - $185,000
Out-of-area services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for out of area • In-network deductible and out-of-pocket maximums apply	For all other services You pay 20% Plan pays 80% after the network deductible is met	
Pharmacy	**In-Network**	
Cost Share and Supply		
Med Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.	Once the medical deductible is met then the customer is responsible for the cost share **Retail (per 30-day supply):** Generic: You pay $15 Preferred Brand: You pay $35 Non-Preferred Brand: You pay $50 **Retail (per 90-day supply):** Generic: You pay $45 Preferred Brand: You pay $105 Non-Preferred Brand: You pay $150 **Home Delivery (per 90-day supply):** Generic: You pay $38 Preferred Brand: You pay $88 Non-Preferred Brand: You pay $125	

Pharmacy	In-Network
• Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. • This plan will not cover out-of-network pharmacy benefits. • Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered. • You can elect brand or generic with no penalty (MAC C). • Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan. • Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply. • Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.	
Drugs Covered	
Prescription Drug List: Your Cigna Performance Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com. Some highlights: • Coverage includes Self Administered injectable drugs, but excludes infertility drugs. • Contraceptive devices and drugs are covered with federally required products covered at 100%. • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered. • Prescription smoking cessation drugs are covered.	
Pharmacy Program Information	
Pharmacy Clinical Management and Prior Authorization • Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician. • Prior authorization is required on specialty medications and quantity limits may apply.	
Pharmacy Cost Management Program **Step Therapy:** Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved. • Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.	
Clinical Outcome Programs: • Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.	

Additional Information

Selection of a Primary Care Provider- Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Out of Pocket Maximum

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards the out-of-pocket maximums
- Medical deductibles apply towards the out-of-pocket maximums

Plan Coverage for Out-of-Network Providers

- The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or at 110% of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or supply or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

Complete Care Management

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, a $250 penalty will be applied.

General Notice of Preexisting Condition Exclusion

- Not applicable

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former 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.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Exclusions

What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list)

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services
- Treatment of TMJ disorders and craniofacial muscle disorders

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

EHB State: NH

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$3,000**/individual or **$6,000**/family For out-of-network providers: **$6,000**/individual or **$12,000**/family Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers **$5,000**/individual or **$10,000**/family (no more than **$6,550** per individual in the family); For out-of-network providers **$10,000**/individual or **$20,000**/family (no more than **$13,100** per individual in the family). Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-866-494-2111** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance/visit	40% coinsurance	None
	Specialist visit	20% coinsurance/visit	40% coinsurance	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **Deductible does not apply	40% coinsurance/visit 40% coinsurance/other services 40% coinsurance/ immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance at an outpatient facility 20% coinsurance in the office	40% coinsurance at an outpatient facility 40% coinsurance in the office	$250 penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail 30 days), $45 copay/prescription (retail 90 days); $38 copay/prescription (home delivery 90 days)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail 30 days), $105 copay/prescription (retail 90 days); $88 copay/prescription (home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail 30 days), $150 copay/prescription (retail 90 days); $125 copay/prescription (home delivery 90 days)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	$250 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	20% coinsurance	40% coinsurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	$250 penalty for no precertification. Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	20% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 20% coinsurance/visit for Chiropractic services	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic services	$250 penalty for failure to precertify speech therapy. Coverage is limited to an annual max of 30 visits for Physical therapy and 60 visits for Speech, Hearing & Occupational therapy and 12 visits annual max for Chiropractic services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	$250 penalty for no precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
	Hospice services	20% coinsurance	40% coinsurance	$250 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered		None
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (12 visits)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$20
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,930**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$600
Coinsurance	$70
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$3,870**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA HDHP 5-2018 **Ben Ver:** 11 **Plan ID:** 7477903

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Digital Prospectors Corporation
Open Access Plus

General Services	In-Network
Physician office visit – Primary Care Physician (PCP)	You pay $25 per visit copay, then plan pays 100%
Physician Office Visit – Specialist	You pay $50 per visit copay, then plan pays 100%
Cigna Telehealth Connection Services • Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)	You pay $25 per visit copay, then plan pays 100%
Urgent care visit • All services including Lab & X-ray	You pay $50 per visit copay, then plan pays 100%
Preventive Care	Plan pays 100%, no copay, no deductible
Preventive Services	Plan pays 100%, no copay, no deductible
Immunizations	Plan pays 100%, no copay, no deductible
Coinsurance	After the plan deductible is met, You pay 0% Plan pays 100%
Calendar year deductible • Benefits for an individual within a family are paid once the individual deductible has been met. • Copays always apply before plan deductible and coinsurance.	Individual: $2,000 Family: $6,000
Out-of-pocket annual maximum • Medical copays apply towards the out-of-pocket maximums • Medical deductibles apply towards the out-of-pocket maximums • This plan includes a combined Medical/Pharmacy out-of-pocket maximum.	Individual: $6,500 Family: $13,000
Lifetime maximum	Unlimited Per individual
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	You pay $250 per visit copay (waived if admitted), then plan pays 100%
Ambulance	After the in-network plan deductible is met, You pay 0% Plan pays 100%
Office surgery – PCP	After the plan deductible is met, You pay 0% Plan pays 100%
Office surgery – Specialist	After the plan deductible is met, You pay 0% Plan pays 100%

General Services	In-Network
Other office services – laboratory	After the plan deductible is met, You pay 0% Plan pays 100%
Other office services – radiology	After the plan deductible is met, You pay 0% Plan pays 100%
Outpatient lab	After the plan deductible is met, Plan pays 100%
Outpatient radiology	After the plan deductible is met, Plan pays 100%
Independent lab	After the plan deductible is met, Plan pays 100%
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 0% Plan pays 100%
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 0% Plan pays 100%
Durable medical equipment • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	After the plan deductible is met, You pay 0% Plan pays 100%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies	Plan pays 100%, no copay, no deductible

Benefits	In-Network
Hospital Services	
Inpatient hospital services	After the plan deductible is met, You pay 0% Plan pays 100%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician	After the plan deductible is met, You pay 0% Plan pays 100%
Outpatient hospital services • $100 in-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.	You pay $100 per admission deductible, Then Plan pays 100%
Outpatient professional services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists	After the plan deductible is met, You pay 0% Plan pays 100%
Skilled nursing facility care • 60 days per calendar year maximum	After the plan deductible is met, You pay 0% Plan pays 100%
Hospice care	After the plan deductible is met, You pay 0% Plan pays 100%

Benefits	In-Network
Home health care • 60 visits per calendar year maximum • The limit is not applicable to mental health and substance use disorder conditions.	After the plan deductible is met, You pay 0% Plan pays 100%
Mental Health and Substance Use Disorder	
Inpatient mental health • Includes Residential Treatment	After the plan deductible is met, Plan pays 100%
Outpatient mental health – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	You pay $50 per visit copay, then plan pays 100%
Outpatient mental health – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	Plan pays 100%, no copay,no deductible
Inpatient substance use disorder • Includes Residential Treatment	After the plan deductible is met, Plan pays 100%
Outpatient substance use disorder – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	You pay $50 per visit copay, then plan pays 100%
Outpatient substance use disorder – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	Plan pays 100%, no copay,no deductible
Therapy Services	
Outpatient physical therapy • 30 visits per calendar year • Limits are not applicable to mental health conditions	Covered same as plan's Physician Office Visit – Specialist
Outpatient speech therapy, hearing therapy and occupational therapy • 60 visits per calendar year • Limits are not applicable to mental health conditions for speech and occupational therapies	Covered same as plan's Physician Office Visit – Specialist
Chiropractic services • 12 visits per calendar year	Covered same as plan's Physician Office Visit – Specialist
Acupuncture	Not Covered
Additional Services	
Medical Specialty Drugs Inpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 0% Plan pays 100%

Benefits	In-Network
Medical Specialty Drugs Outpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 0% Plan pays 100%
Medical Specialty Drugs Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, You pay 0% Plan pays 100%
Medical Specialty Drugs Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, You pay 0% Plan pays 100%
PPACA Women's Health • Includes surgical services, such as tubal ligation (excludes reversals) • Contraceptive devices are included.	Plan pays 100%, no copay,no deductible
Family planning • Includes surgical services, such as vasectomy (excludes reversals) • Includes infertility testing for diagnosis only	Varies based on place of service
Infertility	Not Covered
Abortion • Includes non-elective procedures and elective procedures	Varies based on place of service
TMJ	Not Covered
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum $10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility)	After the plan deductible is met, You pay 0% Plan pays 100%
Out-of-area services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for out of area • In-network deductible and out-of-pocket maximums apply	For all other services You pay 20% Plan pays 80% after the network deductible is met

Pharmacy	In-Network
Cost Share and Supply	

Pharmacy	In-Network
Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.	**Retail (per 30-day supply):** Generic: You pay $15 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $50 **Retail (per 90-day supply):** Generic: You pay $45 Preferred Brand: You pay $90 Non-Preferred Brand: You pay $150 **Home Delivery (per 90-day supply):** Generic: You pay $38 Preferred Brand: You pay $75 Non-Preferred Brand: You pay $125

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

Drugs Covered

Prescription Drug List:
Your Cigna Performance Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectable drugs, but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Prescription smoking cessation drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.
- Prior authorization is required on specialty medications and quantity limits may apply.

Pharmacy Cost Management Program
Step Therapy: Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

Pharmacy Program Information

Clinical Outcome Programs:

- Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

Additional Information

Selection of a Primary Care Provider- Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Out of Pocket Maximum

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards the out-of-pocket maximums
- Medical deductibles apply towards the out-of-pocket maximums

Complete Care Management

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their clients.

General Notice of Preexisting Condition Exclusion

- Not applicable

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former 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.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Exclusions

What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list)

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services
- Treatment of TMJ disorders and craniofacial muscle disorders

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

EHB State: NH

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2,000**/individual or **$6,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, office visits, in-network outpatient hospital facility, prescription drugs, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100** for in-network outpatient hospital visit There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers **$6,500**/individual or **$13,000**/family. Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-866-494-2111** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply	Not covered	None
	Specialist visit	$50 copay/visit Deductible does not apply	Not covered	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge at an outpatient facility No charge in the office	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail 30 days), $45 copay/prescription (retail 90 days); $38 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail 30 days), $90 copay/prescription (retail 90 days); $75 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail 30 days), $150 copay/prescription (retail 90 days); $125 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 per admission deductible Deductible does not apply	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$50 copay/visit Deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/office visit** No charge/all other services** **Deductible does not apply	Not covered	None
	Inpatient services	No charge/admission	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$50 copay/visit for Physical, Speech, Hearing & Occupational therapy** $50 copay/visit for Chiropractic services** **Deductible does not apply	Not covered	Coverage is limited to an annual max of 30 visits for Physical therapy and 60 visits for Speech, Hearing & Occupational therapy and 12 visits annual max for Chiropractic services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	Not covered	Coverage is limited to 60 days annual max.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (12 visits)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,050**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$130
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$660
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,060**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAPin 5-2018 **Ben Ver:** 11 **Plan ID:** 7477874

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  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OPEN ACCESS PLUS

How it works for you

With the Open Access Plus plan (OAP), you get choice. So, each time you need care, you choose the doctor or facility that works best for you.

Options for care:

- **Primary Care Physician (PCP)** – You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network** – Choose to see doctors or other health professionals who are in the Cigna network to keep your costs lower and eliminate paperwork.
- **No-referral specialist care** – If you need to see a specialist, you don't need a referral.

  You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Out-of-network** – You have the freedom to see doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim.
- **Emergency and urgent care** – When you need care, you have coverage.

Predictable out-of-pocket costs – Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered health care costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for covered services. Then, the plan pays the rest. If you receive out-of-network care, out-of-network doctors and facilities may bill you for charges that are more than what your plan pays for covered expenses.

Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.

24/7 service – Whenever you need us, customer service representatives are available to take your call.

Partner with a health advocate – Even when you're not sure where to begin, you'll get confidential assistance from reliable, caring professionals who want to help you take an active role in your health.

Access to myCigna.com

- **Learn** more about your plan, and the coverage and programs that come with it.
- **View** claim history and account transactions; print claim forms.
- **Find** information and estimate costs for medical procedures and treatments.
- **Compare** hospitals by number of procedures performed, patients' average length of stay and cost.

Together, all the way.℠

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Do I have to choose a primary care physician (PCP)?

No, but it is recommended. A PCP gives you and your covered family members a valuable resource and can be a personal health advocate.

Do I need a referral to see a specialist?

You do not need a referral to see an in-network specialist. If you choose an out-of-network specialist, your care will be covered at the out-of-network level.

What is the difference between in-network and out-of-network coverage?

Each time you seek medical care, you can choose your doctor – either a doctor who is in the Cigna network or someone who is not. When you visit an in-network doctor, you receive "in-network coverage" with lower out-of-pocket costs. That's because our in-network health care professionals have agreed to charge lower fees, and your plan covers a larger share of the charges. If you visit a doctor outside of the network, your out-of-pocket costs will be higher.

What if I need to be admitted to the hospital?

In an emergency, you have coverage. Requests for non emergency hospital stays, other than maternity stays must be approved in advance or "precertified." This lets Cigna determine if the services are covered by your plan. Precertification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for cesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the first 48 or 96 hours must be approved.

Who must get precertification?

Your doctor will help you decide which procedures require you to be admitted to the hospital and which can be handled on an outpatient basis. If your doctor is in the Cigna network, he or she will arrange for precertification. If you use an out-of-network doctor, you must make the arrangements. Look at your plan documents to see which procedures need precertification.

What if I go to an out-of-network doctor who sends me to an in-network hospital? Will I pay in-network or out-of-network charges for my hospital stay?

Your plan will cover authorized medical services provided by an Open Access Plus in-network hospital at your in-network coverage level, whether you were sent there by an in- or out-of-network doctor.

How do I find out if my doctor is in the Cigna network before I enroll?

It's quick and easy to search for in-network doctors, specialists, pharmacies and hospitals close to home and work. Go to **Cigna.com** and click on "Find a Doctor." You can review a doctor's background, languages spoken and hospital affiliations, and get directions

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IMPORTANT NOTICE

Special Enrollment Requirements from Cigna

This flyer contains important information you should read before you enroll. If you have any questions about this information, please contact your benefits manager.

If You Are Declining Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If the other coverage is COBRA continuation coverage, you and your dependents must complete your entire COBRA coverage period before you can enroll in this plan, even if your former employer ceases contributions toward the COBRA coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 or later, if you or your dependents lose eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for assistance with group health plan premium payment under a state Medicaid or CHIP plan, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the state Medicaid or CHIP coverage ends or you are determined eligible for premium assistance.

To request special enrollment or obtain more information, contact our Customer Service Team at 866.494.2111

Other Late Entrants

If you decide not to enroll in this plan now, then want to enroll later, you must qualify for special enrollment. If you do not qualify for special enrollment, you may have to wait until an open enrollment period, or you may not be able to enroll, depending on the terms and conditions of your health plan. Please contact your plan administrator for more information.

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Cigna®

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Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this plan as shown in the Summary of Benefits.

If you would like more information on WHCRA benefits, call our Customer Service Team at 866.494.2111.

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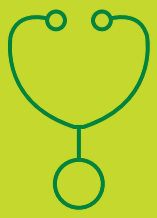
NO PCL

PREVENTIVE HEALTH CARE



A guide to understanding what it is and what's covered

Your Cigna health care plan covers certain preventive care services. Using these services at the right time can help you stay healthier by:

- Preventing certain illnesses and health conditions from happening; or
- Detecting health problems at early stages, when they may be easier to treat

When you receive care in-network, it generally is at a lower cost to you. Depending on your plan, in-network preventive care services may be covered at 100% - but be sure to check your plan materials for details about your specific medical plan.

To make sure you get the care you need — without any unexpected costs — it's important for you to know:

- What preventive care services are and;
- Which services your health plan will cover

What are preventive care services?

Preventive care services are provided during a wellness exam. You and your doctor will determine what tests and health screenings are right for you. The screenings are based on your:

- Age
- Gender
- Personal health history
- Current health

You don't need to have symptoms or be diagnosed with a health issue to receive preventive care services. For example, a flu shot is given to prevent the flu. Other services like mammograms help detect illnesses when there aren't any symptoms. Even if you're in the best shape of your life, a serious condition with no symptoms may put your health at risk.

What isn't a preventive care service?

During your wellness exam, you may receive services that are not considered preventive care services. For example, if your doctor determines that you have a medical issue and you have additional screenings and tests done after a diagnosis is made, this is no longer considered preventive. These services will be considered under your plan's medical benefits, not your preventive care benefits. This means you may be responsible for paying a different share of the cost than you do for preventive care services.

Questions?

Talk with your doctor or call Cigna at the toll-free number on the back of your ID card.

The charts on the following pages list the services and supplies that are considered "preventive care" under your plan.

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Wellness exams

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	● ● ●	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2–4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21, once a year • Ages 22 and older, periodic visits, as doctor advises

The following routine immunizations are currently designated preventive services

SERVICE	SERVICE
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP, Tdap, Td)	Meningococcal (MCV)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV) (age and gender criteria apply depending on vaccine brand)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Alcohol misuse screening	● ● ●	All adults; adolescents age 11-21
Anemia screening	●	Pregnant women
Aspirin to prevent cardiovascular disease; or to reduce risk for preeclampsia[1]	● ●	Men ages 45–79; women ages 55–79; Pregnant women at risk for preeclampsia (coverage available 9/1/15)
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Breast cancer screening (mammogram)	●	Women ages 40 and older, every 1–2 years
Breast-feeding support/counseling, supplies[2]	●	During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test with Pap test	●	Women ages 21–65, every 3 years Women ages 30–65, every 5 years
Chlamydia screening	●	Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening	● ● ●	• Screening of children and adolescents ages 9-11 years and 18-21 years; children and adolescents with risk factors ages 2-8 and 12-16 years • All men ages 35 and older, or ages 20–35 if risk factors • All women ages 45 and older, or ages 20–45 if risk factors
Colon cancer screening	● ●	The following tests will be covered for colorectal cancer screening, ages 50 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires precertification
Congenital hypothyroidism screening	●	Newborns

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Critical congenital heart disease screening	●	Newborns before discharge from hospital
Contraception counseling/education. Contraceptive products and services[1,3,4]	●	Women with reproductive capacity
Depression screening	● ● ●	Ages 11–21, All adults
Developmental screening	●	9, 18, 30 months
Developmental surveillance	●	Newborn 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Diabetes screening	● ●	Adults with sustained blood pressure greater than 135/80
Discussion about potential benefits/risk of breast cancer preventive medication[1]	●	Women at risk
Dental caries prevention Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1] Application of fluoride varnish to primary teeth at time of eruption (in primary care setting)	●	Children older than 6 months Children through age 6 years
Domestic and interpersonal violence screening	●	All women
Fall prevention in older adults (physical therapy, vitamin D supplementation[1])	● ●	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation[1]	●	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	●	Women at risk • Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	●	Pregnant women
Gonorrhea screening	●	Sexually active women age 24 years and younger and older women at risk
Hearing screening (not complete hearing examination)	●	All newborns by 1 month. Ages 4, 5, 6, 8, and 10 or as doctor advises
Healthy diet and physical activity counseling	● ● ●	Ages 6 and older - to promote improvement in weight status; Overweight or obese adults with risk factors for cardiovascular disease
Hemoglobin or hematocrit	●	12 months
Hepatitis B screening	● ● ●	Pregnant women; adolescents and adults at risk
Hepatitis C screening	● ●	Adults at risk; one-time screening for adults born between 1945 and 1965
HIV screening and counseling	● ● ●	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women, annually
Iron supplementation[1]	●	6–12 months for children at risk
Lead screening	●	12, 24 months
Lung cancer screening (low-dose computed tomography)	● ●	Adults ages 55 to 80 with 30 pack-year smoking history, and currently smoke, or have quit within the past 15 years. Computed tomography requires precertification. (coverage effective upon your plan's start or anniversary date on or after 1/1/15)
Metabolic/hemoglobinopathies (according to state law)	●	Newborns
Obesity screening/counseling	● ● ●	Ages 6 and older, all adults
Oral health evaluation/assess for dental referral	●	12, 18, 24, 30 months. Ages 3 and 6
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by Fracture Risk Assessment Score). Computed tomographic bone density study requires precertification

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
PKU screening	●	Newborns
Ocular (eye) medication to prevent blindness	●	Newborns
Prostate cancer screening (PSA)	●	Men ages 50 and older or age 40 with risk factors
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	● ● ●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	Adolescents ages 11-21
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	● ● ●	Ages 10–24
Syphilis screening	● ● ●	Individuals at risk; pregnant women
Tobacco use cessation: counseling/interventions[1]	● ●	All adults[1]; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculin test	●	Children and adolescents at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, 15 and 18 or as doctor advises

● = Men ● = Women ● = Children/adolescents

Other coverage: Your plan supplements the preventive care services listed above with additional services that are commonly ordered by primary care physicians during preventive care visits. These include services such as urinalysis, EKG, thyroid screening, electrolyte panel, Vitamin D measurement, bilirubin, iron and metabolic panels.

1. Subject to the terms of your plan's pharmacy coverage, certain drugs and products may be covered at 100%. Your doctor is required to give you a prescription, including for those that are available over-the-counter, for them to be covered under your Pharmacy benefit. Cost sharing may be applied for brand-name products where generic alternatives are available. Please refer to Cigna's "No Cost Preventive Medications by Drug Category" Guide for information on drugs and products with no out-of-pocket cost.
2. Subject to the terms of your plan's medical coverage, breast-feeding equipment rental and supplies may be covered at the preventive level. Your doctor is required to provide a prescription, and the equipment and supplies must be ordered through CareCentrix, Cigna's national durable medical equipment vendor. Precertification is required for some types of breast pump equipment. To obtain the breast pump and initial supplies, contact CareCentrix at 877.466.0164 (option 3). To obtain replacement supplies, contact Edgepark Medical Supplies at 800.321.0591.
3. Examples include oral contraceptives; diaphragms; hormonal injections and contraceptive supplies (spermicide, female condoms); emergency contraception.
4. Subject to the terms of your plan's medical coverage, contraceptive products and services such as some types of IUD's, implants and sterilization procedures may be covered at the preventive level. Check your plan materials for details about your specific medical plan.

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and, with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

Exclusions

This document provides highlights of preventive care coverage generally. Some preventive services may not be covered under your plan. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). For the specific coverage terms of your plan, refer to the Evidence of Coverage, Summary Plan Description or Insurance Certificate.

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WELCOME TO CIGNA

Together, we can make healthier happen

Learn what your Cigna plan offers

Cigna health plans offer so much more than coverage for basic medical needs. We offer the programs, tools, services and resources you need to help you better manage your health – and health spending. Here are some important highlights to help get the most out of your Cigna health plan starting today – and in the days and months to come.

At Cigna, we want to partner with you and support you in your health journey. We'll be there for you, every step of the way, so you don't have to go it alone.

Life can be busy and complicated. So, we created a simple-to-use tool that can help make your life easier (and healthier) while you're on the go. The myCigna Mobile App helps you personalize, organize and access your important plan information on your phone and tablet. The app is also available in Spanish.

Use the myCigna Mobile App to login in anytime, anywhere to:

- Manage and track claims
- View fax or email ID card information
- Find a health care professional, view quality information, and compare costs
- Review your coverage
- Track your account balances and deductibles

Download the myCigna Mobile App to your mobile device.*

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If you have already registered for myCigna.com:

1. Log in to **myCigna.com** beginning [insert date]
2. Go to the "My Health" tab
3. Click on the health assessment tile
4. Get started

If you have never registered for myCigna:

1. Go to **myCigna.com** any time after [insert date]
2. Register with your Cigna ID, SSN or take the personal questionnaire
3. Go to the "My Health" tab
4. Click on the health assessment tile
5. Get started

Once you enroll, you'll have access to these tools and resources.

And you can take myCigna with you wherever you go. Use your mobile device to personalize, organize and access all the important health information you find on myCigna – check out our award-winning health care professional directory,[2] find an urgent care center in your plan's network, check the price of your prescriptions and more.

Together, all the way.®

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Register on **myCigna.com** and get the myCigna Mobile App. You will need your username and password each time you visit the site.[1]

Cigna ID card

Always keep it with you

Your ID card contains important information about your coverage like:

- The name of your Cigna health plan and the health care professional networks you can access for care
- Addresses where you or you doctor will send your medical and pharmacy claims
- Cigna's 24/7/365 customer service line

ID card will arrive in the mail.

Preventive care

Keeping you well

At Cigna, we focus on helping to keep you well. We encourage you to talk with a doctor who is part of the Cigna network to **determine what tests or health screenings are right for you**. Most Cigna health plans cover certain in-network preventive care services 100%. Covered preventive care services may include, but are not limited to:[3]

- Wellness visits
- Screenings for high blood pressure and cholesterol
- Testing for diabetes and colon cancer
- Clinical breast exams and mammograms
- Pap tests

Care Management Programs

Working together to improve your health

Cigna has many services to help you with your personal health needs, including the following:

- **Care management programs** give you access to a Cigna case manager, trained as a nurse, who works closely with your doctor and contacts you on a regular basis to check on your progress. You can ask for help and guidance with conditions and illnesses such as cancer, end-stage renal disease, neonatal care and pain management.

Access to care

Right Service. Right Place.

Cigna wants to help you find the right services for your health care needs. We also want to make sure that you're getting the best value from your health plan services. That's why we'd like you to keep the following in mind:

- If you need immediate medical attention, your first thought may be to go the emergency room. But an urgent care center may be a more convenient, less expensive alternative (if you have one in your area). An urgent care center can treat you for things like minor cuts, burns and sprains, fever and flu symptoms, joint or lower back pain and urinary tract infections. If you have a serious or life-threatening condition, always dial 911 or visit the nearest hospital.
- Save more when you use a doctor, hospital or facility that's part of the Cigna network. View our health care professional directory to find an in-network doctor or facility near you on **myCigna.com**.

My Health Assistant

Cigna offers an online, personal coaching service with programs that can jump start your goals and help you start feeling healthier and happier. What's more, this service is already part of your plan.

My Health Assistant on myCigna.com includes a variety of online health management programs that can help you turn unhealthy behaviors into healthier achievements. We want to make sure there's a program to meet your personal needs, as well as your personal health improvement style. Choose from one of the following programs to help you establish personal goals and track your progress:

- Control Stress
- Lose Weight
- Eat Better
- Enjoy Exercise
- Quit Tobacco
- Managing Diabetes
- Managing Heart Disease
- Managing Heart Failure
- Managing COPD
- Managing Asthma

Prescriptions

Managing your medications and your health

Choosing the medication that's right for you will be up to you and your doctor. We help by offering an extensive list of covered brand, generic and specialty medications so you can decide what's best for you based on how well it works and how much it costs. Most drugs fall into one of three categories:[4]

- **Generic Medications:** Generic medications have the same active ingredients, dosage and strength as their brand name counterparts. You will usually pay less for generic medications.
- **Preferred Brand Medications:** Preferred brand medications will usually cost more than a generic, but may cost less than a non-preferred brand. When a generic drug isn't available, choosing a preferred brand can be a lower-cost option.
- **Non-Preferred Brand Medications:** Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You will usually pay more for non-preferred medications.

Cigna also gives you access to more than 68,000 pharmacies in our network.[5] If you take maintenance drugs on a regular basis, consider signing up for the Cigna Home Delivery PharmacyÐ* to receive a 90-day supply of your prescription medications directly to you.

* Applicable only if Cigna Home Delivery Pharmacy is part of your benefits plan.

24/7/365 service

A phone call away. Any time, any day.

From health care questions to coverage concerns, whenever you need us, call **1.866.494.2111**. That's the toll-free number printed on the back of your Cigna ID card, and customer service representatives are available to help you 24 hours a day, seven days a week.

- We'll answer questions, help you resolve problems and give you helpful information.
- You can order an ID card, update insurance information and check claim status.
- Access our health information line where Cigna staff, trained as nurses, can help you find answers to your health questions, and help you decide where and when to seek medical attention.
- If you want to speak with someone in Spanish, we have bilingual representatives. We also have services that can translate 150 other languages.

Common health care definitions

You may hear or read about these words. Now you'll know what they mean.

Copay

A preset amount you pay for your covered health care services. The plan pays the rest.

Deductible

An annual amount you'll pay before your health plan begins to pay for covered services.

Coinsurance

Your share of the cost of your covered health care costs after deductibles have been met. Your plan pays the rest of covered charges. If you go out-of-network for care, your expenses may be greater than the coinsurance amount.

Out-of-pocket maximum

The most you'll pay before your plan begins to pay 100% of covered costs. You will still need to pay for any expenses your plan doesn't count toward the maximum, which may include copays.

In-network

Health care professionals, pharmacies and facilities that have contracts with Cigna to deliver services at a negotiated rate (discount). You will typically have lower out-of-pocket costs for services you received in-network.

Out-of-network

A health care professional, pharmacy or facility that doesn't participate in Cigna's network and doesn't provide services at a discounted rate. Using an out-of-network health care professional or facility will typically cost you more.

Primary Care Provider

Also known as your PCP, this is your personal health care provider who coordinates all of your medical care, from routine physicals to recommending specialists. He or she gets to know you, your medical history and your personal preferences. And that can be very valuable.

Precertification

Precertification is getting approval from the health plan before receiving services, such as for routine hospital stays or outpatient procedures. In precertification, Cigna (or its agent) reviews medical criteria to determine coverage under your plan.

866.494.2111 We're here for you 24 hours a day, seven days a week.

Remember you must enroll by: _____

Questions? Write them down here. You can ask us today or contact: _____

866.494.2111 We're here for you 24 hours a day, seven days a week.

1. The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply. Actual myCigna and App features available may vary depending on your plan. The listing of a health care professional or facility in the online directories does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your benefit summary and plan documents, or call the number listed on your ID card, for information about the services covered under your plan benefits.
2. Cigna's online health care cost and quality capabilities on **myCigna.com** were named one of the top ten innovations of 2012 by InformationWeek.
3. Covered preventive care services may vary depending on your age, gender and medical history. Plans may vary and some preventive services may not be covered under your plan. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). For the coverage terms of your specific medical plan, see your plan materials.
4. Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.
5. Pharmacy availability and network will vary based on your plan.

All group health insurance policies and health benefit plans have exclusions and limitations. This information is intended to give you some highlights about your plan. For a complete list of both covered and not-covered services, including benefits that may be required by your state, see your employer's insurance certificate or summary plan description – the official plan documents. If there are any differences between the information shown here and the plan documents, the information in the plan documents takes precedence.

The health care professionals and facilities that participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company (CGLIC), Cigna Behavioral Health, Inc., Cigna Health Management, Inc., Tel-Drug, Inc., and Tel-Drug of Pennsylvania, L.L.C. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms: OK - HP-APP-1 et al (CHLIC), GM6000 C1 et al (CGLIC); TN - HP-POL43/HC-CER1V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

FINDING A DOCTOR OR DENTIST IN OUR DIRECTORY IS EASY

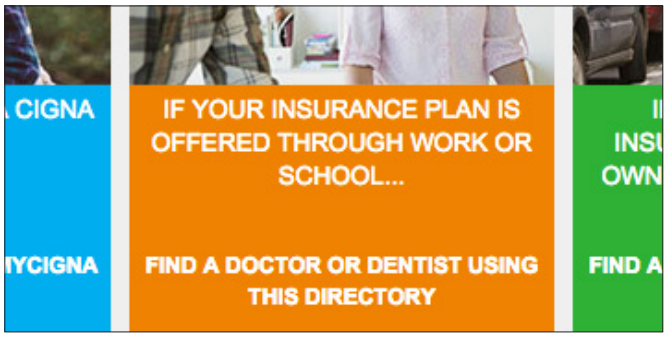
Is your doctor, dentist or hospital in the Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

SEARCH OUR NETWORK IN FIVE SIMPLE STEPS

Step 1

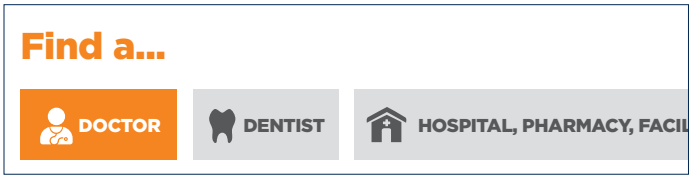
Go to **www.Cigna.com**, click on FIND A DOCTOR/ DENTIST at the top of the screen. Then, select the orange box that reads "If your insurance plan is offered through work."

(If you already have a Cigna plan, log in to **myCigna**.)



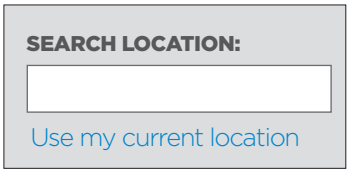
Step 2

Choose what you're looking for: Doctors, dentists or places to receive medical care.



Step 3

Enter the geographic location you want to search.



over >

Together, all the way.℠

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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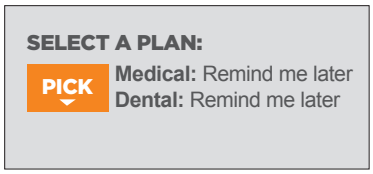
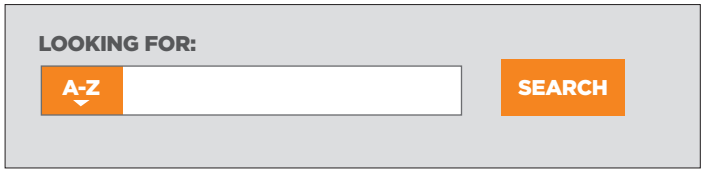
Step 4

Select one of the plans offered by your employer during open enrollment.



Step 5

Enter a name, specialty or other search word. Click SEARCH to see your results.



That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Search first. Then choose Cigna.

There are so many things to love about Cigna. Our directory search is just the beginning.

After you enroll, you'll have access to myCigna – your one-stop source for managing your health plan, anytime, anyplace. On myCigna, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call **866.494.2111**.

Cigna®

Health care professionals and facilities that participate in the Cigna network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna.

90-DAY PRESCRIPTION FILLS

Filling your maintenance medications just got easier with Cigna 90 Now℠

You have a lot going on. Taking your medication every day and remembering to pick up your refill every month isn't always easy. We have a program that can help – it's called Cigna 90 Now.

More choice

Your plan includes a new maintenance medication program called Cigna 90 Now. Maintenance medications are taken regularly, over time, to treat an ongoing health condition. **Cigna 90 Now offers you more choice in how, and where, you can fill your prescription.**

Choose what works best for you

- If you choose to fill your prescription in a 90-day supply, you have to use a 90-day retail pharmacy in your plan's new network, or Cigna Home Delivery Pharmacy℠.*
- If you choose to fill your prescription in a 30-day supply, you can use any pharmacy in your plan's new network.

You choose! 90-day or 30-day supply.

Where you can fill a 90-day prescription

With Cigna 90 Now, your plan offers a new retail pharmacy network that gives you more choice in where you can fill your 90-day prescriptions.

There are thousands of retail pharmacies in your new network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop! If you prefer the convenience of having your medications delivered to your home, you can also use Cigna Home Delivery Pharmacy to fill your prescriptions.*

For more information about your new pharmacy network, you can go to **Cigna.com/Rx90network**.

Why fill a 90-day supply?

Filling your prescriptions in a 90-day supply may help you stay healthy because having a 90-day supply of your medication on-hand typically means you're less likely to miss a dose.** It also means you can make fewer visits to the pharmacy to refill your medication, and depending on your plan, you may be able to save money by filling your prescriptions 90-days at a time.

Here are some of the 90-day retail pharmacies in your network:***

- **CVS** (including Target and Navarro)
- **Walmart**
- **Kroger** (including Harris Teeter Pharmacy, Pick N Save Pharmacy, Fred Meyer Pharmacy, Fry's Food and Drug)
- **Access Health** (including Benzer Pharmacy, Marcs, Big Y Pharmacy, Marsh Drugs, LLC, Snyder Drug Emporium)
- **Good Neighbor Pharmacies** (including Big Y Pharmacy, Super RX Pharmacy, Medical Center Pharmacy, Family Pharmacy, King Kullen Pharmacy)
- **Cardinal Health** (including Freds Pharmacy, Medicine Shoppe Pharmacy, Harris Teeter Pharmacy, Medicap Pharmacy)

Together, all the way.®

Cigna®

Prefer to have your medications delivered to your door?

Then Cigna Home Delivery Pharmacy may be right for you! We'll deliver your maintenance medication to you at the location of your choice. And standard shipping is always free. No more waiting in line at the pharmacy! For more information, please call Customer Service at **800.285.4812**, or visit **Cigna.com/home-delivery-pharmacy**.

Questions?

Please call Customer Service using the number on the back of your Cigna ID card. We're here to help.

90-Day Fills

Get a 90-day prescription for your medication

Take your prescription to a 90-day retail pharmacy in your network, or mail to Cigna Home Delivery Pharmacy

Receive your medication in a 90-day supply for convenience

30-Day Fills

Get a 30-day prescription for your maintenance medication

Take your prescription to any retail pharmacy in your network

Receive your medication

* Plans vary, so some plans may not include Cigna Home Delivery Pharmacy. Please check your plan materials for more information on what pharmacies are covered under your plan.

** Internal Cigna analysis performed March 2016, utilizing 2015 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.

*** Participating 90-day network pharmacies as of April 2016. Subject to change.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

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CIGNA PERFORMANCE 3-TIER PRESCRIPTION DRUG LIST

As of January 1, 2018

Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company

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Table of Contents

Getting started

View your drug list online

This document was last updated 09/01/2017.* To see a current list of the medications covered on your plan's drug list, visit:

myCigna.com – Once you're registered, log in and select Estimate Health Care Costs, then select Get drug costs.

Cigna.com/druglist – Select your drug list name – Performance 3 Tier – from the drop down menu.

Questions? – Call the toll-free number on the back of your Cigna ID card. We're here to help.

* Drug list created: originally created 04/01/2008

Last updated: 05/15/2017, for changes that were effective 07/01/2017

Next planned update: 09/01/17, for changes that will be effective 01/01/2018

Your prescription drug list

This drug list includes the most commonly prescribed medications covered by your plan as of January 1, 2018.[1] These generic and brand name prescription medications are approved by the U.S. Food and Drug Administration (FDA). Medications are listed by the condition they treat, then listed alphabetically within tiers, or coverage/cost levels.

This drug list is not a complete list of covered medications, and not all of the medications listed here may be covered by your specific plan. You should log into **myCigna.com** or check your plan materials to learn more about the medications your plan covers.

How to read your drug list

Use the sample chart below to help you understand this drug list.

TIER 1 $	TIER 2 $$
BLOOD PRESSURE/HEART MEDICATIONS	
afeditab CR	Berinert* (PA)
amlodipine besylate	Bidil
amlodipine besylate-benazepril	Bystolic
amlodipine-valsartan	Cinryze* (PA)
amlodipine-valsartan-HCTZ	Coreg CR
atenolol	Cozaar (ST)
atenolol-chlorthalidone	Diovan (ST)
benazepril	Diovan HCT (ST)
benazepril-HCTZ	Edarbi (ST)
candesartan cilexetil	Edarbyclor (ST)
cartia XT	Exforge
carvedilol	Exforge HCT
clonidine	Firazyr* (PA)
digitek	Hemangeol
digox	Inderal LA
digoxin	Inderal XL
diltiazem ER	Innopran XL
diltiazem CD	Lotrel
diltiazem	Micardis (ST)
dilt-XR	Multaq
enalapril	Nitro-dur
flecainide acetate	Nitrolingual
hydralazine	Nitromist
irbesartan	Nitronal
isosorbide mononitrat	Nitrostat
	Northera* (PA)
	Norvasc
	Ranexa (ST)
	Tekturna
	Tekturna HCT

Tier (coverage/cost level) gives you an idea of the cost level you may pay for a medication

Medications are grouped by the **condition** they treat

Medications in each column are listed in **alphabetical** order

Specialty medications have an asterisk listed next to them

Brand name medications are **capitalized**

Generic medications are **lowercase**

Medications that require approval for coverage or have limits will have an **abbreviation** listed next to them

For illustrative purposes only.

Here's more helpful information on how to read this drug list:

Tiers

Covered medications are divided into tiers, or coverage/cost levels. The tier the medication is listed in determines how much you'll pay when you fill the prescription. Typically, the higher the tier, the greater the cost of the medication.

› **Tier 1 – Typically Generics**	(Lower-cost medication)	**$**
› **Tier 2 – Typically Preferred Brands**	(Medium-cost medication)	**$$**
› **Tier 3 – Typically Non-Preferred Brands**	(Higher-cost medication)	**$$$**

Abbreviations next to medications

Some medications on your drug list have special requirements before they may be covered by your plan. This helps to make sure you're receiving coverage for the right medication, at the right cost, in the right amount and for the right situation. These medications will have an abbreviation next to them in the drug list. Here's what each of the abbreviations mean.

(PA)	**Prior Authorization** – Your doctor has to provide Cigna with information about why you need to use this medication. The medication will only be covered if your doctor requests and receives approval from Cigna.
(ST)	**Step Therapy** – Certain high-cost brand name medications are part of the Step Therapy program. These medications aren't covered unless your doctor requests and receives approval from Cigna. Step Therapy encourages the use of lower-cost, clinically appropriate medications to treat your condition. These are typically generics or preferred brands. You have to try these medications first before your plan covers higher-cost brands.
(QL)	**Quantity Limits** – For some medications, your plan only covers up to a certain amount over a certain number of days. For example, 30mg per day for 30 days. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna.
(AGE)	**Age Requirements** – You must be within a specific age range for this medication to be covered.

Brand name medications are capitalized

In this drug list, brand name medications are capitalized and generic medications begin with a lowercase letter.

Specialty medications are marked with an asterisk

Specialty medications are used to treat complex conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis. In this drug list, specialty medications are marked with an asterisk (*). Some plans may cover these medications on a specialty tier and/or require the use of a preferred specialty pharmacy. Log into **myCigna.com** or check your plan materials to learn more about how your plan covers specialty medications.

No cost-share preventive medications are marked with a plus sign

Health care reform under the Patient Protection and Affordable Care Act (PPACA) requires that most plans cover certain categories of medications and other products as preventive care services. In this drug list, medications with a plus sign (+) next to them may be available to you at no cost-share (copay, coinsurance and/or deductible). Log into **myCigna.com** or check your plan materials to learn more about how your plan covers preventive medications.

Plan exclusions

Some medications shown in this drug list may not be covered by your specific plan. For example, medications used for weight loss or to treat infertility may not be covered. In this drug list, these medications have a carat (^) next to them. Log into **myCigna.com** or check your plan materials to learn more about how your plan covers these medications.

How to find your medication on the drug list

Look for your condition in the alphabetical list below. Then go to that page to see the list of covered medications available to treat the condition.

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
AIDS/HIV		
lamivudine* lamivudine-zidovudine* nevirapine ER* nevirapine*	Isentress HD* Isentress* Kaletra* Norvir* Prezista* Reyataz* Selzentry* Sustiva* Truvada* Viread*	Atripla* Complera* Descovy* Epzicom* Genvoya* Intelence* Odefsey* Prezcobix* Stribild* Tivicay* Triumeq*
ALLERGY/NASAL SPRAYS		
azelastine cromolyn cyproheptadine desloratadine epinephrine auto-injector (QL) fluticasone hydroxyzine ipratropium mometasone (QL) olopatadine phenergan promethazine	Astepro Bactroban Nasal	EpinephrineSnap-V
ALZHEIMER'S DISEASE		
donepezil donepezil ODT memantine pyridostigmine pyridostigmine ER rivastigmine	Mestinon syrup Namenda titration pack	Mestinon tablet Namenda Namenda XR (QL) Namzaric (QL)
ANXIETY/DEPRESSION/BIPOLAR DISORDER		
alprazolam alprazolam ER alprazolam ODT alprazolam XR amitriptyline bupropion bupropion SR bupropion XL buspirone citalopram clomipramine duloxetine escitalopram fluoxetine fluoxetine DR fluvoxamine		Brisdelle (QL) Effexor XR (ST) Fetzima (ST) Forfivo XL (ST) Onfi Pristiq (ST, QL) Prozac (ST) Sarafem (ST) Trintellix (ST) Viibryd (ST) Wellbutrin SR (ST) Xanax Xanax XR Zoloft (ST)

TIER 1 $	TIER 2 $$	TIER 3 $$$
ANXIETY/DEPRESSION/BIPOLAR DISORDER *(cont)*		
fluvoxamine ER lorazepam lorazepam intensol paroxetine paroxetine CR paroxetine ER sertraline trazodone venlafaxine venlafaxine ER		
ASTHMA/COPD/RESPIRATORY		
albuterol budesonide fluticasone-salmeterol montelukast	Advair Diskus Advair HFA Anoro Ellipta Breo Ellipta Combivent Respimat Incruse Ellipta ProAir HFA ProAir Respi-Click Pulmicort Flexhaler Pulmozyme* (PA) QVAR Serevent Diskus Spiriva Spiriva Respi-mat Stiolto Respi-mat Striverdi Respimat Symbicort Ventolin HFA Xolair* (PA)	Adcirca* (PA) Adempas* (PA) Aralast NP* Glassia* (PA) Kalydeco* (PA) Letairis* (PA) Nucala* (PA) Ofev* (PA) Opsumit* (PA) Orenitram ER* (PA) Orkambi* (PA) Pulmicort Respules Remodulin* (PA) Tracleer* (PA) Tyvaso* (PA) Uptravi* (PA)
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
dexmethylphenidate dexmethylphenidate ER dextroamphetamine-amphetamine ER dextroamphetamine-amphetamine guanfacine ER Metadate ER	Vyvanse	Adderall (ST) Adderall XR (ST) Aptensio XR (ST) Concerta ER (ST) Focalin (ST) Focalin XR (ST) Methylin (ST) Mydayis ER Quillichew ER (ST)

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
ATTENTION DEFICIT HYPERACTIVITY DISORDER *(cont)*		
methylphenidate methylphenidate CD methylphenidate ER methylphenidate LA		Quillivant XR (ST) Ritalin (ST) Ritalin LA (ST) Strattera
BLOOD MODIFIERS/BLEEDING DISORDERS		
tranexamic acid*	Amicar 1g* Aranesp* (PA) Droxia Epogen* (PA) Granix* Neulasta* (PA) Procrit* (PA) Soliris* (PA) Zarxio*	Amicar solution, 500mg* Bebulin* (PA) Ceprotin* Neupogen* (PA) Promacta* (PA)
BLOOD PRESSURE/HEART MEDICATIONS		
Afeditab CR amiodarone amlodipine amlodipine-benazepril amlodipine-valsartan amlodipine-valsartan-HCTZ Aspir 81+ aspirin 81mg+ aspirin EC 81mg+ Aspir-low+ atenolol atenolol-chlorthalidone benazepril benazepril- HCTZ candesartan Cartia XT carvedilol children's aspirin+ clonidine Digitek Digox digoxin diltiazem diltiazem ER Dilt-XR dofetilide (QL) doxazosin EcPirin+ enalapril flecainide	Bystolic Byvalson Coreg CR Corlanor (PA) Entresto (PA) Multaq Nitro-Dur 0.3mg, 0.8mg Tekturna Tekturna HCT	Azor Bayer chewable aspirin+ Benicar (ST) Benicar HCT (ST) Berinert* (PA) BiDil (QL) Cardizem LA Cinryze* (PA) Cozaar (ST) Diovan (ST) Diovan HCT (ST) Ecotrin+ Edarbi (ST) Edarbyclor (ST) Exforge Exforge HCT Firazyr* (PA) Haegarda* (PA) Hemangeol Inderal LA Inderal XL Innopran XL Lotrel Micardis (ST) Nitro-Dur 0.1mg, 0.2mg, 0.4mg, 0.6mg Nitrolingual Nitromist Nitrostat Northera* (PA) Norvasc

TIER 1 $	TIER 2 $$	TIER 3 $$$
BLOOD PRESSURE/HEART MEDICATIONS *(cont)*		
hydralazine irbesartan isosorbide isosorbide ER labetalol lisinopril lisinopril- HCTZ losartan losartan- HCTZ low-dose aspirin EC+ Matzim LA metoprolol nadolol nifedipine nifedipine ER nisoldipine olmesartan olmesartan- HCTZ Pacerone propafenone propafenone ER propranolol propranolol ER ramipril Taztia XT telmisartan telmisartan- HCTZ tri-buffered aspirin+ valsartan valsartan- HCTZ verapamil verapamil ER verapamil SR		Ranexa (ST, QL) Tiazac Tikosyn (QL) Toprol XL Tribenzor
BLOOD THINNERS/ANTI-CLOTTING		
aspirin-dipyridamole ER clopidogrel enoxaparin* (QL) fondaparinux* (QL) Jantoven warfarin	Brilinta Effient Eliquis Fragmin* (QL) Xarelto	Pradaxa Savaysa
CANCER		
anastrozole bexarotene* capecitabine* exemestane hydroxyurea imatinib* (PA) letrozole	Actimmune* (PA) Avastin* (PA) Gleostine Herceptin* (PA) Intron A* (PA)	Afinitor Disperz* (PA) Afinitor* (PA) Alecensa* (PA) Arimidex Bosulif* (PA) Cabometyx* (PA) Cometriq* (PA)

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
CANCER *(cont)*		
mercaptopurine methotrexate* raloxifene+ tamoxifen+ temozolomide* (PA)	Nexavar* (PA) Revlimid* (PA) Rituxan* (PA) Sprycel* (PA) Sutent* (PA) Tarceva* (PA) Tasigna* (PA) Trexall* Valstar*	Cotellic* (PA) Erivedge* (PA) Fareston (QL) Femara Gazyva* (PA) Gilotrif* (PA) Gleevec* (PA) Ibrance* (PA) Iclusig* (PA) Imbruvica* (PA) Inlyta* (PA) Jakafi* (PA) Kadcyla* (PA) Lenvima* (PA) Lonsurf* (PA) Lynparza* (PA) Mekinist* (PA) Ninlaro* (PA) Perjeta* (PA) Pomalyst* (PA) Purixan* Stivarga* (PA) Sylatron* (PA) Tafinlar* (PA) Tagrisso* (PA) Targretin* Tecentriq* (PA) Votrient* (PA) Xalkori* (PA) Xatmep* Xtandi* (PA) Zelboraf* (PA) Zykadia* (PA) Zytiga* (PA)
CHOLESTEROL MEDICATIONS		
amlodipine-atorvastatin atorvastatin atorvastatin 10m, 20mg+ fenofibrate fenofibric acid fluvastatin 20mg, 40mg+ fluvastatin ER 80mg+ lovastatin 20mg, 40mg+ niacin ER omega-3 acid ethyl esters pravastatin+	Praluent* (PA) Repatha* (PA) Welchol	Crestor (ST) Korlym (PA) Kynamro* (PA) Livalo (ST) Vascepa Vytorin (ST) Zetia

TIER 1 $	TIER 2 $$	TIER 3 $$$
CHOLESTEROL MEDICATIONS *(cont)*		
rosuvastatin rosuvastatin 5mg, 10mg+ simvastatin simvastatin 10mg, 20mg, 40mg+		
CONTRACEPTIVE PRODUCTS		
Aftera+ Altavera+ Alyacen+ Amethia+ Amethia LO+ Apri+ Aranelle+ Ashlyna+ Aubra+ Aviane+ Azurette+ Balziva+ Bekyree+ Blisovi 24 FE+ Blisovi FE+ Briellyn+ Camila+ Camrese+ Camrese LO+ Caya Contoured+ Caziant+ Chateal+ Cryselle+ Cyclafem+ Cyred+ Dasetta+ Daysee+ Deblitane+ Delyla+ desogestr-eth estrad eth estra+ drospirenone-eth estra-levomef+ drospirenone-ethinyl estradiol+ Econtra EZ+ Elinest+ Emoquette+ Enpresse+ Enskyce+ Errin+ Estarylla+ ethynodiol-ethinyl estradiol+ Fallback Solo+	Beyaz Lo Loestrin FE LoSeasonique Minastrin 24 FE NuvaRing+ Seasonique Taytulla	Conceptrol+ Ella+ Estrostep FE Kyleena* Layolis FE+ Loestrin FE Microgestin+ Microgestin 24 FE+ Microgestin FE+ Mirena* Rivelsa+ Skyla* Take Action+ Trinessa Lo+ Today Contraceptive Sponge+ VCF+

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
CONTRACEPTIVE PRODUCTS *(cont)*		
Falmina+		
Fayosim+		
FC2 Female Condom+		
Femcap+		
Femynor+		
Gianvi+		
Gildagia+		
Gynol II+		
Heather+		
Introvale+		
Jencycla+		
Jolessa+		
Jolivette+		
Juleber+		
Junel+		
Junel FE+		
Junel FE 24+		
Kaitlib FE+		
Kariva+		
Kelnor 1-35+		
Kimidess+		
Kurvelo+		
Larin+		
Larin 24 FE+		
Larin FE+		
Larissia+		
Leena+		
Lessina+		
Levonest+		
levonorgestrel+		
levonorgestrel-eth estradiol+		
levonorg-eth estrad eth estrad+		
Levora+		
Lomedia 24 FE+		
Loryna+		
Low-Ogestrel+		
Lutera+		
Lyza+		
Marlissa+		
Mibelas 24 FE+		
Mono-Linyah+		
Mononessa+		
My Way+		
Myzilra+		
Necon+		
Next Choice One Dose+		
Nikki+		
Nora-Be+		
norethindrone+		

TIER 1 $	TIER 2 $$	TIER 3 $$$
CONTRACEPTIVE PRODUCTS *(cont)*		
norethindron-ethinyl estradiol+		
norethin-eth estra-ferrous+		
norgestimate-ethinyl estradiol+		
Norlyda+		
Norlyroc+		
Nortrel+		
Ocella+		
Opcicon One-Step+		
Option 2+		
Orsythia+		
Philith+		
Pimtrea+		
Pirmella+		
Portia+		
Previfem+		
Quasense+		
Rajani+		
React+		
Reclipsen+		
Rivelsa+		
Setlakin+		
Sharobel+		
Sprintec+		
Sronyx+		
Syeda+		
Tarina FE+		
Tilia FE+		
Tri Femynor+		
Tri-Estarylla+		
Tri-Legest FE+		
Tri-Linyah+		
Tri-LO-Estarylla+		
Tri-LO-Marzia+		
Tri-LO-Sprintec+		
Trinessa+		
Tri-Previfem+		
Tri-Sprintec+		
Velivet+		
Vestura+		
Vienva+		
Viorele+		
Vyfemla+		
Wera+		
Wide Seal Diaphragm+		
Wymzya FE+		
Xulane+		
Zarah+		
Zenchent+		
Zenchent FE+		
Zovia+		

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
COUGH/COLD MEDICATIONS		
benzonatate Bromfed DM brompheniramine-pseudoephedrine-DM hydrocodone BT-homatropine (QL) hydrocodone-chlorpheniramine ER (QL) Hydromet (QL) promethazine-codeine (QL) Tussigon (QL)		Flowtuss (QL) Hycofenix (QL) Tussionex (QL) Tuzistra XR (QL)
DENTAL PRODUCTS		
chlorhexidine Denta 5000 Plus Dentagel doxycycline fluoride 0.25mg, 0.5mg+ fluoride 1mg Fluoridex Fluoritab 0.5mg+ Fluoritab 1mg Flura-Drops+ Ludent fluoride 0.25mg, 0.5mg+ Ludent fluoride 1mg Oralone Paroex Peridex Periogard SF SF 5000 Plus sodium fluoride triamcinolone	Fluorabon+ Fluor-a-Day+ Prevident 5000	Clinpro 5000 Floriva Prevident Prevident 5000 Plus
DIABETES		
glimepiride glipizide glipizide ER glipizide XL metformin metformin ER	Basaglar Bydureon (QL) Byetta Farxiga Glucagen HypoKit (QL) Glucagon Emergency Kit (QL) Humalog Humulin Janumet Janumet XR	Cycloset Glucophage Glucophage XR Riomet VGo

TIER 1 $	TIER 2 $$	TIER 3 $$$
DIABETES *(cont)*		
	Januvia Jardiance Kombiglyze XR Levemir OneTouch test strips and meters Onglyza Soliqua SymlinPen Synjardy Synjardy XR Tresiba TechLite lancets Trulicity (QL) Xigduo XR	
DIURETICS		
acetazolamide chlorthalidone eplerenone furosemide hydrochlorothiazide spironolactone triamterene-HCTZ		Aldactazide Aldactone Dyazide Maxzide Samsca*
EAR MEDICATIONS		
fluocinolone oil neomycin-polymyxin-HC	Cipro HC Ciprodex	
ERECTILE DYSFUNCTION		
	Cialis (PA, QL) Muse (PA, QL) Viagra (PA, QL)	
EYE CONDITIONS		
brimonidine ciprofloxacin dorzolamide-timolol erythromycin fluorometholone gatifloxacin latanoprost neomycin-polymyxin-dexameth ofloxacin olopatadine polymyxin B sul-trimethoprim prednisolone	Alphagan P 0.1% Azasite Azopt Betimol Betoptic S Lotemax drops, suspension Moxeza Pataday Pazeo Pred Mild Restasis Simbrinza	Acuvail Alphagan P 0.15% Alrex Bepreve Besivance Bromsite Combigan Cosopt PF Cystaran (QL) Durezol Eylea* (PA) Ilevro Iluvien* Lastacaft Lotemax ointment

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
EYE CONDITIONS *(cont)*		
timolol tobramycin tobramycin-dexamethasone	Tobradex ointment Travatan Z Vigamox Xiidra	Lucentis* (PA) Lumigan Nevanac Omnipred Ozurdex Patanol Pred Forte Prolensa Tobradex drops Tobradex ST Zioptan (ST, QL) Zirgan Zylet
FEMININE PRODUCTS		
Fem pH Gynazole 1 miconazole 3 terconazole		AVC Relagard Terazol 7
GASTROINTESTINAL/HEARTBURN		
Alophen+ alosetron Anucort-HC balsalazide bisacodyl+ Bisa-lax+ chlordiazepoxide-clidinium Clearlax+ dicyclomine diphenoxylate-atropine dronabinol Ducodyl+ esomeprazole famotidine Gavilyte-C+ Gavilyte-G+ Gavilyte-N+ Gentle laxative+ Glycolax+ Healthylax+ Hemmorex-HC hydrocortisone lansoprazole lansoprazole-amoxicillin-clarithromycin (combo pak) mesalamine metoclopramide metoclopramide ODT	Apriso Canasa Carafate suspension Creon Dexilant GoLytely powder+ Lialda Nexium (ST) Pentasa Proctofoam-HC Zenpep	Aciphex (ST) Akynzeo* (PA, QL) Amitiza Carafate tablet Chenodal Cholbam* (PA) Colyte With Flavor Packets+ Correctol+ Diclegis Donnatal Dulcolax+ Emend* (PA, QL) Entyvio* (PA) Gattex* (PA) Gialax+ GoLytely solution+ Linzess Miralax+ Movantik (PA) Moviprep+ NuLytely with Flavor Packs+ Ome-PPI Osmoprep+ Pancreaze Pertzye Prepopik Prevacid (ST) Procort Protonix powder Protonix tablet (ST)

TIER 1 $	TIER 2 $$	TIER 3 $$$
GASTROINTESTINAL/HEARTBURN *(cont)*		
omeprazole ondansetron ondansetron ODT pantoprazole peg 3350+ peg 3350-electrolyte+ peg 3350 with flavor packets+ Phenadoz Powderlax+ promethazine promethegan Purelax+ rabeprazole ranitidine Smoothlax+ sucralfate TriLyte with flavor packets+ ursodiol		Protonix IV Ravicti (PA) Rectiv Relistor (PA) Sancuso (PA, QL) Sensipar* sfRowasa Suprep+ Sustol (PA) Varubi* (PA, QL) Viberzi Viokace
HORMONAL AGENTS		
Amabelz budesonide EC cabergoline (QL) Covaryx Covaryx H.S. desmopressin* dexamethasone dexamethasone intensol EEMT EEMT H.S. estradiol estradiol (QL) estradiol-norethindrone estrogen & methyltestosterone levothyroxine Levoxyl liothyronine LoCort medroxyprogesterone methylprednisolone Millipred Millipred DP Mimvey Mimvey LO Nature-Throid norethindrone NP Thyroid	Androderm (PA, QL) Androgel (PA, QL) Armour Thyroid Cytomel 50mcg Divigel Duavee Estring (QL) Forteo* Ganirelix* ^ Humatrope* (PA) Lupron Depot* (PA) Lupron Depot-Ped* (PA) Premarin Premphase Prempro Serostim 4mg, 6mg* (PA) Somavert* (PA) Synthroid	Activella Alora (QL) Armour Thyroid Aveed (PA) Climara Climara Pro Combipatch Cytomel 5mcg, 25mcg Deltasone Depo-Testosterone Egrifta* (PA) Elestrin Emflaza* (PA) Entocort EC Estrace Estrogel Evamist Femring H.P. Acthar* (PA) Levo-T Lupron Depot-Ped 30mg kit* (PA) Menostar (QL) Minivelle (QL) Natpara* (PA) Osphena Rayaldee Saizen-saizenprep* (PA)

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
HORMONAL AGENTS *(cont)*		
prednisolone prednisolone ODT prednisone prednisone intensol progesterone testosterone (PA) testosterone cypionate Westhroid WP Thyroid Yuvafem (QL)		Serostim 5mg* (PA) Somatuline Depot* (PA) Striant (PA, QL) Supprelin LA* Testopel (PA) Thyrogen* Tirosint Triostat Unithroid Vagifem (QL) Vivelle-Dot (QL) Zorbtive* (PA)
INFECTIONS		
acyclovir adefovir* amoxicillin amoxicillin-clavulanate ER amoxicillin-clavulanate atovaquone atovaquone-proguanil Avidoxy azithromycin cefdinir cefixime cefuroxime cephalexin ciprofloxacin clarithromycin clarithromycin ER clindamycin dapsone doxy 100 doxycycline doxycycline IR-DR entecavir* erythromycin famciclovir fluconazole hydroxychloroquine itraconazole levofloxacin linezolid (PA) metronidazole minocycline minocycline ER Moderiba* mondoxyne NL Morgidox	Albenza Baraclude solution* Ceftin 125mg suspension Cipro Daraprim (PA) Epclusa* (PA) Harvoni* (PA) Kitabis Pak* Sovaldi* (PA) Tamiflu suspension (QL) Thalomid* (PA)	Alinia Bactrim Bactrim DS Baraclude tablet* Cayston* Ceftin 250mg suspension Cleocin Clindesse Cresemba (PA) Daklinza* (PA) Dificid (PA) E.E.S. 400 Eryped 200 Ery-Tab Metrogel-vaginal Minocin Monurol Noxafil Nuvessa PCE PegIntron* (PA) Plaquenil Sulfatrim Suprax Synagis* (PA) Tamiflu capsule (QL) Tobi Podhaler* Uretron D-S Uribel Urogesic-blue Uta Valtrex vibramycin Viekira Pak* (PA) Viekira XR* (PA) Xifaxan Zepatier* (PA)

TIER 1 $	TIER 2 $$	TIER 3 $$$
INFECTIONS *(cont)*		
moxifloxacin nitrofurantoin nitrofurantoin mono-macro nystatin oseltamivir (QL) penicillin sulfamethoxazole-trimethoprim terbinafine tetracycline tinidazole tobramycin* valacyclovir valganciclovir vancomycin vandazole voriconazole (PA)		Zithromax Zmax
INFERTILITY		
clomiphene citrate ^	Crinone 8%^ Endometrin^ Follistim AQ*^	Gonal-F*^ Makena (PA) Menopur*^
MISCELLANEOUS		
disulfiram NebuSal 3% PulmoSal tetrabenazine* (PA)	Cerdelga* (PA) Orfadin* Vivitrol*	Addyi (QL) Botox* (PA) Cerezyme* (PA) Dysport* Esbriet* (PA) Exjade* Ferriprox Hyper-Sal Jadenu* Kuvan* (PA) Lumizyme* (PA) Myalept* (PA) Naglazyme* (PA) NebuSal 6% Nuedexta (QL) Strensiq* (PA) Syprine* (PA) Vimizim* (PA) VPRIV* (PA) Xenazine* (PA) Xeomin* (PA) Zavesca* (PA)

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
MULTIPLE SCLEROSIS		
Glatopa* (PA)	Ampyra* (PA) Aubagio* (PA) Avonex* (PA) Betaseron* (PA) Copaxone* (PA) Extavia* (PA) Gilenya* (PA) Plegridy* (PA) Rebif* (PA) Tecfidera* (PA)	Lemtrada* (PA) Ocrevus* (PA) Tysabri* (PA) Zinbryta* (PA)
NUTRITIONAL/DIETARY		
B-12 compliance Baby D Drops+ Baby Vitamin D3+ calcitriol calcium children's iron+ cyanocobalamin injection D3-2000+ Daily prenatal+ DDrops+ Delta D3+ Dialyvite Vitamin D3 Max+ D-vi-sol+ D-vita+ FA-8+ fer-iron+ folic acid+ Folixapure Klor-Con M10, M20 Klor-Con Sprinkle levocarnitine multivitamin with fluoride+ multivitamin-iron-fluoride+ PNV-DHA polyvitamin with iron+ polyvitamin-fluoride+ potassium chloride Prena1 Pearl Prenatal + Prenatal Complete+ Prenatal Formula+	CitraNatal Fosrenol Klor-Con M15 K-Tab ER 20meq Mephyton Nestabs DHA OB Complete Prefera OB Prenate Renvela tablet Select-OB + DHA Tristart DHA Tri-vi-flor+ Vitafol vitaMedMD One Rx vitaPearl	Auryxia (QL) Concept DHA D3-50+ Decara+ Dialyvite vitamin D+ Escavite+ Escavite D+ Fer-in-sol+ Feriva 21-7 Ferralet 90 Floriva+ Icar+ Integra Plus Ironup+ Just D+ Klor-Con 8, 10meq Klor-Con 8 K-Tab ER 8meq, 10meq KPN Prenatal+ MVC-fluoride+ Maximum D3+ Nascobal Novaferrum drops+ Optimal D3 M+ Perry Prenatal+ Phoslyra Physicians EZ Use B-12 Poly-Vi-Flor+ Poly-Vi-Flor FS+ Poly-Vi-Flor With Iron+ Poly-vi-sol With Iron+ Prenatal Formula-DHA+

TIER 1 $	TIER 2 $$	TIER 3 $$$
NUTRITIONAL/DIETARY *(cont)*		
Prenatal Multi + DHA+ Prenatal multivitamin+ Prenatal multivitamin-DHA+ Prenatal Plus Prenatal Vitamin+ prenatal vitamin plus low iron PrePlus Virt-PN DHA vitamin D2 Vitajoy daily D+ vitamins A, C, D and fluoride+ vitamin D+ vitamin D3+ vitamin D-400+ Wee care+ Zatean-PN DHA Zavara		Quflora+ Renagel Renvela powder Replesta+ Replesta NX+ Super Daily D3+ Texavite LQ + Thera-D+ Urosex+ Velphoro
OSTEOPOROSIS PRODUCTS		
alendronate (QL) calcitonin-salmon ibandronate* raloxifene risedronate risedronate DR		Actonel (ST) Atelvia (ST) Prolia* (PA) Xgeva* (PA)
PAIN RELIEF AND INFLAMMATORY DISEASE		
acetaminophen-codeine (PA, QL) acitretin allopurinol baclofen butalb-acetaminoph-caff-codeine (PA, QL) butalb-caff-acetaminoph-codeine (PA, QL) butalbital-acetaminophen-caff (QL) Capacet (QL) carisoprodol celecoxib (QL) cyclobenzaprine DermacinRx Empricaine DermacinRx Prizopak	Butrans (QL) Colcrys Cuprimine* (PA) Depen* (PA) Embeda (PA, QL) Enbrel* (PA) Humira* (PA) Hysingla ER (PA, QL) Nucynta (PA, QL) Otezla* (PA) Rasuvo* (PA) Remicade* (PA) Savella Subsys (PA, QL)	Abstral (PA, QL) Actemra* (PA) Actiq (PA, QL) Analpram HC Arymo ER (PA, QL) Benlysta* (PA) Buprenex Celebrex (ST, QL) Cimzia* (PA) colchicine Cosentyx* (PA) Duragesic (PA, QL) Fentora (PA, QL) Fexmid Flector (ST, QL) Frova (QL) Gelsyn-3* (PA) Ilaris* (PA) Indocin Lazanda (PA, QL)

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
PAIN RELIEF AND INFLAMMATORY DISEASE *(cont)*		
diclofenac 0.1% gel (QL)	Uloric	Lidoderm
diclofenac ER	Xtampza ER (PA, QL)	Mitigare
diclofenac-misoprostol		Monovisc* (PA)
dihydroergotamine (QL)		Morphabond ER (PA, QL)
Endocet (PA, QL)		Nucynta ER (PA, QL)
etodolac		Onzetra Xsail (QL)
etodolac ER		Orencia* (PA)
fentanyl (PA, QL)		Orthovisc* (PA)
frovatriptan (QL)		Otrexup* (PA)
Glydo		Oxaydo (PA, QL)
hydrocodone-acetaminophen (PA)		Parafon Forte DSC
hydromorphone (PA, QL)		Pennsaid (ST)
hydromorphone ER (PA, QL)		Percocet (PA, QL)
ibuprofen		Relpax (QL)
indomethacin		Simponi Aria* (PA)
indomethacin ER		Simponi* (PA)
ketorolac (QL)		Stelara* (PA)
leflunomide		Synvisc* (PA)
lidocaine (QL)		Synvisc-One* (PA)
lidocaine viscous		Taltz* (PA)
lidocaine-prilocaine		Voltaren (ST, QL)
Lidopril		Xeljanz XR* (PA)
Lidopril XR		Xeljanz* (PA)
Lido-Prilo Caine Pack		Zohydro ER (PA, QL)
LiproZonePak		
Livixil Pak		
Lorcet (PA, QL)		
Lorcet HD (PA, QL)		
Lorcet Plus (PA, QL)		
Lortab (PA, QL)		
Medolor Pak		
meloxicam		
Metaxall		
metaxalone		
methocarbamol		
morphine (PA, QL)		
morphine ER (PA, QL)		
nabumetone		
naproxen		
naproxen DS		
oxycodone (PA, QL)		
oxycodone ER (PA, QL)		
oxycodone-acetaminophen (PA, QL)		

TIER 1 $	TIER 2 $$	TIER 3 $$$
PAIN RELIEF AND INFLAMMATORY DISEASE *(cont)*		
oxymorphone (PA, QL)		
oxymorphone ER (PA, QL)		
Prilolid		
Primlev (PA, QL)		
Relador Pak		
Relador Pak Plus		
rizatriptan (QL)		
sumatriptan (QL)		
tizanidine		
tramadol (QL)		
tramadol ER (QL)		
Vicodin (PA, QL)		
Vicodin ES (PA, QL)		
Vicodin HP (PA, QL)		
zolmitriptan (QL)		
zolmitriptan ODT (QL)		
PARKINSON'S DISEASE		
benztropine	Apokyn* (PA)	Mirapex
bromocriptine	Azilect	Mirapex ER
carbidopa-levodopa		Neupro
carbidopa-levodopa ER		Rytary
carbidopa-levodopa-entacapone		Sinemet
pramipexole		Sinemet CR
pramipexole ER		Tasmar
ropinirole		
ropinirole ER		
SCHIZOPHRENIA/ANTI-PSYCHOTICS		
aripiprazole		Abilify Maintena (QL)
aripiprazole ODT		Aristada (QL)
chlorpromazine		Invega (ST)
clozapine		Invega Sustenna (QL)
clozapine ODT		Invega Trinza (QL)
haloperidol		Latuda (ST)
olanzapine		Rexulti (ST)
olanzapine ODT		Risperdal (ST)
olanzapine-fluoxetine		Risperdal M-tab (ST)
paliperidone ER		Saphris (ST)
quetiapine		Seroquel (ST)
quetiapine ER		Seroquel XR (ST)
risperidone		Vraylar (ST)
risperidone ODT		
ziprasidone		

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
SEIZURE DISORDERS		
carbamazepine	Keppra	Aptiom
carbamazepine ER	Lamictal ODT	Banzel (QL)
clonazepam	Lamictal XR dose pack	Briviact
divalproex	Lyrica	Carbatrol
divalproex ER	Vimpat	Depakote
Epitol		Depakote ER
gabapentin		Depakote Sprinkle
lamotrigine		Dilantin
lamotrigine ER		Fycompa
lamotrigine ODT		Keppra
levetiracetam		Keppra XR
levetiracetam ER		Lamictal
oxcarbazepine		Lamictal XR
Roweepra		Oxtellar XR
topiramate		Phenytek
		Qudexy XR
		Sabril*
		Spritam
		Tegretol
		Tegretol XR
		Topamax
		topiramate ER
		Trileptal
		Trokendi XR
		Vimpat vial
SKIN CONDITIONS		
acitretin	Aczone	Acanya
acyclovir	Azelex	Atralin (PA age)
adapalene (PA age)	Denavir (QL)	Avar pads
Ala-Cort	Differin (PA age)	Avar LS
Amnesteem (QL)	Epiduo	Avita (PA age)
Avar cleanser	Epiduo Forte	Cleocin T
Avar-E	Eucrisa	Cordran (ST)
BP 10-1	Exelderm solution	Desonate (ST)
calcipotriene	Finacea	Desowen (ST)
calcipotriene-betamethasone DP	Fluoroplex	Drysol
calcitrene	Metrogel	Efudex
Claravis (QL)	Naftin	Elidel
Clindacin ETZ	Tazorac	Enstilar
Clindacin P		Evoclin
clindamycin		Exelderm cream
clindamycin-benzoyl peroxide		Metrocream
clobetasol		Metrolotion
Clodan		Nizoral
clotrimazole-betamethasone		Olux (ST)
Cormax		Onexton
desonide		Picato
diclofenac 0.3% gel		Retin-A (PA age)
doxepin		Retin-A Micro (PA age)
		Sklice
		Soolantra

TIER 1 $	TIER 2 $$	TIER 3 $$$
SKIN CONDITIONS *(cont)*		
econazole		Taclonex
fluocinonide		Targretin*
fluorouracil		Temovate (ST)
hydrocortisone		Tolak
imiquimod		Topicort (ST)
ketoconazole		Tretin-X
metronidazole		Tridesilon (ST)
mupirocin		Veltin
Myorisan (QL)		Xolegel
Neuac gel		
nystatin-triamcinolone		
Permethrin		
Procto-Med HC		
Procto-Pak		
Proctosol-HC		
Proctozone-HC		
Rosadan		
Rosanil		
Scalacort		
sodium sulfaceta-mide-sulfur		
SS 10-2		
SSS 10-5		
SulfaCleanse 8-4		
tacrolimus		
tretinoin (PA age)		
tretinoin microsphere (PA age)		
triamcinolone		
Triderm		
Zenatane (QL)		
SLEEP DISORDERS/SEDATIVES		
armodafinil (PA)	Belsomra (ST)	Xyrem* (PA)
eszopiclone	Silenor (ST)	Zolpimist (ST)
modafinil (PA)		
temazepam		
zolpidem		
zolpidem ER		
SMOKING CESSATION		
bupropion SR+	Chantix (QL)	Nicorette lozenge, gum+
Nicoderm CQ+	Nicotrol (QL)	Zyban
Nicorelief+	Nicotrol NS (QL)	
nicotine gum+		
nicotine lozenge+		
nicotine patch+		
NTS+		
Quit 2+		
Quit 4+		
stop smoking aid+		

Cigna Performance 3-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
SUBSTANCE ABUSE		
buprenorphine buprenorphine-naloxone naloxone naltrexone (QL)	Bunavail Narcan Probuphine Suboxone Zubsolv	
TRANSPLANT MEDICATIONS		
azathioprine* mycophenolate* mycophenolic acid* sirolimus* tacrolimus*	Cellcept* Neoral* Prograf*	Astagraf XL* Envarsus XR* Myfortic*
URINARY TRACT CONDITIONS		
cevimeline dutasteride finasteride oxybutynin oxybutynin ER phenazopyridine potassium ER tamsulosin tolterodine tolterodine ER	Cystagon* Elmiron Thiola	Avodart Jalyn Procysbi* (PA) Rapaflo

Medications that are not covered

The medications listed below aren't covered on your plan's drug list.^^ If you fill a prescription for any of these medications, you'll have to pay the full cost of the medication. You should think about switching to a covered alternative.^^ We've listed some alternatives below for you to talk about with your doctor.

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
ALLERGY/NASAL SPRAYS	Auvi-Q EpiPen EpiPen Jr	epinephrine auto-injector
	Beconase AQ Dymista Nasonex Omnaris QNASL Zetonna	Generic nasal steroids (e.g., fluticasone)
	QNASL Children	budesonide fluticasone triamcinolone
ANXIETY/DEPRESSION/BIPOLAR DISORDER	Aplenzin	bupropion XL
	Anafranil	clomipramine
	Ativan	lorazepam
	Cymbalta	duloxetine
	Lexapro	escitalopram
	Pamelor	nortripyline
	Parnate	tranylcypromine
	Pexeva	paroxetine
	Tofranil	imipramine
	Wellbutrin XL	bupropion XL (ER 24hr tablet)
ASTHMA/COPD/RESPIRATORY	Aerospan Alvesco Arnuity Ellipta Asmanex Asmanex HFA Flovent Diskus Flovent HFA	QVAR
	Bevespi	Anoro Ellipta Stiolto Respimat
	AirDuo RespiClick Dulera	Advair Diskus Advair HFA Breo Ellipta
	Proventil HFA Xopenex HFA	ProAir HFA ProAir RespiClick
	Seebri Neohaler Tudorza Pressair	Spiriva Spiriva Respimat
	Utibron Neohaler	Anoro Ellipta
	Zyflo	zileuton ER montelukast zafirlukast
	Zyflo CR	zileuton ER

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
ATTENTION DEFICIT HYPERACTIVITY DISORDER	Desoxyn	methamphetamine
	Dexedrine	dextroamphetamine ER
BLOOD PRESSURE/HEART MEDICATIONS	Betapace	sotalol
	Cardizem	diltiazem
	Cardizem CD	diltiazem CD/ER Cartia XT
	Isordil Isordil Titradose	isosorbide dinitrate
	Lanoxin	Digitek digoxin
BLOOD THINNERS/ANTI-CLOTTING	Yosprala	aspirin or asprin EC with omeprazole
CANCER	Nilandron	nilutamide
CHOLESTEROL MEDICATIONS	Antara Fenoglide	fenofibrate
	Lipitor	atorvastatin
COUGH/COLD MEDICATIONS	Tussicaps	hydrocodone-chlorpheniramine ER
		promethazine-codeine
DENTAL PRODUCTS	Arestin	minocycline
DIABETES	Accu-Chek, Contour, Freestyle, all other test strips	OneTouch Ultra, OneTouch Verio
	Afrezza Apidra Apidra SoloStar	Humalog
	Fortamet Glumetza metformin ER (generic Fortamet and generic Glumetza)	metformin ER (generic Glucophage XR)
	Invokamet Invokamet XR	Synjardy, Synjardy XR Xigduo XR
	Invokana	Farxiga
	Jentadueto Jentadueto XR Kazano Nesina	Janumet, Janumet XR
	Kombiglyze XR Onglyza Oseni Tradjenta	alogliptin alogliptin-metformin Januvia, Janumet, Janumet XR
	Lantus Toujeo SoloStar	Basaglar Levemir Tresiba
	Novolin, Novolog	Humalog, Humulin
	Tanzeum Victoza	Byetta Bydureon Trulicity
DIURETICS	Edecrin ethacrynic acid	bumetanide furosemide torsemide

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
GASTROINTESTINAL/HEARTBURN	Anusol-HC suppository Cortifoam Uceris foam	Anucort-HC Hemmorex-HC hydrocortisone suppository
	Asacol-HD Colazal Delzicol Dipentum Giazo mesalamine tablet	Apriso balsalazide Lialda Pentasa sulfasalazine sulfasalazine DR
	Librax	chlordiazepoxide-clidinium
	Lotronex	alosetron
	Marinol	dronabinol
	Nexium capsule	esomeprazole
	Omeclamox-pak Prevpac Pylera	lansoprazole-amoxicillin-clarithromycin pak
	omeprazole-bicarbonate Zegerid	omeprazole
	Pepcid	famotidine
	Prevacid SoluTab	Generic prescription PPIs (e.g., lansoprazole)
	Rowasa	mesalamine enema
	Trulance	Amitiza, Linzess
	Zofran	ondansetron
	Zofran ODT	ondansetron ODT
	Zuplenz	ondansetron ondansetron ODT
HORMONAL AGENTS	Axiron Fortesta Natesto Testim Vogelxo	Androgel testosterone
	Cortrosyn	cosyntropin
	DDAVP	desmopressin
	Dexpak Zonacort	dexamethasone
	Genotropin Norditropin Nutropin AQ Omnitrope Saizen Zomacton	Humatrope (PA)
	Hectorol	doxercalciferol
	Rayos	prednisone prednisone intensol
	Uceris tablet	budesonide EC

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
INFECTIONS	Acticlate Doryx Minocin capsule Monodox Oracea Solodyn vibramycin capsule	Generic products (e.g., doxycycline; minocycline)
	Augmentin/ES/XR	amoxicillin-clavulanate ER
	Bethkis Tobi	Kitabis Pak tobramycin
	Diflucan	fluconazole
	E.E.S. 200 Eryped 400	erythromycin ethylsuccinate
	Mepron	atovaquone
	Onmel	itraconazole terbinafine
	Sitavig	acyclovir
	Sporanox	itraconazole
	Targadox	tobramycin
	Valcyte	valganciclovir
	Vancocin	vancomycin
	Zovirax	acyclovir
MISCELLANEOUS	Horizant	gabapentin
PAIN RELIEF AND INFLAMMATORY DISEASE	Amrix	cyclobenzaprine Other generic muscle relaxants
	Belbuca	buprenorphine
	Bupap	butalbital-acetaminophen Marten-Tab Tencon
	Cambia diclofenac drops Duexis Naprelan naproxen CR naproxen ER Pennsaid Tivorbex Vimovo Vivlodex Zipsor Zorvolex	Generic prescription NSAIDs (e.g., celecoxib, meloxicam)
	Conzip	tramadol tramadol ER
	D.H.E 45	dihydroergotamine
	Gralise	gabapentin
	Imitrex Sumavel DosePro Zembrace SymTouch	sumatriptan

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
PAIN RELIEF AND INFLAMMATORY DISEASE *(cont)*	levorphanol	Generic products (e.g., acetaminophen-codeine, hydromorphone, oxycodone)
	Lido-K	lidocaine cream, ointment
	Lorzone	chlorzoxazone
	Migranal	dihydroergotamine
	OxyContin	Xtampza ER (PA) Embeda ER (PA) Hysingla ER (PA)
	Roxicodone	oxycodone
	Sprix	ketorolac
	Treximet	Generic NSAIDs Generic triptans (e.g., sumatriptan, naratriptan)
	Vanatol LQ	butalbital-acetaminophen-caffe
	Zomig	zolmitriptan sumatriptan
	Zomig ZMT	zolmitriptan ODT
PARKINSON'S DISEASE	Lodosyn	carbidopa
	Requip XL	ropinirole ER
SCHIZOPHRENIA/ANTI-PSYCHOTICS	Abilify	aripiprazole
	Fazaclo Versacloz	clozapine clozapine ODT
	Geodon	ziprasidone
	Zyprexa	olanzapine
	Zyprexa Zydis	olanzapine ODT
SEIZURE DISORDERS	Mysoline	primidone
SKIN CONDITIONS	Absorica	Claravis Myorisan Zenatane
	Aldara Zyclara	imiquimod
	Anusol-HC cream	hydrocortisone Procto-Med HC Proctosol-HC Proctozone-HC
	Bensal HP	salicylic acid
	Benzaclin Duac Neuac kit	clindamycin-benzoyl peroxide Neuac gel
	Carac	fluorouracil
	Clindagel	clindamycin
	Clobex	clobetasol
	Cutivate	Generic topical steroid (e.g. betamethasone)
	Ertaczo Extina Luzu Vusion	ketoconazole

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
SKIN CONDITIONS *(cont)*	Halog Ultravate X	clobetasol halobetasol
	Jublia Kerydin	Ciclodan ciclopirox itraconazole terbinafine
	Kenalog	triamcinolone
	Locoid Locoid Lipocream	hydrocortisone
	Loprox	ciclopirox
	Noritate	metronidazole Rosadan
	Oxistat	clotrimazole econazole ketoconazole
	Penlac	Ciclodan ciclopirox
	Plexion	sodium sulfacetamide-sulfur SS 10-2
	Prudoxin Zonalon	doxepin
	Salex	salicylic acid
	Sernivo	betamethasone fluocinonide hydrocortisone
	Siliq	Humira, Cosentyx
	Soriatane	acitretin
	Trianex	triamcinolone Triderm
	Ultravate	clobetasol
	Vanos	fluocinonide
	Verdeso Xerese	desonide acyclovir hydrocortisone
	Ziana	tretinoin clindamycin-benzoyl peroxide
SLEEP DISORDERS/SEDATIVES	Ambien Ambien CR Edluar Intermezzo	zolpidem zolpidem ER
	Nuvigil	armodafinil
	Provigil	modafinil
	Restoril	temazepam

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVES
SUBSTANCE ABUSE	Evzio	Narcan
URINARY TRACT CONDITIONS	Detrol Detrol LA Ditropan XL Enablex Gelnique Myrbetriq Oxytrol Toviaz VESIcare	darifenacin ER oxybutynin ER tolterodine ER trospium ER

^^ These medications require approval from Cigna before they're covered by your plan. If your doctor feels that an alternative medication isn't right for you, he or she can ask Cigna to consider approving coverage of your medication.

Prescription drug list FAQs

We want to make sure you understand your prescription drug coverage so you can get the most from your pharmacy benefit. Below are answers to some of the most commonly asked questions about the Cigna Prescription Drug List.

Why do you make changes to the drug list?

Cigna regularly reviews and updates the prescription drug list. We make updates to the drug list for many reasons, like when new generics become available, medications are no longer available or when medication prices change. For example, the price of a brand name medication may increase much more than other medications that treat the same condition. When that happens, we may try to find lower-cost generic or "preferred brand" alternatives that are just as safe and effective as the higher-cost brand. These changes may include:[1]

- Moving a medication to a lower cost tier. This can happen at any time during the year.
- Moving a medication to a higher cost tier when a generic becomes available. This can happen at any time during the year.
- Moving a medication to a higher cost tier or no longer covering a medication. This typically happens twice per year on January 1st and July 1st.
- Adding requirements to a medication. For example, requiring approval from Cigna before a medication is covered or adding a quantity limit to a medication.

When a medication changes tiers or is no longer covered, you may have to pay a different amount to fill that medication.

Why aren't some medications covered on my drug list?

Some high-cost medications have clinically appropriate alternatives. Meaning, they work the same or similar to another covered prescription medication or over-the-counter (available without a prescription) alternative. To help lower your overall health care costs, these high-cost medications are not covered. If your doctor feels an alternative medication isn't right for you, he or she can ask Cigna to consider approving coverage of your medication.

We also do not cover medications that aren't approved by the U.S. Food and Drug Administration (FDA).

How do you decide what medications are covered?

The Cigna Prescription Drug List is developed in cooperation with Cigna's Pharmacy and Therapeutics Committee, a panel of practicing doctors and pharmacists, most of whom work outside of Cigna. Every medication available on the drug list has been approved by the FDA. The Pharmacy and Therapeutics Committee uses medical resources and references on the safety and efficacy of prescription medications, and doesn't consider finances. The committee's findings are based on clinical evidence and are shared with a separate business decision team. The business team reviews their findings and other factors when deciding the placement of the medication on the drug list. Our goal is to provide access to coverage for safe, clinically effective and low-cost medications.

What medications are covered under the health care reform law?

The Patient Protection and Affordable Care Act, commonly referred to as "health care reform," was signed into law on March 23, 2010. Under this law, certain preventive medications (including some over-the-counter medicines) may be available to you at no cost-share ($0), depending on your plan. Log into **myCigna.com** or check your plan materials to learn more about how your plan covers preventive medications. You can also view the No Cost-Share Preventive Medications drug list on **Cigna.com/druglist**.

For more information about health care reform, visit **www.informedonreform.com** or **Cigna.com**.

Are medications newly approved by the FDA covered on my drug list?

Newly approved medications may not be covered on your drug list for the first six months after they receive FDA approval. These include, but are not limited to, medications, medical supplies or devices covered under standard pharmacy benefit plans. We review all newly

Prescription drug list FAQs *(cont)*

approved medications to determine if should be covered, and if so, at what tier level. If your doctor feels a currently covered medication isn't right for you, he or she can ask Cigna to consider approving coverage of the newly approved medication.

How can I find out how much I'll pay for a specific medication?

Use the Drug Cost tool on **myCigna.com** to learn how much your medication may cost and view lower cost alternatives, if available.

How can I save money on my prescription medications?

You may be able to save money by switching to a lower-cost medication or by filling a 90-day supply, if your plan allows. Talk with your doctor to see if a lower-cost medication, or 90-day supply, may work for you.

What's the difference between brand name and generic medications?

The FDA requires generic medications to have the same quality and performance as brand name medications. A generic medication is the same as a brand name medication in dosage form, active ingredient, strength, route of administration, quality, performance characteristics and intended use. Generics typically cost much less than brand name medications – in some cases, up to 80%–85% less.[2] Just because generics cost less than brands, it doesn't mean they're lower-quality medications.

How can I get help with my specialty medication?

Cigna Specialty Pharmacy Services℠ can help you manage your health and prescription needs.[3] Our therapy management teams, made up of health advocates with nursing backgrounds and pharmacists, provide personalized, 24/7 support. They offer condition-specific education on medication therapy and side effects, help manage the approval process and offer financial assistance programs if you need help paying for your specialty medication.

Call us at **800.351.3606** if you have questions or need help transferring your prescription. You can also go to **cigna.com/specialty-pharmacy-services** to learn more.

Can I fill my prescriptions by mail?

If you take a medication every day to treat an ongoing health condition, you can order up to a 90-day supply through Cigna Home Delivery Pharmacy.℠ [3] To get started, call us at **800.835.3784** or go to **cigna.com/home-delivery-pharmacy**.

Where can I find more information about my prescription drug plan?

Use the online tools and resources on **myCigna.com** or the **myCigna app**[4] to help you better understand and manage your pharmacy benefits. You can view your drug list or search for a specific medication, use Drug Cost tool to estimate how much your medications may cost, find a pharmacy in your network and review your pharmacy claims and payment history.

Exclusions and limitations

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. If your plan provides coverage for certain preventive prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, the prescription may not be covered. Certain drugs may require prior authorization, or be subject to step therapy, quantity limits or other utilization management requirements.

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:[5]

- over-the-counter (OTC) medications (medications that do not require a prescription) except insulin unless state or federal law requires coverage of such drugs;
- prescription drugs or supplies for which there is a non-prescription or OTC therapeutic alternative;
- physician-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or authorized by Cigna;
- implantable contraceptive devices covered under the Plan's medical benefit;
- medications that are not medically necessary;
- experimental or investigational medications, including 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;
- medications that are not approved by the Food & Drug Administration (FDA);
- prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered;
- medications used for fertility, sexual dysfunction, cosmetic purposes, weight loss, smoking cessation, or athletic enhancement;
- prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such drugs;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of prescription drugs and related supplies due to loss or theft;
- drugs which are to be taken by or administered to a covered person while they 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 date of issue; or

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved drug products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless authorized by Cigna as medically necessary.

Cigna reserves the right to make changes to the Drug List without notice. Your plan may cover additional medications; please refer to your enrollment materials for details. Cigna does not take responsibility for any medication decisions made by the doctor or pharmacist. Cigna may receive payments from manufacturers of certain preferred brand medications, and in limited instances, certain non-preferred brand medications, that may or may not be shared with your plan depending on its arrangement with Cigna. Depending upon plan design, market conditions, the extent to which manufacturer payments are shared with your plan and other factors as of the date of service, the preferred brand medication may or may not represent the lowest-cost brand medication within its class for you and/or your plan.

1. State laws in Texas and Louisiana require your plan to cover your medications at your current benefit level until your plan renews. This means that if your medication is taken off the drug list, is moved to a higher cost-share tier or needs approval, your plan can't make these changes until your renewal date. To find out if these state laws apply to your plan, please call Customer Service using the number on the back of your ID card.
2. U.S. Food and Drug Administration (FDA) website, "Understanding Generic Drugs." Retrieved 08/01/2017.
3. Plans vary, so some plans may not include Cigna Specialty Pharmacy Services or Cigna Home Delivery Pharmacy. Please check your plan materials for more information on what pharmacies are covered under your plan.
4. The downloading and use of the myCigna app is subject to the terms and conditions of the app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.
5. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.

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SPECIALTY PHARMACY DRUG LIST

Specialty medications are used to treat complex conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis. This drug list includes the most commonly prescribed specialty medications covered by your plan as of January 1, 2018.+

Depending on your plan, medications marked with an asterisk (*) may be covered under your pharmacy benefit, medical benefit, or covered under both benefits. If you're filling one of these medications at a retail pharmacy, you'll have to switch to Cigna Specialty Pharmacy Services for it to be covered. If the medication is covered under your medical benefit and you're getting it from your health care provider, you're not required to use home delivery.

This drug list is not a complete list of covered specialty medications, and not all of the medications listed here may be covered by your specific plan. This list is also regularly updated. You should log into **myCigna.com** or check your plan materials to learn more about the specialty medications your plan covers.

Cigna Specialty Pharmacy Services can help you manage your health and prescription needs

We want to make sure you're receiving the care and support you need every step of the way. Our therapy management teams, made up of health advocates with nursing backgrounds and pharmacists, are specially trained to deliver the best experience possible by offering:

- 24/7 access to customer service and pharmacists to help you with any questions
- Convenient delivery right to your door, or location of your choice, in packaging designed to protect your privacy
- Helpful coaching and reminder services
- Supplies like tape, bandages, sharps collector, swabs, etc. – at no additional charge
- Educational materials
- Financial assistance programs if you need help paying for your medications

It's easy to get started using Cigna Specialty Pharmacy Services. Call us at **800.351.3606** or go to **cigna.com/specialty-pharmacy-services**.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

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Specialty medications

Drug name

A

abacavir^
abacavir-lamivudine^
abacavir-lamivudine-zidovudine^
Abraxane
Actemra*
Acthrel
Actimmune*
Adagen
Adcetris
Adcirca*^
adefovir dipivoxil*^
Adempas^
Adriamycin
Adrucil
Advate*
Adynovate*
Afinitor Disperz*^
Afinitor*^
Afstyla*
Agrylin*^
Akynzeo^
Aldurazyme*
Alecensa*^
Alferon N*
Alimta
Alkeran
Aloxi
Alphanate*
Alphanine SD*
Alprolix*
Alunbrig^
Amicar*^
amifostine
aminocaproic acid*^
Ampyra*^
Amvisc
Amvisc Plus
anagrelide*^
Anzemet^
Apokyn*
aprepitant^
Aptivus^
Aralast NP
Aranesp
Arcalyst
argatroban
Arixtra
Arranon
Arzerra
Astagraf XL*^
Atgam
Atripla^
Aubagio*^
Austedo^
Avastin
Avonex*
azacitidine
Azasan*^
azathioprine*^

B

Baraclude*^
Bavencio
BCG Vaccine (Tice Strain)
Bebulin*
Beleodaq
Bendeka*
BeneFIX*
Benlysta
Berinert
Betaseron*
Bethkis*
bexarotene*^
Bexxar
bicalutamide*^
BiCNU
Bivigam*
Bleo 15K
bleomycin
Blincyto
Boniva*
Bosulif*^
Botox*
Bravelle
Brineura
busulfan
Busulfex

C

Cabometyx^
Campath
Camptosar
capecitabine*^
Caprelsa^
carboplatin
Carimune NF*
Casodex*^
Cayston
Cellcept*^
Ceprotin*
Cerdelga*^
Cerezyme*
cetrotide
Cholbam^
chorionic gonadotropin
cidofovir
Cimzia*
Cinqair
Cinryze
cisplatin
cladribine
clofarabine
Clolar
Coagadex
Combivir^
Cometriq^
Complera^
Copaxone*
Copegus*^
Corifact
Cosentyx*
Cosmegen
Cotellic*^
Crixivan^
Cuprimine*^
Cuvitru
cyclophosphamide*^
cyclosporine*^
Cyklokapron
Cyramza
Cystadane^
Cystagon^
cytarabine
Cytogam
Cytovene

D

dacarbazine
Dacogen
Daklinza*^
Darzalex*
daunorubicin
Daunoxome
DDAVP
decitabine
Defitelio*
Depen*^
Depocyt
Descovy^
desmopressin
didanosine^
Docefrez*
docetaxel*
Doxil
doxorubicin
Duopa
Dupixent*
Dysport*

E

Edurant^
Egrifta*
Elaprase
Elelyso
Eligard*
Elitek
Ellence
Eloctate*
Eloxatin
Elspar
Emcyt*^
Emend^
Emflaza^
Empliciti*
Emtriva^
Enbrel*
enoxaparin
entecavir*^
Entyvio*
Envarsus XR*^
Epclusa^
epirubicin
Epivir HBV^

Specialty medications

Drug name

Epivir^
Epogen
epoprostenol
Epzicom^
Erbitux
Erivedge*^
Erwinaze
Esbriet*^
Ethyol
Etopophos
etoposide*^
Evotaz^
Exjade*^
Exondys 51
Extavia*
Eylea

F

Fabrazyme*
Farydak^
Faslodex
Feiba NF*
Firazyr*
Firmagon
Flebogamma DIF
Flolan
floxuridine
fludarabine
fluorouracil
flutamide*^
Follistim AQ
Folotyn
fondaparinux
Forteo*
Fragmin
Fusilev
Fuzeon

G

Gamastan S-D*
Gammagard Liquid*
Gammagard S-D*
Gammaked*
Gammaplex
Gamunex-C*
ganciclovir
ganirelix
Gattex
Gazyva
Gel-One*
Gelsyn-3*
gemcitabine
Gemzar
Gengraf*^
Genotropin*
Genvisc 850*
Genvoya^
Gilenya*^
Gilotrif^
Glassia
Glatopa*
Gleevec*^
Gliadel
Gonal-F
Gonal-F RFF
Gonal-F RFF Redi-Ject
Granix

H

H.P. Acthar*
Haegarda
Halaven
Harvoni*^
Hecoria*^
Helixate FS*
Hemofil M*
Hepagam B
Hepsera*^
Herceptin
Hexalen*^
Hizentra*
Humate-P*
Humatrope*
Humira*
Hyalgan*
Hycamtin*^
Hylenex*
Hymovis
Hyperhep B S-D
Hyperrab S-D
Hyperrho S-D
Hyqvia

I

ibandronate*
Ibrance*^
Iclusig^
Idamycin PFS
idarubicin
Idelvion*
Ifex
ifosfamide
Ifosfamide-Mesna
Ilaris*
Iluvien
imatinib*^
Imbruvica^
Imfinzi
Imlygic
Imogam Rabies-HT
Imuran*^
Incivek*^
Increlex
Infergen*
Inflectra*
Ingrezza^
Inlyta*^
Intelence^
Intron A*
Invirase^
Iprivask*
Iressa^
irinotecan
Isentress HD^
Isentress^
Istodax
Ixempra
Ixinity*

J

Jadenu Sprinkle*^
Jadenu*^
Jakafi^
Jetrea
Jevtana*
Juxtapid^

K

Kadcyla
Kalbitor
Kaletra^
Kalydeco^
Kanuma
Kepivance
Kevzara*
Keytruda
Kineret
Kisqali Femara Co-Pack*^
Kisqali*^
Kitabis Pak
Koate*
Koate-DVI*
Kogenate FS*
Kovaltry*
Krystexxa
Kuvan*^
Kyleena*
Kynamro
Kyprolis*

L

lamivudine HBV^
lamivudine^
lamivudine-zidovudine^
Lartruvo
Lemtrada*
Lenvima^
Letairis*^
leucovorin*^
Leukine
leuprolide*
levoleucovorin
Lexiva^
Liletta
Lipodox
Lonsurf^
lopinavir-ritonavir^
Lovenox
Lucentis
Lumizyme
Lupaneta Pack*
Lupron Depot*
Lupron Depot-Ped*
Lynparza^
Lysteda^

Specialty medications

Drug name

M

Maci
Macugen
Marqibo
Matulane^
Mekinist*^
melphalan^
Menopur
mesna
Mesnex^
methotrexate*^
MICRhoGAM Ultra-Filtered Plus
Mircera
Mirena
mitomycin
mitoxantrone
Moderiba*^
Monoclate-P*
Mononine*
Monovisc*
Mozobil
Mustargen
Myalept
mycophenolate*^
mycophenolic acid*^
Myfortic*^
Myobloc
Myozyme

N

Nabi-HB
Naglazyme
Natpara
Natrecor
Navelbine
Neoral*^
Neulasta*
Neumega
Neupogen
nevirapine ER^
nevirapine^
Nexavar*^
Nexavir
Ninlaro^
Nipent
Norditropin*
Northera^
Norvir^
Novarel
Novoeight*
Novoseven RT*
Nplate
Nucala*
Nulojix
Nuplazid^
Nutropin AQ*
Nuwiq

O

Obizur
Ocaliva^
Ocrevus*
Octagam*
octreotide*
Odefsey^
Odomzo*^
Ofev^
Olysio*^
Omnitrope*
Oncaspar
Onivyde
Opdivo
Opsumit*^
Orencia Clickject*
Orencia*
Orenitram ER^
Orfadin^
Orkambi^
Orthovisc*
Otezla*^
Otrexup*
Ovidrel
oxaliplatin

P

paclitaxel
pamidronate*
Panhematin
Panretin*
paricalcitol (vial)
paricalcitol*^ (capsule)
Pegasys*
Pegintron*
Perjeta
Photofrin
Plegridy*
Pomalyst*^
Portrazza
Praluent*
Praxbind
Pregnyl
Prezcobix^
Prezista^
Prialt
Privigen*
Procrit
Procysbi^
Profilnine*
Prograf*^
Prolastin C
Proleukin
Prolia
Promacta*^
Provenge
Provisc
Pulmozyme*
Purixan^

R

Radicava*
Rapamune*^
Rasuvo
Rebetol*^
Rebif Rebidose*
Rebif*
Reclast*
Recombinate*
Remicade*
Remodulin
Repatha*
Repronex
Rescriptor^
Retrovir^
Revatio*^
Revlimid*^
Reyataz^
Rheumatrex^
RhoGam Ultra-Filtered Plus
Rhophylac
Riastap
Ribasphere Ribapak*^
Ribasphere*^
Ribatab*^
ribavirin*^
Rilutek*^
riluzole*^
Rituxan
Rituxan Hycela
Rixubis*
Rubraca^
Ruconest
Rydapt*^

S

Sabril^
Saizen*
Saizen-Saizenprep*
Samsca*^
Sandimmune*^
Sandostatin LAR Depot
Sandostatin LAR*
Sandostatin*
Selzentry^
Sensipar^
Serostim*
Signifor
Signifor LAR
sildenafil*^
Siliq*
Simponi Aria*
Simponi*
Simulect
sirolimus*^
Skyla
Soliris
Somatuline Depot
Somavert
Sovaldi*^
Spinraza
Sprycel*^
stavudine^
Stelara*
Stimate
Stivarga*^
Strensiq
Stribild^

Specialty medications

Drug name

Sucraid^
Supartz FX*
Supartz*
Supprelin LA*
Sustiva^
Sutent*^
Sylatron*
Sylvant
Synagis*
Synarel*
Synribo
Synvisc*
Synvisc-One*
Syprine*^

T

tacrolimus*^
Tafinlar*^
Tagrisso^
Taltz*
Tarceva*^
Targretin*^
Tasigna*^
Taxotere*
Tecentriq*
Tecfidera*^
Technivie*^
Temodar (vial)
Temodar*^ (capsule)
temozolomide*^
teniposide
Tepadina
tetrabenazine^
Tev-Tropin*
Thalomid*^
Theracys
Thiotepa
Thrombate III
Thymoglobulin
Thyrogen
Tivicay^
Tobi Podhaler*
Tobi*
tobramycin*
Toposar
topotecan*
Torisel
Tracleer*^
tranexamic acid^
Treanda
Trelstar*
Tretten
Trexall*^
Trisenox
Triumeq^
Trizivir^
Truvada^
Tybost^
Tykerb*^
Tymlos*
Tysabri*
Tyvaso
Tyzeka*^

U

Unituxin
Uptravi^

V

Valchlor
Valstar
Vantas*
Varubi^
Vectibix
Velcade
Veletri
Vemlidy^
Venclexta^
Ventavis
Victrelis*^
Vidaza
Videx^
Videx EC^
Viekira Pak*^
Viekira XR*^
Vimizim
vinblastine
Vincasar PFS
vincristine
vinorelbine
Viracept^
Viramune XR^
Viramune^
Virazole*
Viread^
Vistide
Vistogard^
Visudyne
Vitekta^
Vivitrol*
Vonvendi
Voraxaze
Votrient*^
VPRIV*

W

Wilate*
WinRho SDF*

X

Xalkori*^
Xeljanz XR*^
Xeljanz*^
Xeloda*^
Xenazine^
Xeomin*
Xermelo^
Xgeva
Xiaflex*
Xolair*
Xtandi*^
Xuriden^
Xyntha*
Xyrem^

Y

Yervoy
Yondelis*

Z

Zaltrap
Zanosar
Zarxio
Zavesca^
Zejula^
Zelboraf*^
Zemaira
Zemplar*^
Zepatier*^
Zerit^
Zevalin
Ziagen^
zidovudine^
Zinbryta
Zinplava
Zoladex*
zoledronic acid*
Zolinza^
Zomacton*
Zometa*
Zorbtive
Zortress*^
Zydelig^
Zykadia*^
Zytiga*^

* If your plan requires you to use home delivery for specialty medications and the specialty medication marked with an asterisk (*) is covered under your pharmacy benefit, you have to fill this medication through Cigna Specialty Pharmacy Services for it to be covered. Depending on your plan, you may be able to fill your prescription one time at any in-network retail pharmacy before you have to use Cigna Specialty Pharmacy Services.

^ This Oral specialty medication may be covered differently than other specialty medications. Refer to your plan materials or **myCigna.com** for coverage information.

Cigna reserves the right to make changes to the Drug List without notice. Your plan may cover additional medications; please refer to your enrollment materials for details. Cigna does not take responsibility for any medication decisions made by the doctor or pharmacist. Cigna may receive payments from manufacturers of certain preferred brand medications, and in limited instances, certain non-preferred brand medications, that may or may not be shared with your plan depending on its arrangement with Cigna. Depending upon plan design, market conditions, the extent to which manufacturer payments are shared with your plan and other factors as of the date of service, the preferred brand medication may or may not represent the lowest-cost brand medication within its class for you and/or your plan.

+ State laws in Texas and Louisiana require your plan to cover your medications at your current benefit level until your plan renews. This means that if your medication is taken off the drug list, is moved to a higher cost-share tier or needs approval, your plan can't make these changes until your renewal date. To find out if these state laws apply to your plan, please call Customer Service using the number on the back of your ID card.

Cigna®

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Certain features described in this document may not be applicable to your specific health plan, and plan features may vary by location and plan type. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

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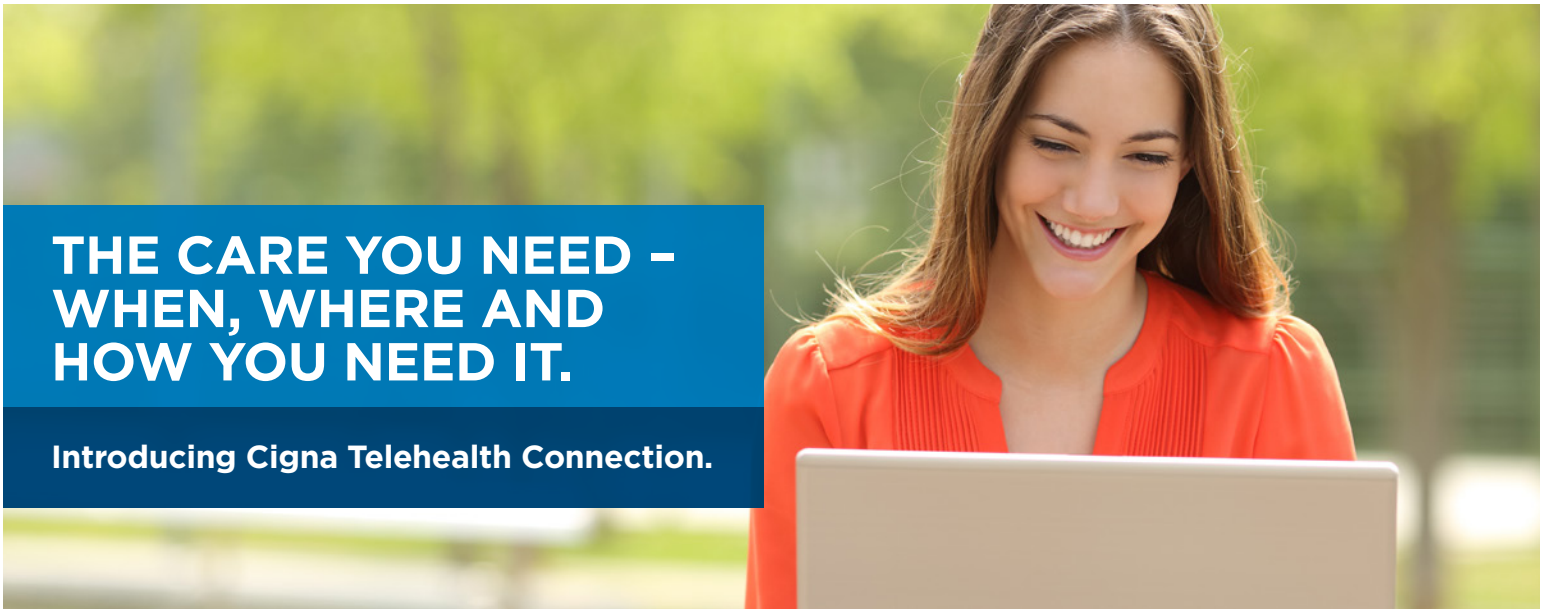

THE CARE YOU NEED – WHEN, WHERE AND HOW YOU NEED IT.

Introducing Cigna Telehealth Connection.

Choice is good. More choice is even better.

Now Cigna provides access to **two** telehealth services as part of your medical plan – **Amwell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both Amwell and MDLIVE, you can speak with a doctor for help with:

- sore throat
- headache
- stomachache
- fever
- cold and flu
- allergies
- rash
- acne
- UTIs and more

The cost savings are clear.

Televisits with Amwell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Amwell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, you have access to the **Cigna Behavioral Health** network of providers.

- Go to **Cignabehavioral.com** to search for a video telehealth specialist
- Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Choose with confidence.

Amwell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

Register for one or both today so you'll be ready to use a telehealth service when and where you need it.

AmwellforCigna.com*
855-667-9722

MDLIVEforCigna.com*
888-726-3171

Signing up is easy!

Set up and create an account with one or both Amwell and MDLIVE

Complete a medical history using their "virtual clipboard"

Download vendor apps to your smartphone/mobile device**

*Availability may vary by location and plan type and is subject to change. See vendor sites for details.

**The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Amwell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services, websites and mobile apps are provided exclusively by Amwell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. Amwell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for Amwell/MDLIVE services.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Dental Benefit Summary

Group Number: 00499412

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1]http://health.costhelper.com/dental-crown.html.

Option 1 or 2: With your **Low Plan or High Plan** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	**Option 1: Low Plan**		**Option 2: High Plan**	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$75	$25	$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	50%	50%	50%	50%
Orthodontia	Not Covered		50%	50%
Annual Maximum Benefit	$1500	$1500	$1500	$1500
Maximum Rollover	Yes		Yes	
Rollover Threshold	$700		$700	
Rollover Amount	$350		$300	
Rollover In-network Amount	$500		$500	
Rollover Account Limit	$1250		$1200	
Lifetime Orthodontia Maximum	Not Applicable		$1500	
Dependent Age Limits	26		26	

A Sample of Services Covered by Your Plan:

		Option 1: Low Plan *Plan pays (on average)*		Option 2: High Plan *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	80%	80%
	Fillings‡	80%	80%	80%	80%
	Perio Surgery	80%	80%	80%	80%
	Periodontal Maintenance	80%	80%	80%	80%
	Frequency:	Once Every 3 Months (Enhanced)		Once Every 3 Months (Enhanced)	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%	80%	80%
	Root Canal	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%	80%	80%
Major Care	Bridges and Dentures	50%	50%	50%	50%
	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Simple Extractions	50%	50%	50%	50%
	Single Crowns	50%	50%	50%	50%
	Surgical Extractions	50%	50%	50%	50%
Orthodontia	Orthodontia	Not Covered		50%	50%
	Limits:			Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and dental network, which can be found on the first page of your dental benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00499412

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000

Dental Maximum Rollover®

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1500	$700	$350	$500	$1250
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,750 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

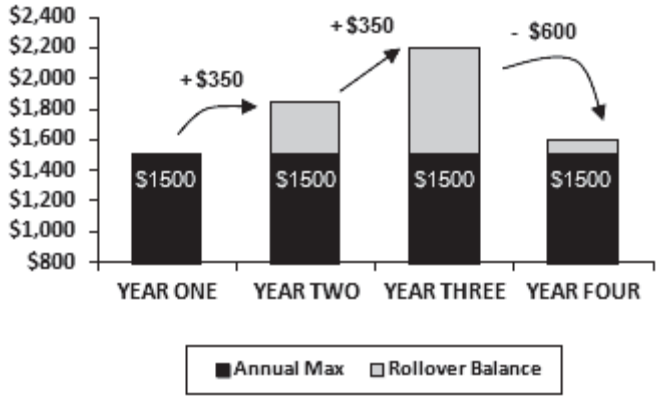
Here's how the benefits work:

YEAR ONE: Jane starts with a $1,500 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $700 Threshold, she receives a $350 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,850. This year, she submits $50 in claims and receives an additional $350 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,200. This year, she submits $2,100 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $1,600 ($1,500 Plan Annual Maximum + $100 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.

College Tuition Services

Special reward for participants enrolled in the Dental plan

Your employer has worked with Guardian to make College Tuition Benefit services available to eligible members enrolled in a Dental plan. Welcome to the College Tuition Benefits Rewards program! You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholar Consortium of colleges.

You can use your College Tuition Benefits Rewards at over 340 private colleges and universities across the nation. 80% of SAGE colleges have received an "America's Best" ranking by US News and World Reports. Here is how the service works

- You will receive 2,000 rewards for each year you have Guardian Dental Plan benefits
- Each Tuition Reward point equals a $1 tuition reduction
- Tuition Rewards can be given to your relatives including children, nephews, nieces, and grandchildren

To learn more about the program and how to get started, go to: www.Guardian.CollegeTuitionBenefit.com to set up your account. If you have any questions, please feel free to visit the website or contact College Tuition Benefit directly at 215-839-0119.

Register Today!

Guardian's Group Dental Insurance is underwritten by The Guardian Life Insurance Company of America (Guardian) or its subsidiaries. The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian. #2014-15077 Exp. 12/16.

(Print and cut out ID Card)

College Tuition Benefits Rewards – ID Card

Register@
www.Guardian.CollegeTuitionBenefit.com
User ID: Is your Guardian Dental Plan Number that can be found on your Dental ID Card
Password: Guardian

f o l d

The College Tuition Benefit
150 E. Swedesford Road, Suite 100
Wayne, PA 19087
Phone: (215) 839-0119
Fax: (215) 392-3255

Vision Benefit Summary

Group Number: 00499412

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

Visit any doctor with your **Full Feature** plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Network Signature Plan	
Copay		
Exams Copay	$ 20	
Materials Copay *(waived for elective contact lenses)*	$ 20	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $50
Single Vision Lenses	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $86
Lenticular Lenses	$0	Amount over $126
Frames	80% of amount over $150	Amount over $48
Contact Lenses *(Elective)*	Amount over $150	Amount over $120
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 30% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price^	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(cosmetic extras, glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	

‡‡Benefit includes coverage for glasses or contact lenses, not both.

‡‡‡The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

^ For the discount to apply your purchase must be made within 12 months of the eye exam. In addition Full-Feature plans offer 30% off additional prescription glasses and nonprescription sunglasses, including lens options, if purchased on the same day as the eye exam from the same VSP doctor who provided the exam.

For VSP, only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Vision Provider

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and vision network, which can be found on the first page of your vision benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00499412.
Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

On average, 15% off the usual charge or 5% off promotional price for vision laser surgery. Members' out-of-pocket costs are limited to $1,800 per eye for LASIK and $1,500 per eye for PRK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

GUARDIAN®

Group Number: 00499412

Digital Prospectors Corp.

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Disability

Disability Benefit Summary

Group Number: 00499412

About Your Benefits:

You probably have insurance for your car or home, but what about the source of income that pays for it? You rely on your paycheck for so many things, but what if you were suddenly unable to work due to an accident or illness? How will you put food on the table, pay your mortgage or heat your home? Disability insurance can help replace lost income and make a difficult time a little easier. Protect your most valuable asset, your paycheck-enroll today!

What Your Benefits Cover:

	Short-Term Disability	Long-Term Disability
Coverage amount	60% of salary to maximum $2000/week	60% of salary to maximum $10000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	12 weeks	Social Security Normal Retirement Age
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement not required	Health Statement not required
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	30	30
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	Not Applicable	3 months look back; 12 months after exclusion
Survivor benefit: Additional benefit payable to your family if you die while disabled.	4 weeks	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (long-term):** For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
- **Earnings definition:** Your covered salary is based on your previous year's W2 statement.
- **Special limitations:** Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA.

Contract #.s GP-1-LTD94-A,B,C-1.0 et al.; GP-1-LTD2K-1.0 et al; GP-1-LTD07-1.0 et al. Contract #.s GP-1-STD94-1.0 et al; GP-1-STD2K-1.0 et al; , GP-1-STD07-1.0 et al.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended.

Life Benefit Summary

Group Number: 00499412

About Your Benefits:

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

What Your Benefits Cover:

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $50,000 Basic Term Life coverage for all full time employees.	$10,000 increments to a maximum of $300,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage equal to one times the employee's life benefits.	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse‡ Benefit	N/A	Up to 50% of employee coverage to a max of $150,000
Child Benefit	N/A	Your dependent children age 14 days to 26 years. $1,000 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $50,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 $150,000, 65-69 $50,000, 70+ $10,000. Spouse Less than age 65 $25,000, 65-69 $10,000, 70+ $0. Dependent children $10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes

	BASIC LIFE	VOLUNTARY TERM LIFE
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 50% at age 70	50% at age 75

Subject to coverage limits

‡ **Spouse coverage terminates at age 70.**

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

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Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and use our Life Insurance Explorer Tool.

Bi-weekly premiums displayed. Cost of AD&D is included.

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	**< 30**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**65–69†**
$10,000	$.38	$.46	$.52	$.69	$1.05	$1.61	$2.46	$3.58	$6.42
$20,000	$.76	$.92	$1.03	$1.39	$2.10	$3.21	$4.91	$7.15	$12.83
$30,000	$1.14	$1.39	$1.55	$2.08	$3.14	$4.82	$7.37	$10.73	$19.25
$40,000	$1.51	$1.85	$2.07	$2.77	$4.19	$6.43	$9.82	$14.31	$25.66
$50,000	$1.89	$2.31	$2.59	$3.46	$5.24	$8.03	$12.28	$17.89	$32.08
$60,000	$2.27	$2.77	$3.10	$4.15	$6.29	$9.64	$14.73	$21.46	$38.49
$70,000	$2.65	$3.23	$3.62	$4.85	$7.33	$11.24	$17.19	$25.04	$44.91
$80,000	$3.03	$3.69	$4.14	$5.54	$8.38	$12.85	$19.64	$28.62	$51.32
$90,000	$3.41	$4.15	$4.65	$6.23	$9.43	$14.46	$22.10	$32.19	$57.74
$100,000	$3.79	$4.62	$5.17	$6.92	$10.48	$16.06	$24.55	$35.77	$64.15
$110,000	$4.16	$5.08	$5.69	$7.62	$11.53	$17.67	$27.01	$39.35	$70.57
$120,000	$4.54	$5.54	$6.20	$8.31	$12.57	$19.27	$29.47	$42.92	$76.99
$130,000	$4.92	$6.00	$6.72	$9.00	$13.62	$20.88	$31.92	$46.50	$83.40
$140,000	$5.30	$6.46	$7.24	$9.69	$14.67	$22.49	$34.38	$50.08	$89.82
$150,000	$5.68	$6.92	$7.75	$10.39	$15.72	$24.09	$36.83	$53.65	$96.23
$160,000	$6.06	$7.39	$8.27	$11.08	$16.76	$25.70	$39.29	$57.23	$102.65
$170,000	$6.43	$7.85	$8.79	$11.77	$17.81	$27.31	$41.74	$60.81	$109.06
$180,000	$6.81	$8.31	$9.31	$12.46	$18.86	$28.91	$44.20	$64.39	$115.48
$190,000	$7.19	$8.77	$9.82	$13.15	$19.91	$30.52	$46.65	$67.96	$121.89
$200,000	$7.57	$9.23	$10.34	$13.85	$20.95	$32.12	$49.11	$71.54	$128.31
$210,000	$7.95	$9.69	$10.86	$14.54	$22.00	$33.73	$51.56	$75.12	$134.72
$220,000	$8.33	$10.15	$11.37	$15.23	$23.05	$35.34	$54.02	$78.69	$141.14
$230,000	$8.71	$10.62	$11.89	$15.92	$24.10	$36.94	$56.47	$82.27	$147.55
$240,000	$9.08	$11.08	$12.41	$16.62	$25.15	$38.55	$58.93	$85.85	$153.97
$250,000	$9.46	$11.54	$12.92	$17.31	$26.19	$40.15	$61.39	$89.42	$160.39
$260,000	$9.84	$12.00	$13.44	$18.00	$27.24	$41.76	$63.84	$93.00	$166.80
$270,000	$10.22	$12.46	$13.96	$18.69	$28.29	$43.37	$66.30	$96.58	$173.22
$280,000	$10.60	$12.92	$14.47	$19.39	$29.34	$44.97	$68.75	$100.15	$179.63
$290,000	$10.98	$13.39	$14.99	$20.08	$30.38	$46.58	$71.21	$103.73	$186.05
$300,000	$11.35	$13.85	$15.51	$20.77	$31.43	$48.19	$73.66	$107.31	$192.46

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
Policy Election Amount Up to 50% of Employee Amount to a maximum $150,000									
Spouse									
$5,000	$.19	$.23	$.26	$.35	$.52	$.80	$1.23	$1.79	$3.21
$10,000	$.38	$.46	$.52	$.69	$1.05	$1.61	$2.46	$3.58	$6.42
$15,000	$.57	$.69	$.78	$1.04	$1.57	$2.41	$3.68	$5.37	$9.62
$20,000	$.76	$.92	$1.03	$1.39	$2.10	$3.21	$4.91	$7.15	$12.83
$25,000	$.95	$1.15	$1.29	$1.73	$2.62	$4.02	$6.14	$8.94	$16.04
$30,000	$1.14	$1.39	$1.55	$2.08	$3.14	$4.82	$7.37	$10.73	$19.25
$35,000	$1.33	$1.62	$1.81	$2.42	$3.67	$5.62	$8.59	$12.52	$22.45
$40,000	$1.51	$1.85	$2.07	$2.77	$4.19	$6.43	$9.82	$14.31	$25.66
$45,000	$1.70	$2.08	$2.33	$3.12	$4.72	$7.23	$11.05	$16.10	$28.87
$50,000	$1.89	$2.31	$2.59	$3.46	$5.24	$8.03	$12.28	$17.89	$32.08
$55,000	$2.08	$2.54	$2.84	$3.81	$5.76	$8.83	$13.51	$19.67	$35.29
$60,000	$2.27	$2.77	$3.10	$4.15	$6.29	$9.64	$14.73	$21.46	$38.49
$65,000	$2.46	$3.00	$3.36	$4.50	$6.81	$10.44	$15.96	$23.25	$41.70
$70,000	$2.65	$3.23	$3.62	$4.85	$7.33	$11.24	$17.19	$25.04	$44.91
$75,000	$2.84	$3.46	$3.88	$5.19	$7.86	$12.05	$18.42	$26.83	$48.12
$80,000	$3.03	$3.69	$4.14	$5.54	$8.38	$12.85	$19.64	$28.62	$51.32
$85,000	$3.22	$3.92	$4.39	$5.89	$8.91	$13.65	$20.87	$30.40	$54.53
$90,000	$3.41	$4.15	$4.65	$6.23	$9.43	$14.46	$22.10	$32.19	$57.74
$95,000	$3.60	$4.39	$4.91	$6.58	$9.95	$15.26	$23.33	$33.98	$60.95
$100,000	$3.79	$4.62	$5.17	$6.92	$10.48	$16.06	$24.55	$35.77	$64.15
$105,000	$3.97	$4.85	$5.43	$7.27	$11.00	$16.87	$25.78	$37.56	$67.36
$110,000	$4.16	$5.08	$5.69	$7.62	$11.53	$17.67	$27.01	$39.35	$70.57
$115,000	$4.35	$5.31	$5.95	$7.96	$12.05	$18.47	$28.24	$41.14	$73.78
$120,000	$4.54	$5.54	$6.20	$8.31	$12.57	$19.27	$29.47	$42.92	$76.99
$125,000	$4.73	$5.77	$6.46	$8.65	$13.10	$20.08	$30.69	$44.71	$80.19
$130,000	$4.92	$6.00	$6.72	$9.00	$13.62	$20.88	$31.92	$46.50	$83.40
$135,000	$5.11	$6.23	$6.98	$9.35	$14.14	$21.68	$33.15	$48.29	$86.61
$140,000	$5.30	$6.46	$7.24	$9.69	$14.67	$22.49	$34.38	$50.08	$89.82
$145,000	$5.49	$6.69	$7.50	$10.04	$15.19	$23.29	$35.60	$51.87	$93.02
$150,000	$5.68	$6.92	$7.75	$10.39	$15.72	$24.09	$36.83	$53.65	$96.23

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
Policy Election Amount									
Child(ren)									
$1,000	$0.12	$0.12	$0.12	$0.12	$0.12	$0.12	$0.12	$0.12	$0.12
$2,000	$0.24	$0.24	$0.24	$0.24	$0.24	$0.24	$0.24	$0.24	$0.24
$3,000	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36
$4,000	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47
$5,000	$0.59	$0.59	$0.59	$0.59	$0.59	$0.59	$0.59	$0.59	$0.59
$6,000	$0.71	$0.71	$0.71	$0.71	$0.71	$0.71	$0.71	$0.71	$0.71
$7,000	$0.83	$0.83	$0.83	$0.83	$0.83	$0.83	$0.83	$0.83	$0.83
$8,000	$0.95	$0.95	$0.95	$0.95	$0.95	$0.95	$0.95	$0.95	$0.95
$9,000	$1.07	$1.07	$1.07	$1.07	$1.07	$1.07	$1.07	$1.07	$1.07
$10,000	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
‡**Spouse coverage premium is based on Employee age. Coverage for the spouse terminates at spouse's age 70.**
†Benefit reductions apply.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00499412

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

Voluntary Life Only:

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-LB-90, GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Enhanced AD&D: A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

THE PREMIUM ONLY PLAN - Plan Summary

The Premium Only Plan enables you to pay your share of premiums for group insurance coverage with pre-tax dollars.** When you participate in the Plan, the money will be deducted from your pay before income and social security taxes are withheld. This means that you will not have to pay federal income tax, Social Security tax or Medicare tax on the amount of your premium payments that are paid through the Premium Only Plan. In some states you also may not have to pay state or local income taxes on amounts paid through the Premium Only Plan on a pre-tax basis. You may wish to consult your legal and/or tax advisor regarding the actual tax savings you may expect to enjoy by participating in the Premium Only Plan.

How the Plan Works

Three things must happen before you can use the Premium Only Plan to pay your share of premiums for Eligible Benefits with pre-tax dollars:

- First, you must be eligible to participate. You are eligible to participate in the Premium Only Plan if you meet the eligibility requirements set forth in the Plan Highlights.
- Second, you must actually join the Premium Only Plan. You may join the Premium Only Plan on the date indicated in the Plan Highlights. Upon meeting the Plan's eligibility requirements, you should complete an Enrollment Agreement, whether or not you currently elect to participate in the Plan's pre-tax premium benefits.
- Third, you must be eligible to participate in and must separately enroll in the underlying group insurance plans whose premiums you will be paying through the Premium Only Plan. While you pay your share of the premiums for these Eligible Benefits through the Premium Only Plan, the Eligible Benefits are not part of the Premium Only Plan itself. Their terms are set forth in separate plan documents (which may be insurance contracts), and enrollment in these Eligible Benefits involves a separate process. Eligibility to participate in the Premium Only Plan does not guarantee eligibility to participate in the Eligible Benefits it funds.

The Premium Only Plan is voluntary. If you are eligible to join the Premium Only Plan, you will be required to complete an Enrollment Form before you can pay premiums through the Plan. You must complete and return the Enrollment Form to the Plan Administrator prior to or upon becoming initially eligible to participate, in accordance with any procedures the Plan Administrator may establish. Once you have initially enrolled in the Premium Only Plan, you will have the opportunity to change your election for each upcoming Plan Year during an open enrollment period before the beginning of that Plan Year. If you fail to return a new completed Enrollment Form and similar agreements for any underlying Benefits to the Plan Administrator on or before the date the Plan Administrator specifies during the annual open enrollment period, you will be treated as having (a) elected to reelect for the upcoming Plan Year the same Benefit coverage(s) you currently have in effect and (b) agreed to reduce your compensation for the upcoming Plan Year equal to your share of the premiums for the Benefit coverage(s) you are deemed to have elected.

If you elect to pay premiums on a pre-tax basis through the Premium Only Plan, your salary reductions will go directly to the insurance company to pay for your share of the coverage you have separately elected, on a pre-tax basis. The insurance company will pay your benefits as provided in the insurance contract. In the case of a self-insured arrangement, your salary reductions will likewise be used to fund your share of the coverage you have selected, on a pre-tax basis, and your benefits will be paid by the Employer's self-insured plan in accordance with that plan's governing document(s).

You can use the Premium Only Plan to pay your share of the premium for any of the Eligible Benefits listed in the Plan Highlights.

Changes During the Year

In general, your elections under the Premium Only Plan cannot be changed during the Plan Year, which begins and ends of the dates indicated in the Plan Highlights. This means that once you make your elections under the Plan, you can withdraw from the Plan or change your underlying Benefits coverage only during the open enrollment period that occurs

** If your employer includes Group Term Life Insurance as a Benefit under the Premium Only Plan, the cost of such insurance coverage in excess of $50,000 will be included in your taxable income as imputed income as required by law.

before the next Plan Year begins. Once you have made your elections for a given Plan Year, federal law allows you to change your election mid-year only under limited circumstances. The change you make, moreover, must be on account of, and consistent with, the circumstances giving rise to the change. If an event permitting a mid-year election change occurs, you must inform the Plan Administrator and submit all required forms necessary to implement the change within a reasonable period of time as established by the Plan Administrator after the date of the event giving rise to the requested change. Your Plan Administrator will advise you of this time frame. If you believe you have experienced an event that permits you to make a mid-year election change, however, you should immediately contact your Plan Administrator to confirm how long after the occurrence of the event you have to make a mid-year election change.

Changes in Status

If you experience a Change in Status during the Plan Year, you may revoke your old election and make a new election, as long as both the revocation and the new election are on account of and consistent with the Change in Status. A Change in Status includes: (1) a change in your marital status, including marriage, death of your spouse, divorce, legal separation, or annulment; (2) a change in the number of your Dependents ("Dependent" means a tax dependent under the Internal Revenue Code), including birth, adoption, placement for adoption, or death of a Dependent; (3) an event that changes the employment status of you or your spouse or Dependent, including termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, or change in worksite that requires you to change your election under an underlying Benefit plan. (In addition, if eligibility for a cafeteria plan (including this Plan) or other benefit plan sponsored by your employer or your spouse or Dependent's employer depends on the employment status of you or your spouse or Dependent and there is a change in employment status (e.g., from full-time to part-time or salaried to hourly) that causes you or your spouse or Dependent to become eligible or lose eligibility under the plan, that change is a Change in Status.); (4) an event that causes a Dependent to satisfy or no longer satisfy eligibility for a Benefit plan due to attainment of age, student status, or some similar circumstance; (5) a change in residence of you or your spouse or Dependent; and (6) any other event determined in the sole discretion of the Plan Administrator to be a Change in Status under Internal Revenue Service rules.

The Plan Administrator, in its sole discretion, will determine if your proposed revocation and new election are on account of and consistent with a Change in Status. In general, IRS rules provide that an election change is consistent with a Change in Status if it is on account of and corresponds with a Change in Status that affects coverage eligibility. The IRS has also imposed more specific requirements in the following situations:

- **Loss of Spouse or Dependent Eligibility.** For accident or health coverage, if the Change of Status is your divorce, annulment or legal separation, death of a spouse or Dependent, or a Dependent ceasing to satisfy coverage eligibility requirements, your mid-year election options are limited to canceling the applicable spouse or Dependent's coverage. However, if you, your spouse or Dependent becomes eligible for COBRA (or similar state law) continuation coverage (for a reason other than divorce, annulment or legal separation from you) under a plan maintained by your employer, you may increase your election to pay for the coverage.

- **Coverage Under Another Employer's Plan**. If you, your spouse or Dependent becomes eligible for coverage under another cafeteria plan or underlying benefit plan due to a change in your marital status or a change in employment status of you, your spouse or Dependent, an election under this Plan to cease or decrease coverage for that person is consistent only if his coverage goes into effect or is increased under the other plan.

Additional Events Permitting a Mid-Year Election Change

There are other events that will permit you to change your Plan election mid-year:

- **Significant Curtailment of Coverage.** If an underlying benefit plan coverage offered is significantly curtailed or ceases, you may revoke your election for that coverage under the Plan and elect "similar" coverage, if any. Coverage is "significantly curtailed" if there is an overall reduction amounting to reduced coverage generally. The Plan Administrator in its sole discretion determines whether a curtailment is "significant" or other coverage is "similar."

- **Medicare/Medicaid Entitlement.** If you, or your spouse or Dependent enrolled in an underlying accident or health plan of your employer becomes entitled to Medicare or Medicaid, you may elect to cancel or reduce coverage for yourself or your spouse or Dependent, as applicable. If you or your spouse or Dependent have been entitled to Medicare or Medicaid and lose eligibility for such coverage, you may elect to start or increase coverage for you or your spouse or Dependent under an underlying accident or health plan of your employer (as permitted by that plan).

- **Judgment, Decree or Order.** If you receive a judgment, decree or order from a divorce, separation, annulment or custody proceeding that requires accident or health coverage for your Dependent child or Dependent foster child, you must change your Plan election accordingly. You may also make a mid-year election to revoke coverage for the child if the order requires your spouse, former spouse or another person to provide coverage for the child and it is provided.

- **Addition, Significant Improvement, or Elimination of Option.** If your employer adds or eliminates a benefit package or other coverage option, or significantly improves coverage under an existing benefit package option or other option, during a Plan Year, you may make a mid-year change to elect the newly-added or significantly improved option (or elect another option if yours is eliminated) and make corresponding elections with respect to other benefit package options providing similar accident or health coverage. (The right to elect a newly-added or significantly improved option mid-year extends to active Participants and to Employees who have met the Plan's eligibility requirements but have elected not to currently participate. The Plan Administrator determines in its sole discretion whether a benefit or coverage option provides "similar coverage."

- **Change in Cost of Coverage.** If the cost of any coverage funded through the Plan increases or decreases during the Plan Year, your salary deduction will be automatically adjusted to reflect this. If the cost increase (or decrease) is significant, you may elect to increase your salary deduction prospectively or revoke your election and prospectively elect another option, if any, that provides similar coverage. (You may drop your coverage if there is no similar coverage.) The Plan Administrator determines in its sole discretion whether a benefit option provides "similar coverage" and whether a cost increase or decrease is "significant."

- **Change in Coverage of Spouse or Dependent Under Other Employer's Plan.** You may make a prospective election change on account of and corresponding to a change made under another employer plan, including a plan of your employer or a plan of a spouse's, former spouse's, or Dependent's employer if: (1) the other plan allows participants to make an election change that would be allowed under IRS rules; or (2) your Plan's Plan Year is different from the relevant period of coverage under the other employer plan. The Plan Administrator will determine in its sole discretion whether a proposed mid-year change is permitted in this situation.

- **Special Enrollment Rights.** If you or your spouse or Dependent is entitled to special enrollment rights under a group health plan under the Health Insurance Portability and Accountability Act of 1996, you may revoke a prior group health coverage election and make a new election that corresponds with the special enrollment right. Special enrollment rights arise if: (1) you or your spouse or Dependent declined group health coverage because you had other coverage that was COBRA coverage, and the COBRA coverage is terminated, or the other coverage was non-COBRA and employer contributions for the coverage terminated (a mid-year election change in this situation must be elected no later than 30 days after the event that creates the special enrollment right); or (2) you acquire a new Dependent by marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents due to acquisition of a new spouse or Dependent child is consistent with the special enrollment right. An election change on account of a special enrollment due to birth, adoption, or placement for adoption of a new Dependent child may be effective retroactively to the date of birth, adoption, or placement for adoption by up to 30 days, subject to the terms of the underlying group health plan.

- **Loss of Other Group Health Coverage.** If you or your spouse or Dependent lose group health coverage sponsored by a governmental or educational institution (such as a state children's health insurance program, certain Indian tribal programs, a state health benefits risk pool, or a foreign government group health plan), you may change your election to add group health coverage for you or your spouse or Dependent, as applicable.

- **Other Permitted Election Changes.** You may also be allowed to make other mid-year election changes under the Plan if the Plan Administrator determines in its sole discretion that the change is consistent with IRS rules.

If you stop working for your employer and return in a later Plan Year, you will again become eligible to participate in the Plan if you meet the eligibility requirements. If you stop working for the Employer and return in the same Plan Year, you may participate in the Plan during that Plan Year as described in the following Note:

Note: While termination or commencement of employment generally are events that permit a mid-year election change, the IRS is concerned that employees in some instances may terminate employment and be rehired shortly thereafter in order to justify a mid-year election change during a Plan Year. For this reason, your Plan provides that if you terminate employment, are rehired within a certain number of days (as determined by the Plan Administrator) in the same Plan Year, and are eligible to reenter the Plan as described above, your pre-termination elections will be reinstated and you will not be permitted to make a new election for the remainder of the Plan Year upon returning to work. Your Plan Administrator has established a procedure setting a minimum time period between termination and reemployment within the same Plan Year that will permit you to make a mid-year election change upon returning to work. You should see your Plan Administrator if you have any questions about this issue.

Special rules may be applicable if you take an unpaid leave of absence, including unpaid leave pursuant to the Family and Medical Leave Act during the Plan Year. If you intend to take such leave, please contact the Plan Administrator to discuss what options are available to you.

Other Things You Should Know

The Plan Administrator can answer your questions about the Plan and will provide you with any forms you need. The Plan Administrator also keeps the Plan's records and is responsible for operating the Plan. The Plan Administrator's name, address and telephone number are shown in the Plan Highlights.

The Plan's Sponsor maintains a copy of the documents governing the Plan that you may review upon request. The Plan document is more precise than this Plan Summary, so if anything in this description seems to differ from the Plan document, the terms of the Plan document will control.

The Plan's Sponsor, by written action of its Board of Directors, a general partner or the sole proprietor, as applicable, may amend or terminate the Plan at any time, but must notify you about any changes that affect your benefits. The Plan also may terminate if the Sponsor ceases to be a payroll client of ADP, Inc.

In the event you are involved in a divorce, separation, or custody proceeding, your benefits under the Plan may be subject to a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is an order issued under a state's domestic relations law that requires health benefit coverage for the child of a participant under a group health plan. QMCSOs generally will be directed primarily towards an underlying group health plan rather than this Plan, but may be directed towards the Plan. You should contact the Plan Administrator if you receive an order that you think may be a QMCSO.

Claim Procedures

Claims for benefits that are insured will be reviewed in accordance with procedures contained in the insurance policies. All other general claims or requests should be directed to the Plan Administrator. In the event that a claim is denied in whole or in part, the claimant will be informed of the procedures to be followed to appeal the decision.

Any person whose claim has been denied may file a written appeal with the Plan Administrator within 90 days after receipt by the claimant of notification of the denial or within 90 days after the claim is deemed denied. The claimant or his authorized representative may review any pertinent documents and submit any issues or comments to the Plan Administrator. The claimant and/or his authorized representative will be afforded an opportunity to meet with the Plan Administrator for a full and fair review of the claim and the Plan Administrator's decision. The decision of the Plan Administrator on appeal will normally be made within 60 days of its receipt of a written appeal. The time for rendering a decision may be extended for an additional 60 days because of special circumstances, by the Plan Administrator and the reasons therefor, including references to specific Plan provisions. If the claimant is not notified of the decision within 60 days (120 days under special circumstances), then the claim will be deemed denied on appeal.

Addendum to Plan Summary for Premium Only Plan

The Patient Protection and Affordable Care Act (the "Affordable Care Act") makes key changes regarding coverage of children under employer health plans. The Affordable Care Act imposes a coverage mandate on group health plans. If a plan offers coverage for children, then the plan must make coverage available until a child's 26th birthday.

Please see your Plan Administrator for a list of the group health plans for which the coverage rule will be implemented and the effective date of the change.

Your employer will tell you when and how you can make a coverage election under its group health plans in light of this change and, if applicable, an election to pay for that coverage on a pre-tax basis under the Premium Only Plan. A child for purposes of pre-tax payment of premiums under the Premium Ony Plan includes a biological or adopted child, stepchild or eligible foster child. You may make a permitted election under the Premium Only Plan when the employer first implements the coverage rule or, if later, when you initially become eligible to participate in the Premium Only Plan or during the next open enrollment period. Note that coverage for children is only permitted on a pre-tax basis under the Premium Only Plan through the end of the calendar year in which a child attains age 26.

If you have any questions, please contact the Plan Administrator.

Addendum to Plan Summary for Premium Only Plan
CHIPRA Special Enrollment Rights

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") authorizes new special enrollment rights for group health plans that will permit you to change your Plan election mid-year. Thus, if you or your Dependent is entitled to CHIPRA special enrollment rights under a group health plan, you may revoke a prior group health coverage election that corresponds with the CHIPRA special enrollment rights. The CHIPRA special enrollment rights arise if: (1) you or your Dependent is covered under a State Medicaid or State child health plan, and that coverage is terminated due to a loss of eligibility; or (2) you or your Dependent becomes eligible for State premium assistance under a State Medicaid or State child health plan. A mid-year election change in this situation must be elected not later than 60 days after the event that creates the CHIPRA special enrollment right. If you have any questions about making a mid-year election change based on the CHIPRA special enrollment rights, please contact the Plan Administrator.

PREMIUM ONLY PLAN

IMPORTANT INFORMATION ON HOW YOU MAY INCREASE YOUR TAKE HOME PAY

We are pleased to offer you our Premium Only Plan (POP). By taking part in this employee benefit plan, you'll essentially be giving yourself a raise by increasing your take-home pay.

The Premium Only Plan allows employee payroll deductions for group insurance premiums to be taken before taxes instead of after taxes. The extra money you put in your pocket comes from not having to pay Social Security and Federal Income taxes on your premium deductions. In some states you also save by not having to pay State Income taxes either.

	With POP	Without POP
Monthly Gross Pay	$2000	$2000
Pre-tax premium payment	185	0
• Medical $125		
• Dental 30		
• LTD 10		
• Term Life 10		
• Vision 7		
• AD & D 3		
Taxable Gross Income	1815	2000
Federal Tax	177	205
Social Security/Medicare	139	153
State Tax	51	62
Post-tax premium payment	0	185
TAKE HOME PAY	**$1448**	**$1395**

With POP, this employee's take home pay increased by $636 per year.

Illustration based on a single employee residing in New York state with one federal exemption at 2002 tax rate. Amounts in this illustration have been rounded to whole dollars. Individual results may vary.
Rules regarding state income taxability vary by state.

A more human resource.℠

Your Retirement.

Get there one step at a time.

Digital Prospectors 401(k) Retirement Plan

Plan for what's ahead

Knowing your goals for retirement—and what it will take to reach them—is key to creating a strategy that works for you. Learn how the plan helps you save and stay on track to reach your goals.

Choose how you want to get there

Understanding investments puts you on the right path to choosing options that best meet your goals and preferences. Get the basics to boost your knowledge and make smart investing decisions.

Start moving in the right direction

Your plan makes it easy for you to start saving for your future financial security. Take the first step and enroll today.

Take the first step.

Enroll Today.

The retirement years hold many possibilities. Do you have plans for this next phase in your life? Many of us do. Whether you see yourself working less, starting a new career, enjoying hobbies or traveling, chances are you'll need to plan ahead and save.

Ready to enroll in the plan?
Go to page 6 to find out how to get started saving now.

The future offers the potential for a longer life and the need for more income in retirement. You may need 70%-90% of your current annual income to replace your salary and live comfortably once you stop working or change your lifestyle in retirement. We all want the financial security to afford to spend retirement as we choose. And while Social Security may help, it probably won't be enough. It's up to you to make up the difference—and your plan can help.

Digital Prospectors 401(k) Retirement Plan can help you reach your future financial goals, and it's easy to get started. The sooner you enroll, the sooner you can take advantage of these great benefits:

- **Employer contributions**
- **Tax-advantaged saving through pre-tax contributions and the Roth 401(k) option**
- **Convenient, automatic payroll deductions**
- **Investments that make saving easy**
- **Plan features that simplify planning**
- **An account you can take with you**

This guide contains all the information you need to get started on your path to future financial security. Take a few moments to decide how much to save, how to choose the right investments for your needs and goals, and open your retirement account today.

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Plan for what's ahead.

Whatever you decide is ahead in retirement, you'll want to be able to afford to live comfortably. The plan is a convenient way to get you started.

YOUR CONTRIBUTIONS

How much you save will have a big impact on how much money you will have when you retire. You can contribute from 1% to 90% of your pre-tax salary to the plan each year. Your plan also allows you to contribute on an after-tax basis through Roth 401(k) contributions.

The IRS limit on your total annual contributions is $18,000 (2017). Those age fifty or over can save an additional $6,000 with catch-up contributions (2017).

Try to save as much as you can to meet your retirement goals and take full advantage of the employer match and tax savings your plan offers.

YOUR EMPLOYER HELPS

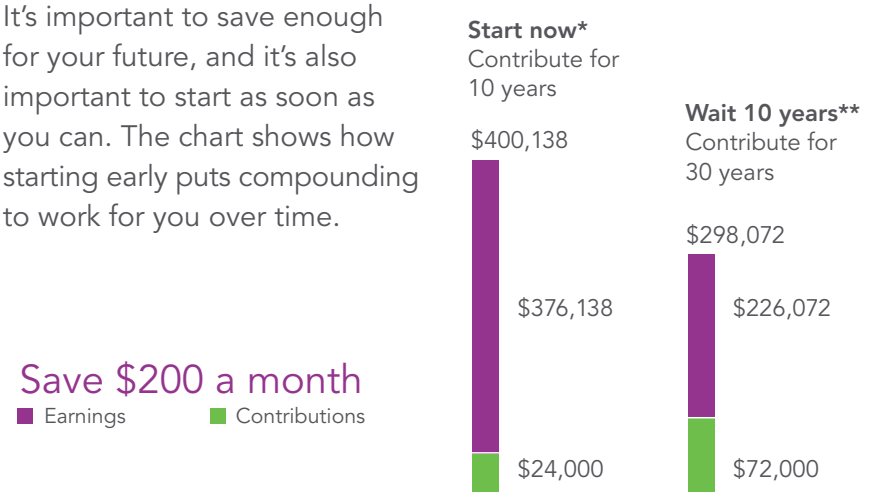
You decide how to invest this contribution. See your Plan Information for details.

A SMART AND EASY WAY TO SAVE MORE

Save Smart® is a plan feature that can help you save more for your future. It automatically increases your pre-tax plan contributions by 1, 2, or 3% annually on the date you choose—such as the month you expect to receive a raise. Saving more can make a big difference in how much money you have to live on in retirement. You can elect this feature on your plan website.

Starting now can pay off

It's important to save enough for your future, and it's also important to start as soon as you can. The chart shows how starting early puts compounding to work for you over time.



Starting Now
allows the account to grow an additional 10 years!

This hypothetical illustration assumes pre-tax contributions made at the beginning of each month and an annual effective rate of return of 8% and reinvestment of earnings. * Start now assumes the contributions are invested for 40 years; ** Wait 10 years assumes contributions are invested for 30 years. Results are for illustrative purposes only and are not meant to represent the past or future performance of any specific investment vehicle. Investment return and principal value will fluctuate and, when redeemed, the investment may be worth more or less than its original cost. Taxes are due upon withdrawal. Withdrawals taken prior to age 59½ may be subject to a 10% tax penalty.

REDUCE YOUR INCOME TAXES TODAY BY SAVING PRE-TAX

There are benefits to saving in the plan pre-tax. Saving pre-tax lowers your taxable income. It allows you to pay less in taxes now and take more income home. You can see the advantage of pre-tax saving in the chart: it costs less to contribute when you save pre-tax so you can afford to save more than you think.

» **The out-of-pocket amount is less than the amount contributed in the plan.**

You are not required to pay taxes on your savings and earnings until you start making withdrawals. In retirement, you may be in a lower tax bracket because you are working part-time or not at all, so deferring taxes can be a benefit. It may also help your account compound faster by putting more money to work for you now with the money you may have paid in taxes.

Pre-Tax Saving

It costs less than you think to save for your retirement.

	Annual Salary: $30,000		**Tax Bracket: 15%**
Pre-tax Contribution Rate	**2%**	**4%**	**6%**
» Weekly Plan Contribution	$11.54	$23.08	$34.62
Weekly Tax Savings	$1.73	$3.46	$5.19
» Weekly Out-of-Pocket Amount	$9.81	$19.62	$29.43
Annual Contribution	$600	$1200	$1800
Account Balance After 30 Years	**$75,015**	**$150,030**	**$225,044**

This chart is for illustrative purposes only. This example assumes contributions made at the beginning of the month and an 8% annual effective rate of return compounded monthly. Results are not meant to represent past or future performance of any specific investment vehicle. Investment return and principal value will fluctuate and when redeemed, the investment may be worth more or less than its original cost. Taxes are due upon withdrawal. Withdrawals taken prior to age 59½ may be subject to a 10% tax penalty.

CONSIDER THE ROTH 401(K) OPTION

Your plan offers another tax-advantaged savings option: a Roth 401(k). With Roth, your contributions are taxed now—instead of when you retire. Your contributions and earnings grow tax-free, which means you pay no taxes when you make a withdrawal if certain conditions are met. A Roth 401(k) may be right for you if:

- Your federal income tax rate will be higher when you retire
- You expect to invest for many years and reach a higher tax bracket when you retire

You can also use the Roth 401(k) calculator on the plan web site to help you decide.

You Decide: Roth or Traditional 401(k)

	Traditional 401(k)	**Roth 401(k)**
Employee Contributions	Before-tax dollars	After-tax dollars
Account Growth (earnings)	Tax-deferred until distribution	Tax-free at distribution (if distribution is qualified)
Federal Tax	Reduces current taxable income by contribution amount	Contribution is taxable in current year
	Taxes paid at withdrawal	No taxes due on qualified withdrawals*
Distributions	Available at age 59½	Tax-free, provided you had the account at least five years and you are: - at least 59½, or are - disabled or deceased

*Tax law requirements must be met.

Choose how you want to get there.

INVESTMENT OPTIONS

You control how your savings is invested. You have a variety of investment options in your plan to help you create the asset allocation that is right for your needs and goals. See the Performance Summary for a complete fund listing.

Two ways to invest

You decide which investment approach you prefer:

Choose an asset allocation fund.* Your plan offers a solution for creating a diversified asset allocation for your account with just one investment option. Just choose either the fund with the date closest to your anticipated retirement date or the risk-based fund with the allocation that most closely reflects your investor type, whichever type your plan offers. It's that easy!

If you choose this approach, you can skip to page 6 to get started.

Create your own asset allocation. You can create your own asset allocation from the investments offered in the plan. When you build your own mix, it's important to spread your savings among different investments, which can help smooth the ups and downs of market cycles and reduce risk.

Your account allocation is one of the most important decisions you can make in your retirement planning and can have a big impact on your investment results. To help you get yours right, complete the Investor Profiler on page 5.

NEED HELP CHOOSING INVESTMENTS?
Visit www.mykplan.com to access calculators, tools and information to help with your planning.

Guidelines every investor should know:

- **Put time on your side.** Starting now can increase your chances of affording a comfortable retirement. It will give your account more time to benefit from compounding. With more time, you can consider investing more aggressively, which may provide greater growth potential.
- **Understand risk.** All investments carry some risk. **Market risk,** the change in value of your investment in response to stock market conditions, is usually the risk people think of. However, **inflation risk,** the risk your money will not maintain its purchasing power over time, is equally important. In general, the more risk an investment carries, the greater the potential for a higher return. Those with less risk offer lower potential return.
- **Diversify.** A diversified allocation can help manage risk. Spreading your money across different asset classes can help smooth out stock market fluctuations and reduce overall risk.
- **Think long term.** Once you've created a diversified investment mix for your age, years to retirement and risk tolerance, stick with it. You'll want to review your strategy as life changes occur or you near retirement.
- **Invest regularly.** Making regular automatic contributions, like you do in the plan, is an easy way to invest. Each contribution buys shares in your investment funds—some at lower prices and some at higher prices. Over time, this process may lower the average purchase price of your investments.

* The underlying mutual funds in the portfolios of asset allocation funds are subject to stock market risk and invest in individual bonds whose yields and market values fluctuate, so that your investment may be worth more or less than its original cost. The target date of a target date mutual fund is the approximate date when an investor plans to begin withdrawing their money from the fund. The principal value of a target date fund is not guaranteed at any time, including at the target date.

Ibbotson, Roger and Kaplan, Paul, "Does asset allocation policy explain 40 percent, 90 percent or 100 percent of performance?" Financial Analysts Journal, Jan./Feb. 2000.

Diversification and dollar cost averaging does not guarantee a profit or protect against a loss in a declining market. There is no guarantee that your balance will increase over time.

Personal Investor Profile

Answer the following questions to determine your investor profile score.

Key A-D
1 - Strongly Disagree
2 - Disagree
3 - Neutral
4 - Agree
5 - Strongly Agree

Risk Tolerance		Circle Score
A	I'm willing to risk short-term loss for a potentially higher long-term gain.	1 2 3 4 5
B	Earning higher long-term returns to allow my money to outpace inflation is one of my most important investment objectives.	1 2 3 4 5
C	I'm willing to tolerate sharp up and down swings in the value of my investments for a potentially higher return than I might expect from more stable investments.	1 2 3 4 5
D	I do not expect to withdraw money from my retirement savings within the next five years.	1 2 3 4 5

Key E-F
1 - 0 - 4 Years
2 - 5 - 9 Years
3 - 10 - 14 Years
4 - 15 - 19 Years
5 - 20+ Years

Time Horizon		Circle Score
E	Number of years until I expect to take distributions from my retirement plan.	1 2 3 4 5
F	Number of years until I plan to retire.	1 2 3 4 5

Total the circled numbers for your score. **Your Score**

Investor Profile Score

Match your investor profile score to one of the sample portfolios. Next, using the list of plan investments in the performance summary, choose investments that match the asset categories for the portfolio you selected.

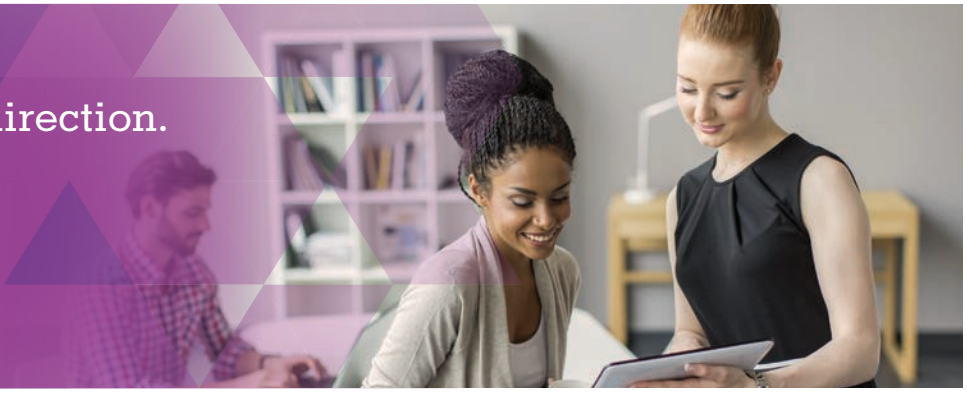
Score Range:	6 - 13	14 - 22	23 - 30
				
	75% Income 18% Growth 7% Aggressive Growth	60% Income 29% Growth 11% Aggressive Growth	40% Income 43% Growth 17% Aggressive Growth	5% Income 68% Growth 27% Aggressive Growth

LOW — RISK/REWARD POTENTIAL — HIGH

Sample asset allocation models are for illustrative purposes only. They are not intended to be, nor construed as, investment advice.

04-3014-0516

Start moving in the right direction.



ENROLL TODAY

Here's what you need to do to open your retirement account:

- Review the information in this guide and either complete any necessary forms or follow the instructions to open your retirement account.
- Designate an account beneficiary. Submit your completed form to your employer or complete this step online.
- Consider saving enough to get the full plan match. If you're not saving enough, you could be missing out on money that could be yours.
- Elect account features to help with planning like Save Smart® and automatic Account Rebalancing. You can get information and elect them on www.mykplan.com.
- Track your progress using the account resources available to help.

NAMING A BENEFICIARY FOR YOUR ACCOUNT IS IMPORTANT.
In the event of your death, your account will be passed to the person(s) you name.

If you are single, or married and want to name your spouse as your sole primary beneficiary, you can designate your beneficiary online. If you are married and want to designate someone other than your spouse, you must print the form available online and follow the instructions to complete it.

Be sure to complete this important step in your retirement planning.

ENROLLMENT INSTRUCTIONS (Do Not Send to ADP)

Follow these simple steps to enroll in your company retirement plan.

I DECIDE HOW MUCH TO SAVE

Deductions are subject to maximum deferral and contributions limits. Refer to your Summary Plan Description (SPD) or consult your Plan Administrator to review plan limits. Through your plan, you can make:

- **Before-tax contributions**
- **Roth 401(k) contributions**

II CHOOSE YOUR INVESTMENTS

The list of your plan's investments is on the following page(s).

III ENROLL

You can either enroll online or use the automated Voice-Response System. You will need your User ID and Password to enroll.

- **Enrolling with no prior account balance:** Please use the password you received in the mail to enroll.
- **Enrolling with an existing account balance:** Use your current password to enroll if you have an account balance in your Plan due to a rollover/employer non-elective contribution.

Log on: www.mykplan.com (if available) OR Call: 1-800-mykplan(1-800-695-7526)

Once you have accessed your account, follow the steps to choose your contribution amount and investments. You will receive confirmation of your enrollment.

! OTHER IMPORTANT CONSIDERATIONS

Designate your beneficiary(ies): It's an important step in managing your account because it provides a way for you to pass ownership of your account assets on to your beneficiary(ies) after your death. Either submit a completed Beneficiary Designation Form or designate your beneficiary online.

Elect Save Smart: this feature lets you increase your pre-tax contributions by 1, 2, or 3% annually on the date you choose. It can help you meet your retirement savings goals by saving automatically over time.

Elect automatic Account Rebalancing: It's important to keep your asset allocation balanced. Once you've created your diversified allocation, this feature can keep it balanced for you.

ENROLLMENT INSTRUCTIONS

II PLAN INVESTMENTS

Remember to review the fund prospectuses, which provide complete information about the funds, including fees and expenses, before choosing your investments. See the Web site or your Plan Administrator to obtain fund prospectuses.

When you create your asset allocation, your investment election must total 100%.

Asset allocation funds.

These funds generally offer a diversification solution through just one fund.

9B	Franklin LifeSmart 2025 Retirement Target Fund - Class A
2T	Franklin LifeSmart 2035 Retirement Target Fund - Class A
SO	Franklin LifeSmart 2045 Retirement Target Fund - Class A
GC	BlackRock Global Allocation Fund, Inc. - Investor A Class
JP	Janus Balanced Fund - Class A

Create your own asset allocation.

S9	Federated Capital Preservation Fund - ISP
3U	Pioneer Short Term Income Fund - Class A
KV	Janus Flexible Bond Fund - Class A
8C	Putnam Income Fund - Class A
J4	Aberdeen Equity Long Short Fund - Class A
2S	Templeton Global Total Return Fund - Class A
9U	Putnam Diversified Income Trust - Class A
6U	BlackRock S&P 500 Index Fund - Institutional Class
5P	JPMorgan Equity Income Fund - Class A
3C	Putnam Equity Income Fund - Class A
L8	Franklin Rising Dividends Fund - Class A
A1	Janus Forty Fund - Class A
1R	Putnam Equity Spectrum Fund - Class A
DN	Franklin Small Cap Value Fund - Class A
LI	Janus Triton Fund - Class A
LK	MFS International Value Fund - Class A
P0	Oppenheimer International Growth Fund - Class A
ZH	American Funds New World Fund - Class R3
73	Neuberger Berman Real Estate Fund - Class A

Social Security #: ___ – ___ – ____ Phone #: ___ – ___ – ____

Employee Name: _____
Last, First, Middle

Address: _____ _____
Street Apt. # / PO Box #

_____ ___ _____ – _____
City State Zip Code

Birth Date: ___ – ___ – ____ Hire Date: ___ – ___ – ____
Month Day Year Month Day Year

I ROLLOVER INSTRUCTIONS

The Rollover Form is used to invest prior plan money in your Plan account. The rollover must be completed within 60 days of receipt of the distribution, come from another employer's plan or an IRA and represent all or a portion of a lump sum distribution, or an installment distribution of less than ten years. In the context of a direct rollover, in which the funds are never actually made payable to you, the 60-day period for completing a rollover is inapplicable.

Section II.A. Check (✓) the appropriate box to identify the source of this Rollover.

Section II.B. Identify the total amount of the rollover. A certified or bank check must accompany this form for the stated dollar amount. Pre-printed checks are required. Handwritten checks will be returned to the Plan Administrator. **Please include your Social Security Number and Plan Number on the check made payable to Reliance Trust Company**.

Section III. Read the acknowledgment, and then sign and date the form.

Note: If you have not previously enrolled in the Plan, you must complete a Beneficiary Form and give it to your Plan Administrator. **Do not send to ADP.**

II ROLLOVER AMOUNT/SOURCE

A. This rollover is a distribution from:

☐ Individual Retirement Account ☐ SIMPLE IRA (IRA must be in existence for at least 2 years) ☐ §457 Plan ☐ §403(b) Tax Sheltered Annuity

☐ Qualified Plan of (check one): ☐ an Unrelated Employer ☐ a Related Employer

Note: If you do not check a box, we will understand you have certified that the rollover is from an unrelated employer.

B. Select rollover type:

☐ Before-Tax 401(k) $ _____.__
TOTAL ROLLOVER AMOUNT

☐ Roth 401(k) $ _____.__ = $ _____.__ + $ _____.__
TOTAL ROLLOVER AMOUNT Contributions Earnings

NOTE: Rollovers of Roth 401(k) monies may only be made via direct rollover and may not be rolled over from an IRA.

III ACKNOWLEDGMENT, ROLLOVER INVESTMENT DIRECTION AND SIGNATURE

I have read and understand the Summary Plan Description and Participant Fee Disclosure Statement, have completed the Beneficiary Form if I have not previously enrolled in the plan, and agree to be bound by the provisions of the Plan. I have also reviewed a description of each of the funds, and understand the objectives, risks, expenses and charges associated with each. I certify that:

- I received the distribution from the source indicated above within the last 60 days (60-day requirement not applicable in the case of a direct rollover).
- The rollover is from the rollover source indicated above and has not been combined with any money that would disqualify the rollover.
- No portion of this rollover contribution represents amounts received as a hardship distribution from an employer plan.

I understand that if I do not have a plan account one will be established for my rollover contribution and invested in the plan default fund. Once my account has been established, I will be mailed my account access information and can make investment allocation changes through the plan website or Voice Response System. If I already have a plan account established, I direct that my rollover contribution be invested in accordance with my investment election on file.

In an effort to prevent short-term trading and market timing, many investment companies have established excessive trading and/or redemption fee policies for certain investments. ADP Retirement Services, whenever possible, implements the investment company's market timing policy (please review the fund's prospectus for information on a specific fund company's policies). However, there are instances when ADP Retirement Services may need to implement its own market timing policy, which could differ from the investment company's policy, in order to ensure compliance with the fund's prospectus. Because investment options in your retirement savings plan may be subject to these policies, please refer to your Plan Participant Web site (or, if the Web site is not available to you, call a Client Services Representative) for additional information.

_____ _____
Signature of Employee/Participant Date

FOR PLAN ADMINISTRATOR USE ONLY (MUST BE COMPLETED)

Company Code: ____ Date Received: _____ Plan Administrator Approval: _____ Date Roth 401(k) contributions began: *(If not provided, ADP will use date contribution is received)* _____ / _____ / 20_____

Recordkeeping Plan #: 717690

Fund Name[1]/Inception	Morningstar Category	Ticker[2]
Income		
Federated Capital Preservation Fund - ISP (08/1986)	N/A	N/A
Pioneer Short Term Income Fund - Class A (07/2004)	Short-Term Bond	STABX
Janus Flexible Bond Fund - Class A (07/2009)	Intermediate-Term Bond	JDFAX
Putnam Income Fund - Class A (11/1954)	Intermediate-Term Bond	PINCX
Templeton Global Total Return Fund - Class A (09/2008)	World Bond	TGTRX
Putnam Diversified Income Trust - Class A (10/1988)	Nontraditional Bond	PDINX
Growth & Income		
Aberdeen Equity Long Short Fund - Class A (10/2001)	Long-Short Equity	MLSAX
Franklin LifeSmart 2025 Retirement Target Fund - Class A (08/2006)	Target-Date 2025	FTRTX
Franklin LifeSmart 2035 Retirement Target Fund - Class A (08/2006)	Target-Date 2035	FRTAX
Franklin LifeSmart 2045 Retirement Target Fund - Class A (08/2006)	Target-Date 2045	FTTAX
BlackRock Global Allocation Fund, Inc. - Investor A Class (10/1994)	World Allocation	MDLOX
Janus Balanced Fund - Class A (07/2009)	Allocation--50% to 70% Equity	JDBAX
Growth		
BlackRock S&P 500 Index Fund - Institutional Class (04/2013)	Large Blend	BSPIX
JPMorgan Equity Income Fund - Class A (02/1992)	Large Value	OIEIX
Putnam Equity Income Fund - Class A (06/1977)	Large Value	PEYAX
Franklin Rising Dividends Fund - Class A (01/1987)	Large Blend	FRDPX
Janus Forty Fund - Class A (09/2004)	Large Growth	JDCAX
Putnam Equity Spectrum Fund - Class A (05/2009)	Mid-Cap Blend	PYSAX
Aggressive Growth		
Franklin Small Cap Value Fund - Class A (03/1996)	Small Value	FRVLX
Janus Triton Fund - Class A (07/2009)	Small Growth	JGMA
MFS International Value Fund - Class A (10/1995)	Foreign Large Blend	MGIAX
Oppenheimer International Growth Fund - Class A (03/1996)	Foreign Large Growth	OIGAX
American Funds New World Fund - Class R3 (06/2002)	Diversified Emerging Mkts	RNWCX
Neuberger Berman Real Estate Fund - Class A (06/2010)	Real Estate	NREAX

Federated Capital Preservation Fund - ISP
STRATEGY: The fund seeks to offer investors stable principal and current income. The fund invests in stable value products, including traditional GICs, synthetic GICs, separate account GICs and money market instruments. The fund serves as a conservative investment option for qualified retirement plan investors, and features a track record of more than 25 years.

Pioneer Short Term Income Fund - Class A
STRATEGY: The investment seeks a high level of current income to the extent consistent with a relatively high level of stability of principal. Normally, at least 80% of the fund's net assets (plus the amount of borrowings, if any, for investment purposes) are invested in debt securities that are rated investment grade at the time of purchase or cash and cash equivalents. The fund may invest up to 20% of its total assets in securities of non-U.S. issuers, including up to 5% of its total assets in debt securities of emerging market issuers.

Janus Flexible Bond Fund - Class A
STRATEGY: The investment seeks maximum total return, consistent with preservation of capital. The fund normally invests at least 80% of its net assets (plus any borrowings for investment purposes) in bonds. Bonds include, but are not limited to, government notes and bonds, corporate bonds, convertible bonds, commercial and residential mortgage-backed securities, and zero-coupon bonds. It will invest at least 65% of its assets in investment grade debt securities. The fund will limit its investment in high-yield/high-risk bonds, also known as "junk" bonds, to 35% or less of its net assets.

Putnam Income Fund - Class A
STRATEGY: The investment seeks high current income consistent with prudent risk. The fund invests mainly in bonds that are securitized debt instruments (such as mortgage-backed investments) and other obligations of companies and governments worldwide denominated in U.S. dollars, are either investment-grade or below-investment-grade in quality (sometimes referred to as "junk bonds") and have intermediate- to long-term maturities (three years or longer). It typically uses to a significant extent derivatives, such as futures, options, and swap contracts, for both hedging and non-hedging purposes.

Templeton Global Total Return Fund - Class A
STRATEGY: The investment seeks total investment return consisting of a combination of interest income, capital appreciation, and currency gains. Under normal market conditions, the fund invests primarily in fixed and floating rate debt securities and debt obligations (including convertible bonds) of governments, government agencies and government-related or corporate issuers worldwide (collectively, "bonds"). Bonds may be denominated and issued in the local currency or in another currency. Bonds include debt securities of any maturity, such as bonds, notes, bills and debentures. The fund is non-diversified.

Putnam Diversified Income Trust - Class A
STRATEGY: The investment seeks as high a level of current income as Putnam Investment Management, LLC believes is consistent with preservation of capital. The fund invests mainly in bonds that are securitized debt instruments (such as mortgage-backed investments) and other obligations of companies and governments worldwide, are either investment-grade or below-investment-grade in quality (sometimes referred to as "junk bonds") and have intermediate- to long-term maturities (three years or longer).

Aberdeen Equity Long Short Fund - Class A
STRATEGY: The investment seeks long-term capital appreciation. The fund will invest at least 80% of the value of its net assets, plus any borrowings for investment purposes, in equity securities of companies that are organized under the laws of, or have their principal office in the United States, have their principal securities trading market in the United States, derive the highest concentration of their annual revenue or earnings or assets from goods produced, sales made or services performed in the United States (and meets one or more of the other criteria); and/or issue securities denominated in the currency of the United States.

Franklin LifeSmart 2025 Retirement Target Fund - Class A
STRATEGY: The investment seeks the highest level of long-term total return consistent with its asset allocation. Under normal market conditions, the investment manager allocates the fund's assets among the broad asset classes of equity, fixed-income and alternative (non-traditional) investments and strategies by investing primarily in a distinctly-weighted combination of underlying funds, predominantly other Franklin Templeton mutual funds and exchange-traded funds (ETFs), based on each underlying fund's predominant asset class and strategy. These underlying funds, in turn, invest in a variety of U.S. and foreign equity, fixed-income and alternative investments.

Franklin LifeSmart 2035 Retirement Target Fund - Class A
STRATEGY: The investment seeks long-term total return consistent with its asset allocation. Under normal market conditions, the investment manager allocates the fund's assets among the broad asset classes of equity, fixed-income and alternative (non-traditional) investments and strategies by investing primarily in a distinctly-weighted combination of underlying funds, predominantly other Franklin Templeton mutual funds and exchange-traded funds (ETFs), based on each underlying fund's predominant asset class and strategy. These underlying funds, in turn, invest in a variety of U.S. and foreign equity, fixed-income and alternative investments.

Note: Important information regarding these funds is contained in this Performance Summary. For complete information about any fund contained herein, including fund objectives, risks, fees and expenses, please obtain a copy of the fund's prospectus from your Financial Advisor and/or plan sponsor.

Franklin LifeSmart 2045 Retirement Target Fund - Class A
STRATEGY: The investment seeks long-term total return consistent with its asset allocation. Under normal market conditions, the investment manager allocates the fund's assets among the broad asset classes of equity, fixed-income and alternative (non-traditional) investments and strategies by investing primarily in a distinctly-weighted combination of underlying funds, predominantly other Franklin Templeton mutual funds and exchange-traded funds (ETFs), based on each underlying fund's predominant asset class and strategy. These underlying funds, in turn, invest in a variety of U.S. and foreign equity, fixed-income and alternative investments.

BlackRock Global Allocation Fund, Inc. - Investor A Class
STRATEGY: The investment seeks to provide high total investment return. The fund invests in a portfolio of equity, debt and money market securities. Generally, the fund's portfolio will include both equity and debt securities. It may invest up to 35% of its total assets in "junk bonds," corporate loans and distressed securities. The fund may also invest in Real Estate Investment Trusts ("REITs") and securities related to real assets (like real estate- or precious metals-related securities) such as stock, bonds or convertible bonds issued by REITs or companies that mine precious metals.

Janus Balanced Fund - Class A
STRATEGY: The investment seeks long-term capital growth, consistent with preservation of capital and balanced by current income. The fund pursues its investment objective by normally investing 35-65% of its assets in equity securities and the remaining assets in fixed-income securities and cash equivalents. It normally invests at least 25% of its assets in fixed-income senior securities. The fund's fixed-income investments may reflect a broad range of credit qualities and may include corporate debt securities, U.S. government obligations, mortgage-backed securities and other mortgage-related products, and short-term securities.

BlackRock S&P 500 Index Fund - Institutional Class
STRATEGY: The investment seeks to provide investment results that correspond to the total return performance of publicly-traded common stocks in the aggregate, as represented by the Standard & Poor's 500 Index. The fund is a "feeder" fund that invests all of its assets in the Master Portfolio of MIP, which has the same investment objective and strategies as the fund. At least 90% of the value of the fund's assets is invested in securities comprising the S&P 500 Index. The percentage of the fund's assets invested in a given stock is approximately the same as the percentage such stock represents in the S&P 500 Index.

JPMorgan Equity Income Fund - Class A
STRATEGY: The investment seeks capital appreciation and current income. Under normal circumstances, at least 80% of the fund's assets will be invested in the equity securities of corporations that regularly pay dividends, including common stocks and debt securities and preferred stock convertible to common stock. "Assets" means net assets, plus the amount of borrowings for investment purposes. Although the fund invests primarily in securities of large cap companies, it may invest in equity investments of companies across all market capitalizations.

Putnam Equity Income Fund - Class A
STRATEGY: The investment seeks capital growth and current income. The fund invests mainly in common stocks of midsize and large U.S. companies, with a focus on value stocks that offer the potential for capital growth, current income, or both. Value stocks are issued by companies that the adviser believes are currently undervalued by the market. The adviser may consider, among other factors, a company's valuation, financial strength, growth potential, competitive position in its industry, projected future earnings, cash flows and dividends when deciding whether to buy or sell investments.

Franklin Rising Dividends Fund - Class A
STRATEGY: The investment seeks long-term capital appreciation. The fund invests at least 80% of its net assets in investments of companies that have paid consistently rising dividends. It invests predominantly in equity securities, primarily common stock. The fund may invest in companies of any size, across the entire market spectrum. It may invest up to 25% of its total assets in foreign securities.

Janus Forty Fund - Class A
STRATEGY: The investment seeks long-term growth of capital. The fund pursues its investment objective by normally investing primarily in a core group of 20-40 common stocks selected for their growth potential. It may invest in companies of any size, from larger, well-established companies to smaller, emerging growth companies. The fund may also invest in foreign securities, which may include investments in emerging markets. It is non-diversified.

Putnam Equity Spectrum Fund - Class A
STRATEGY: The investment seeks capital appreciation. The fund invests in equity securities of companies of any size, including both growth and value stocks, that the managers believe have favorable investment potential. The adviser expects to invest in leveraged companies, which employ significant leverage in their capital structure through borrowing from banks or other lenders or through issuing fixed-income, convertible or preferred equity securities, and their fixed income securities are often rated below-investment-grade (sometimes referred to as "junk bonds"). The fund is non-diversified.

Franklin Small Cap Value Fund - Class A
STRATEGY: The investment seeks long-term total return. The fund normally invests at least 80% of its net assets in investments of small-capitalization (small-cap) companies. Small-cap companies are companies with market capitalizations not exceeding either: 1) the highest market capitalization in the Russell 2000 Index; or 2) the 12-month average of the highest market capitalization in the Russell 2000 Index. It generally invests in equity securities that the fund's investment manager believes are undervalued at the time of purchase and have the potential for capital appreciation. It may invest up to 25% of its total assets in foreign securities.

Note: Important information regarding these funds is contained in this Performance Summary. For complete information about any fund contained herein, including fund objectives, risks, fees and expenses, please obtain a copy of the fund's prospectus from your Financial Advisor and/or plan sponsor.

Janus Triton Fund - Class A
STRATEGY: The investment seeks long-term growth of capital. The fund pursues its investment objective by investing primarily in common stocks selected for their growth potential. In pursuing that objective, it invests in equity securities of small- and medium-sized companies. Generally, small- and medium-sized companies have a market capitalization of less than $10 billion. Market capitalization is a commonly used measure of the size and value of a company. The fund may also invest in foreign securities, which may include investments in emerging markets.

MFS International Value Fund - Class A
STRATEGY: The investment seeks capital appreciation. The fund normally invests its assets primarily in foreign equity securities, including emerging market equity securities. Equity securities include common stocks and other securities that represent an ownership interest (or right to acquire an ownership interest) in a company or other issuer. The advisor focuses on investing the fund's assets in the stocks of companies it believes are undervalued compared to their intrinsic value (value companies).

Oppenheimer International Growth Fund - Class A
STRATEGY: The investment seeks capital appreciation. The fund mainly invests in the common stock of growth companies that are domiciled or have their primary operations outside of the United States. It may invest 100% of its assets in securities of foreign companies. The fund may invest in emerging markets as well as in developed markets throughout the world. It normally will invest at least 65% of its total assets in common and preferred stocks of issuers in at least three different countries outside of the United States, and emphasize investments in common stocks of issuers that the portfolio managers consider to be "growth" companies.

American Funds New World Fund - Class R3
STRATEGY: The investment seeks long-term capital appreciation. The fund invests primarily in common stocks of companies with significant exposure to countries with developing economies and/or markets. Under normal market conditions, the fund will invest at least 35% of its assets in equity and debt securities of issuers primarily based in qualified countries that have developing economies and/or markets.

Neuberger Berman Real Estate Fund - Class A
STRATEGY: The investment seeks total return through investment in real estate securities, emphasizing both capital appreciation and current income. The fund normally invests at least 80% of its net assets in equity securities issued by real estate investment trusts ("REITs") and common stocks and other securities issued by other real estate companies. The managers define a real estate company as one that derives at least 50% of its revenue from, or has at least 50% of its assets in, real estate. The fund may invest up to 20% of its net assets in debt securities of real estate companies. It is non-diversified.

ADDITIONAL DISCLOSURES

For more complete information on the investment options, including the investment objectives, risks, charges and expenses, please consult the prospectuses and other comparable documents. Investors should carefully consider the investment objectives, risks, charges and expenses before investing. This, and additional information about the investment options, can be found in the prospectuses, which can be obtained by calling your Merrill Lynch Financial Advisor and/or plan sponsor. Please read these documents carefully before investing.

NAV (Net Asset Value) is determined by calculating the total assets, deducting total liabilities and dividing the result by the number of shares outstanding.

Performance information for all publicly traded mutual funds, excluding Money Market funds, is provided by Morningstar®. Performance information for Money Market funds and certain other types of funds is provided by the respective fund manager.

Expressed in percentage terms, Morningstar's calculation of total return is determined each month by taking the change in monthly net asset value, reinvesting all income and capital-gains distributions during that month, and dividing by the starting NAV. Reinvestments are made using the actual reinvestment NAV, and daily payoffs are reinvested monthly.

The Investment Strategy is provided by Morningstar® for all publicly traded mutual funds. Investment Strategy information for Money Market funds and certain other types of funds are provided by the respective fund manager.

Investment Type Definitions:

The investment types are four broad investment categories; each fund is categorized based on where the fund is listed in Morningstar, Inc.'s investment category. Income: Money Market, Stable Value, and Fixed Income investment funds. Growth and Income: Balanced and Lifestyle investment funds. Growth: Large and Mid Capitalization investment funds. Aggressive Growth: Small Capitalization, Specialty, Foreign Stock and World Stock investment funds.

The Morningstar Category identifies funds based on their actual investment styles as measured by their underlying portfolio holdings (portfolio statistics and compositions over the past three years). If the fund is new and has no portfolio, we estimate where it will fall before assigning a more permanent category. When necessary, we may change a category assignment based on current information.

Note: Important information regarding these funds is contained in this Performance Summary. For complete information about any fund contained herein, including fund objectives, risks, fees and expenses, please obtain a copy of the fund's prospectus from your Financial Advisor and/or plan sponsor.

Plan information

ACCOUNT ACCESS

You can access your account anytime.*

- www.mykplan.com
- 1-800-695-7526
  You may also speak with a Service Representative Monday through Friday 8 am– 9 pm ET on days when the New York Stock Exchange is open.

PLAN ELIGIBILITY

You can take advantage of this employee benefit as soon as you have met your plan's age and service eligibility requirements:

- You are immediately eligible to participate in the plan on the next plan entry date.

CONTRIBUTIONS

- **Pre-tax:** 1% to 90%
- **Roth 401k:** 1% to 90%
- If you're over 50, you may also make a catch-up contribution in excess of Internal Revenue Code or plan limits. You may save an additional $6,000 in your plan.

EMPLOYER CONTRIBUTIONS

Safe Harbor Contribution equals 100% on the first 3% of the participants compensation...,Plus 50% of the next 2% of the participant`s compensation.

VESTING

Your contributions and any amounts you rolled into the plan, adjusted for gains and losses, are always 100% yours. Your company contribution account vests according to the following schedule:

Years of service:	1	2	3	4	5	6	7
Safe Harbor Contribution % vested:	Immediately vested						

PLAN INVESTMENTS

You choose how to invest your savings. You may select from the following:

- The variety of investments listed in the Performance Summary.

LOANS

Your plan allows you to borrow from your savings. (A fee may apply.)

- Number of loans outstanding at any one time: 1
- Minimum loan amount: $500
- Maximum repayment period: Generally, 5 years, unless for the purchase of a primary residence.
- Interest rate: Prime + 2%

*Except during scheduled maintenance.

Customer Service Representatives are employed by ADP Broker-Dealer, Inc., an affiliate of ADP, LLC, One ADP Boulevard, Roseland, NJ 07068, Member FINRA.

WITHDRAWALS

Types:

- Rollover
- Age 59½
- Hardship

Special rules: Special rules exist for each type of withdrawal. You may be subject to a 10% penalty in addition to federal and state taxes if you withdraw money before age 59½. See your Web site for more information.

DISTRIBUTIONS

Vested savings may be eligible for distribution upon retirement, death, disability or termination of employment.

ROLLOVERS

Having all your savings in one place can make it easier to plan for retirement. Rollovers are accepted into the plan, even if you are not a participant yet. See the Rollover form for instructions for transferring money into your plan.

ACCOUNT MANAGEMENT FEATURES

You may elect this feature online at www.mykplan.com or by calling 1-800-695-7526.

Save Smart® allows you to save gradually over time, as you can afford to, to help you meet your retirement savings goals. This feature lets you increase your pre-tax plan contribution by 1, 2, or 3% annually on the date you choose.

Automatic Account Rebalancing can help you maintain the long-term investment strategy you decide is appropriate for meeting your savings goals. Once you have created your diversified asset allocation for your savings, automatic Account Rebalancing will rebalance your account as often as you choose: quarterly, semi-annually, or annually.

To get help with your retirement strategy, you may consult with your plan's financial advisor(s):

April Ylvisaker
(207)871-1980
april.ylvisaker@ml.com

Take the first step.

Enroll Today.

ACCOUNT RESOURCES

Once you set up your account, it's easy to stay connected and get information.

Online: www.mykplan.com

The website provides instant access to your retirement account and the ability to make changes and perform transactions. You'll also find tools and calculators to help with your investment planning decisions so you can make the most of your plan benefit:

- Research plan investments
- Transfer balances
- Change your contribution amounts
- Elect Save Smart® and automatic Account Rebalancing
- Get prospectuses

Phone: 1-800-695-7526

The Voice Response System connects you to your plan account over the phone. Call 1-800-695-7526 to get account information and perform many of the transactions available on the website.

You can also speak to a Customer Service Representative Monday – Friday, 8am – 9pm ET.

QUARTERLY ACCOUNT STATEMENT

Stay informed about your progress. Your statement has details about your account, investment performance, and account activity for the period. Available on your plan website.

Customer Service Representatives are employed by ADP Broker-Dealer, Inc., an affiliate of ADP, LLC, One ADP Boulevard, Roseland, NJ 07068. Member FINRA.

If you were provided with access information at your enrollment meeting, you can enroll online now at https://www.mykplan.com/enroll

You'll need to enter the plan number and passcode you received at the enrollment meeting:

Plan number: 717690

Passcode: digtprosp-ESS

AFTER YOU OPEN YOUR ACCOUNT AND YOUR PLAN IS LIVE, YOU CAN:

- access the resources on the web and Voice-Response System
- speak to a representative
- review your quarterly account statements (when available)

Use your User ID and Password to get your account information and access the site. Your Password will be mailed to you. If you lose your Password or want to change it, just call 1-800-695-7526 or go to www.mykplan.com and follow the prompts.

WANT TO LEARN MORE?

Scan the code with your mobile device to enroll.

Get there one step at a time.

000001_ENG_010001

ADP: A Global Leader

Founded in 1949, Automatic Data Processing, Inc. (ADP) and its companies bring more than 60 years of unrivaled industry experience. ADP is a strong, stable partner you can rely on:

- Serving more than 620,000 businesses in more than 125 countries[1]
- Exceptionally strong Aa1 credit rating from Moody's and AA from Standard & Poor's[2]
- Pays approximately 24 million (1 in 6) workers in the U.S. and 10 million elsewhere[1]
- Top-ranked company in Financial Data Services in FORTUNE® magazine's The World's Most Admired Companies[3]
- Forbes magazine —100 Most Innovative Companies[4]

[1] Source: Automatic Data Processing LLC, 2013 Annual Report.
[2] Source: Moody's and Standard & Poor's.
[3] Source: FORTUNE® Magazine's Most Admired Companies 2014.
[4] Source: Forbes Magazine, August 2013.

Investment options are available through ADP Broker-Dealer, Inc., an affiliate of ADP, LLC, One ADP Blvd., Roseland, NJ 07068. Member FINRA.

ADP, LLC and its affiliates do not offer investment, tax or legal advice and nothing contained in this communication is intended to be, nor should be construed as, advice or a recommendation for a particular investment option. Questions about how laws, regulations and guidance apply to a specific plan should be directed to your plan administrator or legal, tax or financial advisor.

1/2011-FN

For complete information about a particular fund or to obtain a fund prospectus (or information statement, in the case of commingled funds), go to www.mykplan.com or call the Voice-Response System. You should carefully consider an investment option's objectives, risks, charges and expenses before investing. The prospectus (or information statement, as applicable) contains this and other important information about the investment option and investment company. Please read the prospectus/information statement carefully before you invest or send money.

ADP Broker-Dealer, Inc.
One ADP Boulevard
Roseland, NJ 07068
Member FINRA

A more human resource.℠

04-3012-1215

This book was printed on 30% Post-Consumer recycled fiber.

Digital Prospectors 401(k) Retirement Plan
Summary Plan Description

INTRODUCTION

Sooner or later, you're going to need savings to supplement your retirement income. Achieving financial security for your future is not just a matter of how much you earn, but more importantly, it's a matter of how much you save.

By saving regularly through your Company's 401(k) savings Plan, even if only a few dollars each payday, you can accumulate more money in a few years than you would think possible. It is one of the surest ways to give yourself a head start on developing financial security.

Digital Prospectors Corporation wants to help you meet your financial goals with this Plan. Your savings grow faster with tax-deferred dollars, Company contributions (if any), and investment opportunities. Set your goals high and join the Plan.

This booklet describes the major features of the Digital Prospectors 401(k) Retirement Plan effective as of May 01, 2015. Read this booklet carefully and think about it. The question should not be whether you should join, but how little or how much you should invest for your financial security.

Copies of the Plan and certain related documents are available for your review in the offices of the Company. IF THERE ARE ANY DIFFERENCES BETWEEN THIS DESCRIPTION AND THE TERMS OF THE PLAN DOCUMENT, THE TERMS OF THE PLAN DOCUMENT WILL GOVERN. Likewise, any oral information provided to you regarding the terms of the Plan is not binding on the Plan or the Plan's administrator to the extent it conflicts with the terms of the Plan document.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

All employees of Digital Prospectors Corporation and any participating Affiliates, if applicable are eligible to participate in the Plan.

WHEN DOES PLAN PARTICIPATION BEGIN?

You will become a participant on the first day of the month following your date of hire.

HOW DOES THE PLAN WORK?

The basic operation of the Plan is simple:

You may elect to defer a percentage of your eligible pay every pay period. This contribution is known as your Elective Deferrals. In order to make Elective Deferrals, you must complete an Enrollment Form and return it to the Company prior to the date established by the administrator at your Company, or enroll through the ADP Voice Response System or the Participant Website. You should consult the administrator at your Company to learn which enrollment methods are available for your Company. Your Elective Deferrals will then begin in the first payroll cycle of the following month.

For purposes of the Plan, eligible earnings is defined as compensation as reflected on your Form W-2 including your Elective Deferrals and any other contributions you may have made to a "Section 125" cafeteria plan, and any qualified transportation fringe benefits under Section 132(f)(4) of the Internal Revenue Code (the "Code"). If you are self-employed, your eligible earnings will be your Earned Income. For purposes of determining benefits under the Plan, eligible earnings also will include payments made within the later of 2-1/2 months after you sever from employment (as defined under Section 401(k) of the Code) and the end of the Plan Year or Limitation Year (whichever is applicable) that includes your severance date, if they are (1) payments that, absent a severance from employment, would have been paid to you while you continued in employment with the Company and are regular compensation for services during or outside your regular working hours, commissions, bonuses, or other similar compensation; (2) payments for accrued sick, vacation or other leave (but only if you would have been able to use the leave if your employment continued); or (3) payments you receive under a nonqualified deferred compensation plan (but only if the payments are taxable and would have been paid to you if your employment had continued). If the Company makes "differential wage payments" (defined below) to employees who are on active military duty for a period of more than 30 days, those payments also will be included in eligible earnings. "Differential wage payments" are any payments made by an employer to an individual for any period during which the individual is performing service in the uniformed services while on active duty for a period of more than 30 days and which represents all or a portion of the wages he or she would have received from the employer if the individual were performing services for the employer. Please note that the inclusion in eligible earnings of any post-termination amounts (including differential wage payments) described in this paragraph is subject to the exclusions from eligible earnings elected by the Company, if any, described earlier in this Section.

The amount of your Elective Deferrals and any additional Company contributions are invested as you direct in accordance with the investment options provided in the Plan. These contributions (other than contributions of Roth Elective Deferrals, as explained in the discussion of Elective Deferrals in the Section entitled "What contributions are made to the Plan?") and any accumulated investment earnings on all contributions will be tax-deferred until you receive a distribution. Special rules apply regarding the tax treatment of earnings on Roth Elective Deferrals . See the Section entitled "How are my distributions from the Plan taxed?" below.

The Plan has several features that allow you to tailor it to your own personal needs. You decide whether or not you want to make Elective Deferrals from 1% to 90% of your eligible earnings. You decide how all contributions attributable to your total Account Balance are to be invested. You also have the right to change these decisions (see Question "What Happens if I Change my Mind?").

WHAT CONTRIBUTIONS ARE MADE TO THE PLAN?

- **ELECTIVE DEFERRALS**

Under our Plan you are able to make two kinds of Elective Deferrals. You may make Pre-Tax Elective Deferrals, or you may make Roth Elective Deferrals. If you make a Pre-Tax Elective Deferral, then your current taxable income is reduced by the amount of the deferral contribution so you pay less in current federal income taxes. Later, when the Plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings (unless you further delay income taxation by properly rolling these amounts over to another eligible tax qualified plan or a traditional individual retirement account). Therefore, with a Pre-Tax Elective Deferral, federal income taxes on the deferral contributions and on the earnings are only postponed. Eventually, you will have to pay taxes on these amounts. With a Roth Elective Deferral, you must pay current income tax on the deferral contribution. If you elect to make Roth Elective Deferrals, the deferral amounts are subject to federal income taxes in the year of deferral, but the deferrals and, as long as the distribution is "qualified", the earnings on the deferrals are not subject to federal income taxes when distributed to you (see the Section entitled "How are my Distributions from the Plan Taxed?"). You may contribute any combination of Pre-Tax Elective Deferrals and Roth Elective Deferrals from 1% to 90% (in whole percentages) of your eligible earnings. The total combined amount of your eligible earnings that you may defer either as a Pre-Tax Elective Deferral or as a Roth Elective Deferral is subject to both the Plan's limit on the maximum deferral percentage and the Internal Revenue Code limit on deferrals (see the section entitled "Are there any limits to the amount I can contribute?").

There are several ways to contribute Roth Elective Deferrals to the Plan. The first is by electing to contribute Roth Elective Deferrals directly to the Plan. (Roth Elective Deferrals contributed directly to the Plan will be recorded in a Roth Elective Deferral Account.) The second is by making a Roth Rollover Contribution to the Plan (see the section entitled "If I received a distribution from another eligible retirement plan, may I contribute that amount to the Plan?"). Except where otherwise indicated in this Summary Plan Description, Roth Elective Deferrals are treated the same as Pre-Tax Elective Deferrals under the Plan.

- **SAFE HARBOR MATCHING CONTRIBUTIONS**

  The Company will make a Safe Harbor Matching Contribution equal to 100% on the first 3% of your eligible earnings that you defer as an Elective Deferral and an additional 50% on the next 2% of your eligible earnings that you defer as an Elective Deferral.

  You must make Elective Deferrals in order to receive the Safe Harbor Matching Contribution.

  Safe Harbor Matching Contributions will be made each pay period.

  Each year that the Company will make Safe Harbor Matching Contributions, you will be notified at least 30 days (and no more than 90 days) prior to the beginning of the Plan Year that the Safe Harbor Matching Contributions will be made.

  If any employer Matching Contributions were contributed to the Plan before the Plan provided for Safe Harbor Matching Contributions, such Contributions are subject to the vesting, withdrawal, and distribution rules discussed later in this booklet.

ARE THERE ANY LIMITATIONS TO THE AMOUNT I CAN CONTRIBUTE?

Ordinarily, the Internal Revenue Service requires retirement plans that permit employees to defer taxes by making elective contributions to satisfy certain complex tests. Depending on the results of these tests, restrictions on contributions for certain higher paid employees may be necessary.By providing a Safe Harbor Contribution as described above, the Plan is not subject to these tests.

Congress also limits the annual dollar amount of Elective Deferrals that you can contribute to your account. For 2016, the limit is $18,000. After 2016, this limit will be adjusted for inflation.

Congress also limits the annual eligible earnings to be considered for purposes of qualified plan contributions and testing. For 2016, this limit is $265,000. This limit may also be increased periodically to reflect cost-of-living increases.

Finally, Congress limits the total amount of “annual additions” (contributions made to the Plan by you or by the Company on your behalf) allocated to your account each year. For 2016, this limit is the lesser of 100% of your eligible earnings (without regard to any exclusions from eligible earnings that your employer may have elected under the Plan) or $53,000.

For any Plan Year in which you contribute both Pre-Tax Elective Deferrals and Roth Elective Deferrals to the Plan, if it becomes necessary to make a corrective distribution of a portion of your Elective Deferrals to you to meet any of the above requirements, Pre-Tax Elective Deferrals will be returned before Roth Elective Deferrals.

DOES THE PLAN ALLOW “CATCH-UP” CONTRIBUTIONS?

While there are limitations to the amount of Elective Deferrals you can contribute, you will be permitted to exceed those limits if you are eligible to make a “catch-up” contribution. Catch-up

contributions are contributions that exceed either a statutory limit (such as the annual limit described above on the annual dollar amount of Elective Deferrals you can contribute to your account - $18,000 for 2016), your Plan's limit on the amount of Elective Deferrals you can contribute to your account, or any restrictions on contributions for certain higher paid employees that may be necessary as a result of certain tests.

If you are eligible to participate in the Plan and are projected to reach age 50 during a calendar year, you will be eligible to make a catch-up contribution at any time during that calendar year – you do not need to wait until your birthday. (There are special eligibility rules for collectively bargained (union) employees, however, that may delay the availability of catch-up contributions for these employees. If you are a union employee, you should confirm with your Plan's administrator when you will be eligible to make catch-up contributions to the Plan.)

If you are eligible to make catch-up contributions, you should contact your Plan's administrator to learn whether you need to take any special steps to make catch-up contributions under your Plan. If you wish to arrange to make catch-up contributions in excess of your Plan's limit on contributions, you will not be able to do so through either the ADP Voice Response System or the Participant Website; instead, you will have to arrange this through your Plan's administrator.

For 2016, the limit on catch-up contributions is $6,000. After 2016, this limit will be adjusted for inflation.

WHAT DOES VESTING MEAN?

Vesting is your right to the contributions in your total Account Balance. In other words, to be vested refers to that portion of your Account Balance that is yours and which cannot be forfeited. Upon termination of Employment, you are entitled to the entire vested portion of your Account Balance.

You are always 100% fully vested in your Elective Deferral , Safe Harbor Matching and Rollover (if any) Contribution Accounts.

In some circumstances, the Company may need to make special contributions on your behalf called Qualified Matching Contributions or Qualified Nonelective Contributions. If made, you are always 100% vested in these contribution accounts.

If you terminate Employment due to death, Disability (defined later in this booklet) or attainment of age 65, the Plan's Normal Retirement Age, you will also be 100% fully vested in your total Account Balance.

If you leave the Company for any other reason, you will be vested in your Nonelective Contributions Account according to the following schedule:

Years of Service	**Vested %**
Less than 2 years	0%
At least 2 years, but less than 3	20%

At least 3 years, but less than 4	40%
At least 4 years, but less than 5	60%
At least 5 years, but less than 6	80%
6 Years or more	100%

Your Years of Service for vesting are counted from your date of hire. For vesting, you will be credited with a Year of Service for each 12-month period beginning on your date of hire and ending on your last day of Employment with the Company and its affiliated companies, if any.

If you terminate employment and are rehired within the next 12 months, your period of absence will be included in determining your service for vesting purposes. If you are temporarily absent from service for a reason other than termination of employment, a period of up to 12 months will be counted in determining your service for vesting purposes. If you are absent from service for a reason other than termination, subsequently terminate and are then rehired within 12 months of your termination date, the period from your termination to the date you are rehired will count as vesting service. If you are in qualified military service, that military service will be considered service for vesting purposes to the extent required by federal law.

You will not be credited with vesting service during a Period of Severance. A Period of Severance usually occurs because you have terminated employment. If your employment is terminated and you are not rehired within the 12 consecutive months beginning on your date of termination, you will incur a 1-year Period of Severance. Each 12 consecutive months thereafter is considered another 1-year Period of Severance. If you are on a leave of absence for maternity or paternity reasons, you will not be considered to have begun a Period of Severance until the second anniversary of the first date of your leave if you have not returned to employment. The first 12 months of a maternity/paternity leave count as vesting service. The next 12 months neither count as service toward vesting nor as a Period of Severance.

If you terminate employment and are later rehired, your pre-termination service, including partial years, will always count in determining your vesting in any Employer contributions made on your behalf after you are rehired. However, if you are rehired after a five-year Period of Severance, your service after you are rehired will not count in determining your vesting in the Employer contributions that were made on your behalf before you first terminated.

CAN I FORFEIT ANY PORTION OF MY ACCOUNT?

If you terminate employment before becoming 100% vested in your account balance but do not take a distribution from the Plan, the non-vested portion of your account balance will be forfeited as of the date you have a five-year Period of Severance.

If you terminate employment before becoming 100% vested in your account balance and receive a distribution of the vested portion of your account, the non-vested portion of your account will be forfeited when you take your distribution. (Participants who terminate employment with a 0% vested percentage are deemed to take a distribution when they terminate.) If you are rehired as an employee eligible to participate in the Plan, however, the forfeited amount will be restored to your account if you repay the entire amount previously distributed to you within five years of your reemployment or,

if earlier, before you incur a five-year Period of Severance. If you do not repay the distribution - or if you are rehired after you have incurred a five-year Period of Severance, the forfeited portion of your account balance will remain forfeited and will not be restored. You should consult with your Plan's administrator if you are rehired and interested in repaying the portion of your account balance previously distributed to you.

WHAT HAPPENS IF I BECOME PERMANENTLY DISABLED?

If you become Disabled under the Plan while you were employed by the Employer, you become 100% vested in all your total Account Balance. You are considered to have a Disability when you become eligible for disability benefits under the Social Security Act.

HOW ARE CONTRIBUTIONS INVESTED?

Amounts contributed to the Plan are held in a trust created under the Plan. Contributions allocated to your account are invested according to your direction. Each of the investment funds that are offered has different investment objectives. The Administrative Committee has provided you with a description of each of these investment funds. Contact the Administrative Committee if you have questions regarding the different investments offered in the Plan.

WHAT HAPPENS IF I CHANGE MY MIND?

At any time, you can request that changes be made to your Elective Deferrals. The following requests for changes to Elective Deferrals made by 4:00 p.m. ET on a business day will be effective as of the next available payroll after your request is received:

- Increase or decrease the amount of your contribution;
- Suspend your contributions by changing your contributions to 0%; or
- Resume your contributions after you suspended your Elective Deferrals.

The following requests for changes that are received by 4:00 p.m. ET on a business day will be in effect the next business day:

- The investment of your future contributions; or
- Reallocate/transfer your current Account Balance.

WILL I RECEIVE A STATEMENT OF MY ACCOUNT?

You will receive a quarterly statement that shows the activity in your account for the calendar quarter, including contributions and investment earnings.

HOW IS THE VALUE OF MY ACCOUNT DETERMINED?

The value of your Account Balance can change depending on several factors, which include:

(a) Contributions that are made to the account;

(b) Increases or decreases in the market value of investments;

(c) Cost of investment management expenses, transactional costs and service charges (contact the administrator at the Company for information on these expenses, transactional costs and service charges, if any) ; and

(d) Loans and loan repayments.

All investments involve some risk. Thus, the value of the different investments may go down as well as up and the value of your account will vary accordingly. The statement of your account will reflect all transactions affecting the value of your account.

WHEN CAN I RECEIVE PLAN BENEFITS?

Benefits are payable to you after you leave the Company for any reason (retirement, termination, Disability or death):

- If you leave the Company, you can receive your vested benefit in a single lump sum payment or have the payment paid as a "direct rollover" to an individual retirement account or individual retirement annuity (an “IRA”) or to another employer's tax qualified plan. If you are eligible to establish a Roth IRA, you also may elect a direct rollover of the non-Roth portion of your vested benefit to a Roth IRA. If any portion of your vested benefit is attributable to Roth Elective Deferrals or Roth Rollover Contributions, that portion may only be rolled over to a Roth IRA or to a 401(k) plan or 403(b) plan that provides for Roth contributions.

- If you leave the Company, and the value of your vested account balance (minus any rollover contribution account but including any outstanding loan balance) is $5,000 or less on the applicable Valuation Date as provided under the Plan, the Company can cash your entire vested account balance out of the Plan

  If you are determined to be cashout-eligible and you fail to make a distribution election, the portion of your account balance attributable to your Roth Elective Deferral account and Roth Rollover Contribution account, if any, will be automatically rolled over to a Roth IRA established by a Roth IRA provider selected by the Administrator if that portion (excluding any outstanding loan balance) is greater than $1,000. The remaining portion of your account balance will be separately rolled over to a traditional IRA if that portion (excluding any outstanding loan balance) is greater than $1,000. If either portion is less than $1,000, it will be distributed to you in a lump sum.

If your account balance is automatically rolled over to an IRA, the IRA provider selected by your Company will establish an IRA for your benefit and the amount rolled over will be invested in an investment product designed to preserve principal and provide a reasonable rate of return and liquidity. Fees for the IRA will be charged against the IRA unless, if permitted by the IRA provider, you contact the IRA provider and request to make payment of the fees out-of-pocket. You may also contact the IRA provider at any time to request a distribution or rollover of your IRA balance.

Contact the Administrative Committee for further information regarding the Plan's procedures with regard to the automatic rollover process, the IRA provider that the Company has selected to hold automatic rollover IRAs for the Plan, and the IRA investment vehicle, as well as fees and interest rate earned on the account. The name, address, and telephone number of the Administrative Committee may be found in the Miscellaneous Items Section at the back of this Summary Plan Description.

- If your Account Balance (excluding any rollover contribution account but including any outstanding loan balance account) is greater than $5,000 as of the applicable Valuation Date as provided under the Plan, in addition to either a lump sum or direct rollover, you may choose to receive installments, request a partial withdrawal, or defer receiving payments until age 70½. If you choose to defer payments, your account will continue to be invested the way you direct and will be adjusted for any gains or losses which occur.

- In the event of your death before termination of Employment and before distribution of your benefits has begun, you will be 100% vested. Upon your death, your vested Account Balance will be payable in a single lump sum to your beneficiary. If your beneficiary is your surviving spouse, he or she may elect to roll over a lump sum distribution to another qualified plan or IRA. Any portion of a lump sum distribution attributable to Roth Elective Deferrals or Roth Rollover may only be rolled over by a surviving spouse to a qualified plan that accepts Roth contributions or to a Roth IRA. A non-spouse beneficiary may elect a direct rollover of a lump sum distribution to an IRA in accordance with and to the extent permitted under guidance issued by the Internal Revenue Service. Any portion of a lump sum distribution attributable to Roth Elective Deferrals or Roth Rollover Contributions may only be rolled over by a non-spouse beneficiary to a Roth IRA. Beneficiaries eligible to establish a Roth IRA may also elect a direct rollover of the non-Roth portion of a lump sum distribution to a Roth IRA, in accordance with and to the extent permitted under guidance issued by the Internal Revenue Service. The Plan's administrator is not responsible for determining eligibility to elect a direct rollover of non-Roth amounts to a Roth IRA. Please see the section of this SPD entitled "How Are My Distributions From the Plan Taxed" for further important information about direct rollovers to a Roth IRA of the non-Roth portion of a lump sum distribution. If you are not married, you may name anyone as your beneficiary, or change your beneficiary at any time on a form provided for that purpose. If you are married, you must name your spouse as beneficiary unless your spouse consents to the selection of someone else. Unless otherwise elected, the beneficiary will be your spouse or, if you have no surviving spouse, your descendants, or if you have no surviving descendants, your beneficiary will be your estate.

- If you continue working for the Company after age 70½ and you are a more than 5% owner, you must begin to receive your benefits by April 1 following the year in which you reach age 70½, even if you are still employed at the time. If you are not a 5% owner, you must begin to receive your benefits by April 1 following the later of the year in which you reach age 70½ or terminate Employment.

HOW ARE MY DISTRIBUTIONS FROM THE PLAN TAXED?

Distributions from this Plan that are received by you or your beneficiary are subject to current income taxes. However, under certain circumstances, such as a distribution to your spouse as your beneficiary, the income taxes on Plan distributions may be postponed or reduced. You will receive additional information about distributions from the Plan at the time you or your beneficiary is entitled to receive a benefit.

Distribution rules provide that any part of a distribution (including after-tax contributions) from a qualified plan (such as this Plan) can be rolled over to an eligible retirement plan. "Eligible retirement plans" to which a distribution may be rolled over include another employer's tax-qualified retirement plan; a §403(a) qualified annuity plan; a governmental §457 plan; a §403(b) tax-sheltered annuity; or an IRA. Any part of a distribution attributable to Roth Elective Deferrals or Roth Rollover Contributions may only be rolled over to a Roth IRA or to an employer's 401(k) plan or 403(b) plan that provides for Roth contributions. It is your responsibility to confirm that the plan to which you intend to roll over your distribution will accept the rollover from this Plan. Certain types of distributions are not eligible to be rolled over. These include distributions that are one of a series of substantially equal payments made over the life (or joint life expectancies) of the participant and his or her beneficiary, or over a specified period of 10 years or more, hardship withdrawals or a minimum required distribution under the Internal Revenue Code.

You are permitted to elect to have any distribution that is eligible for rollover treatment transferred directly to an eligible retirement plan (a "direct rollover" or "direct transfer"). You will receive a written explanation of your distribution options within a reasonable period of time before receiving a distribution that is eligible to be rolled over.

If you elect to have your benefit transferred as a direct rollover to an eligible retirement plan, then you must provide the administrator at your Company, in a timely manner, with information regarding the transferee plan. The administrator at your Company is entitled to reasonably rely on the information that you provide to him or her, and will not independently verify it.

Federal income tax withholding at a rate of 20% is required on any taxable distribution that is eligible to be rolled over but is not transferred directly to an eligible retirement plan. You cannot elect to forego withholding on these distributions. The only exception to this requirement is if your vested benefit is less than $200. Such amounts may also be subject to a 10% penalty tax if they are distributed before you attain age 59-1/2, but this amount is not withheld from a distribution. Mandatory 20% federal income tax withholding also applies to any eligible rollover distribution to your surviving spouse or non-spouse beneficiary that is not directly rolled over.

If you elect a direct rollover of the non-Roth portion of your benefit to a traditional IRA, your direct

rollover will not be subject to federal income tax withholding at the time of the transfer.

If you wish to elect a direct rollover of the non-Roth portion of your benefit to a Roth IRA, please note that any such direct rollover to a Roth IRA must be included in gross income, but is not subject to 10% excise tax for premature distributions. If a participant, beneficiary or alternate payee elects a direct rollover of the non-Roth portion of a distribution to a Roth IRA, no amount will be withheld from the direct rollover for federal income tax purposes. ***CAUTION: This means that a participant, beneficiary, or alternate payee making this election will be responsible for making sure he/she is able to pay the full amount of all required income taxes in connection with such a direct rollover. For this reason, participants, beneficiaries and alternate payees considering a direct rollover of non-Roth amounts to a Roth IRA are strongly encouraged to consult their tax advisor before making this election.*** If this Plan generally permits distribution and in-service withdrawal elections to be made on-line, please note that you may need to complete a paper form to make this particular election. Please contact your Plan's administrator for further information.

Roth Elective Deferrals are subject to federal income taxes in the year of deferral , but the deferrals and, as long as the distribution is "qualified", the earnings on the deferrals are not subject to federal income taxes when distributed to you. In order for the earnings on Roth Elective Deferrals and Roth Rollover Contributions to be distributed tax-free, any distribution from your Roth Elective Deferral or Roth Rollover Contribution Accounts must be a "qualified" distribution. In order to be a qualified distribution, the distribution must occur after one of the following: (1) your attainment of age 59½, (2) your disability (please note that "disability" for this purpose has a special meaning, as discussed below), or (3) your death. In addition, the distribution must occur after the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make a Roth Elective Deferral contribution to our Plan (or to another 401(k) Plan or 403(b) plan if such amount was rolled over into our Plan) and ending on the last day of the calendar year that is 5 years later. For example, if you make your first Roth Elective Deferral under this Plan on November 30, 2007, your 5-year participation period will end on December 31, 2011. If you made your first Roth Elective Deferral under another eligible retirement plan on September 1, 2006, and later make a Roth Rollover Contribution from that plan to this Plan, your 5-year participation period for all Roth Elective Deferrals in this Plan (whether contributed directly to this Plan or contributed as a Roth Rollover Contribution) will end on December 31, 2010. It is not necessary that you make a Roth Elective Deferral in each of the five years of your participation period. In the event that all or any portion of your Account Balance is distributed to a death beneficiary or an alternate payee under a qualified domestic relations order, the event and 5-year participation rule generally are determined by your situation (i.e., whether you would have met the requirements for a qualified distribution), not the situation of the person receiving the distribution.

As noted above, the term "disability" has a special meaning for purposes of whether a distribution of Roth Elective Deferrals or Roth Rollover Contributions and earnings on account of disability is a qualified distribution. For this purpose only, "disability" means that you are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in your death or to be of long-continued and indefinite duration. This definition may not be the same as the Plan's definition of Disability for other purposes under the Plan (for example, when your account becomes fully vested because of a Disability). If you request a qualified distribution of Roth Elective Deferrals and earnings on the grounds that your are disabled, you may be required to furnish proof to the Administrator that you meet the definition of disability for

purposes of a qualified distribution.

If a distribution from your Roth Elective Deferral or Roth Rollover Contribution accounts is not a qualified distribution, the earnings distributed with the Roth Elective Deferrals and Roth Rollover Contributions will be taxable to you at the time of distribution (unless you roll over the distribution to a Roth IRA or to another 401(k) plan or 403(b) plan that accepts Roth contributions). In addition, in some cases, there may be a 10% additional tax for early distributions on the earnings that are distributed.

You may want to consult with a professional tax advisor before you take a distribution of your benefits from the Plan. You may want to discuss other alternative methods available to you to defer the payment of taxes as well as applicable federal, state and/or local tax rules that may affect your distribution.

MAY I WITHDRAW FUNDS WHILE STILL EMPLOYED?

You may withdraw all or part of your vested Account Balance once you reach age 59½ . You may elect to limit the source of such a withdrawal to your Roth Elective Deferral and Roth Rollover Contribution Accounts to the extent the amount in the Sub-account is otherwise distributable. You may also withdraw any or part of your Rollover Contributions Account including any Roth Rollover Contributions Account to the extent the amount in the Sub-account is otherwise distributable in the Plan, at any time and at any age. See the section entitled "How are my distributions from the Plan taxed?" for important information regarding how distributions from your Roth Elective Deferral and Roth Rollover Contribution Accounts are taxed.

In the event of a financial hardship you may withdraw your own Elective Deferrals (excluding earnings on your Elective Deferrals) as well as any vested Nonelective Contributions. Safe Harbor Matching Contributions are not permitted to be withdrawn in the event of a financial hardship.

To make a hardship withdrawal under current Internal Revenue Service rules, you must be able to show that you are suffering an immediate and heavy financial hardship and that the money cannot be obtained from any other source. You must take any non-hardship in-service withdrawals that may be available to you under the Plan before you may obtain a hardship withdrawal. You also must first obtain the maximum available loan under the Plan. You will not be required to take the maximum available loan before receiving a hardship withdrawal to the extent that repaying the loan would increase the amount of your hardship. If you either do not take a loan or take a loan of less than the maximum available amount before requesting a hardship withdrawal, you must certify to your Plan's administrator in writing that repaying the maximum available loan amount would increase the amount of your hardship. You will need to contact your Plan's administrator if you need to provide this certification.

Circumstances that qualify as an immediate and heavy financial hardship are:

(a) Expenses for medical care (described in Section 213(d) of the Internal Revenue Code) previously incurred by you, your spouse, your dependent or your primary

beneficiary under the Plan or necessary for you, your spouse, dependent or your primary beneficiary under the Plan to obtain medical care;

(b) Costs directly related to the purchase of your principal residence (excluding mortgage payments);

(c) Tuition, related educational fees, and room and board expenses for the next twelve (12) months of post-secondary education for yourself, your spouse or dependent or your primary beneficiary under the Plan;

(d) Amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence;

(e) Payments for burial or funeral expenses for your deceased parent, spouse, children or other dependents or your primary beneficiary under the Plan; or

(f) Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code (determined without regard to whether the loss exceeds 10% of adjusted gross income).

For this purpose, a "primary beneficiary under the Plan" is an individual who is named as your beneficiary under the Plan and has an unconditional right to all or a portion of your account balance if you die. In addition, the amount of your hardship withdrawal must be no more than the amount necessary to satisfy your immediate and heavy financial need, plus any income taxes or penalties which are expected to result from the distribution. The minimum permitted hardship withdrawal is $500.

As previously explained, a hardship withdrawal is not considered to be an eligible rollover distribution by the IRS. The hardship withdrawal may be subject to a 10% excise tax imposed by the IRS. You will be suspended from making elective contributions for 6 months after you receive a hardship withdrawal that includes Elective Deferrals.

If you are a qualified member of the reserves, you also may be eligible to request a qualified reservist distribution. A qualified reservist distribution is an exception to Plan restrictions on withdrawal of elective deferrals. Further, the extra 10% tax on a payout before age 59½ does not apply to a qualified reservist distribution. A qualified reservist distribution from the Plan is:

- attributable to Pre-Tax Elective Deferrals,
- available to a person who because he or she is a member of a reserve component was ordered or called to active duty for more than 179 days (or for an indefinite period), and
- made during the period that began or begins on the date of the order or call to duty and ended or ends at the close of the active-duty period.

A person who receives or received a qualified reservist distribution may, during the two-year period

that begins on the day after the end of his or her active-duty period, contribute to an IRA an amount up to the amount of the qualified reservist distribution. Although the limits on IRA contributions don't apply to this special contribution, no deduction is allowed for it. This provision applies to a person ordered or called to active duty after September 11, 2001 and applies to a distribution after September 11, 2001.

HOW DO LOANS WORK?

Loans will be made on a uniform and non-discriminatory basis. Sole proprietors, partners and certain shareholder/employees that were excluded from taking a plan loan under prior law prior to 2002 are eligible to take a loan from the Plan.

The minimum loan is $500. You can borrow up to 50% of your vested Account Balance to a maximum of $50,000. However, the $50,000 amount in the preceding sentence is reduced by the highest outstanding loan balance you had under the Plan during the previous one-year period.

Loans must be fully repaid through payroll deductions within 5 years unless the loan is used for the purchase of your primary residence. Loans used to purchase your primary residence may be repaid within a period of no more than 30 years. You have to repay any outstanding loan before a new loan can be made. You may prepay an outstanding loan in full, by certified check, at any time.

The interest rate for a loan will be the rate in effect in the month your loan is effective. The interest rate is the prime rate as published in The Wall Street Journal on the 14th of each month, plus two percentage points. This interest rate is effective for any loan processed as of the 16th day of the month.

When you take a loan from the Plan, your repayment of the loan is secured by your Account Balance. If you terminate Employment, any remaining payments are due immediately unless you are a party in interest. If you qualify as a party in interest you may continue to repay your loan after termination of Employment. If you do not repay the loan, the outstanding loan balance will be included in your gross income for federal income tax purposes as if it were distributed to you. If you die with an outstanding loan balance, your death will cause your loan to be in default, and your outstanding loan balance will be regarded as if it were distributed to you.

If you enter into a period of military leave, your loan repayments will be suspended for the duration of your leave. If you enter into a leave of absence without pay, or at a rate of pay (after employment and income tax withholding) that is less than your required loan installments, your loan repayment obligation will be suspended for up to one year (or until the date your final loan payment is due, if earlier). If you do not resume repayments within any administrative grace period provided under the ADP Prototype Program after you return from a leave of absence (or when the suspension of your repayment obligation ends, if earlier, as explained in this paragraph), your loan will be in default and will be included in your gross income for federal income tax purposes as if it were distributed to you.

IF I RECEIVED A DISTRIBUTION FROM ANOTHER ELIGIBLE RETIREMENT PLAN, MAY I CONTRIBUTE THAT AMOUNT TO THE PLAN?

Yes. You may make a Rollover Contribution of benefits, in cash (exclusive of any outstanding notes on plan loans), from an "eligible retirement plan" to this Plan. You may not make a Rollover Contribution to the Plan that includes any voluntary nondeductible, i.e., "after-tax" contributions.

You may make a Rollover Contribution of non-Roth assets to this Plan from the following types of eligible retirement plans:

- a traditional IRA (rollovers from IRAs are limited to taxable distributions, i.e., your non-taxable IRA contributions plus earnings on any of your IRA contributions whether taxable or not);
- a SIMPLE IRA (as long as the SIMPLE IRA has been in existence for at least two years at the time of the distribution);
- an employer's qualified plan;
- a §403(a) qualified annuity plan;
- a governmental §457 plan; or
- a §403(b) tax-sheltered annuity.

In addition, you may make a "Roth rollover contribution" to the Plan. Roth rollover contributions will be recorded in a separate account called a Roth rollover account. A Roth rollover contribution is a rollover contribution that consists of Roth 401(k) deferrals and earnings that you roll over to this Plan from another eligible retirement plan in which you have participated. A Roth rollover contribution to this Plan must be in the form of a direct rollover to this Plan from the other eligible retirement plan. If you are interested in making a Roth rollover contribution to this Plan, please contact the Administrator beforehand.

You may request a direct transfer of your account in an eligible retirement plan or you may be able to roll over a distribution which was tax deferred (i.e., does not include any "after-tax" contributions), but with respect to a rollover you must do so within 60 days of receiving a distribution from the other plan.

WHAT ARE THE TOP-HEAVY PROVISIONS?

A top-heavy plan is a plan in which more than 60% of the combined Account Balances held under the Plan belong to "key employees". Key employees are generally officers, shareholders, and owners who earn above a certain compensation level and/or own more than a specified interest in the Company. If the Plan becomes top-heavy under applicable Internal Revenue Service rules, the Plan would be required to provide for minimum contributions and top-heavy vesting. The minimum contribution is generally a contribution by the Company allocated to all eligible Participants employed during the Plan Year equal to 3% of their eligible earnings (without regard to any exclusions from eligible earnings that your employer may have elected under the Plan) unless all key

employees receive a contribution of less than 3% of their eligible earnings. The amount you contribute to the Plan as an Elective Deferral is not included in calculating the 3% minimum contribution which may be required but is included in determining the contribution made on behalf of key employees. The 3% allocation will be made under this Plan or may be made under another defined contribution plan if the Company maintains one. Please note that if the Company maintains a defined benefit plan in which a participant also participates in addition to this Plan, the minimum contribution is 5%. In this case, the minimum contribution will be satisfied by providing for an accrued benefit under the defined benefit plan or by making the 5% contribution either to this Plan or to another defined contribution plan maintained by the Company. For more information on how a top-heavy contribution, if any, will be satisfied under the Plan, please contact the Plan's administrator.

WHAT ADMINISTRATIVE FEES MAY BE CHARGED TO YOUR PLAN ACCOUNT, AND HOW ARE THEY ASSESSED?

Plan administrative services, such as legal, consulting, audit, accounting, trustee, and recordkeeping services, may be required to administer our Plan. The cost for these services may be paid by the Company or from the Plan, or both. The actual fees deducted from your Account, if any, will be reflected on your quarterly account statement and on the Plan's Participant Website. For information about Plan administrative expenses and how they may be assessed, please refer to the "Plan Administrative Expenses" section of the Participant Fee Disclosure Statement, which is provided to you separately and incorporated herein by reference.

Administrative fees for certain services or transactions you request may be charged directly to your Account. For information about these charges, please refer to the "Individual Expenses" section of the Participant Fee Disclosure Statement, which is provided to you separately and incorporated herein by reference. If you request or receive a distribution of all or a portion of your Account Balance (whether in-service or following the date you leave the Company) or a plan loan, administrative fees for the processing of these transactions that are charged directly against your Account will be taken pro-rata from all of the mutual funds and collective investment funds in which your Account Balance is invested at the time the fees are taken from your account. The fees will not reduce the proceeds of the transaction requested (other than upon a complete distribution of your Account Balance).

WHAT FEES ARE CHARGED BY THE INVESTMENT FUNDS HELD IN YOUR ACCOUNT?

The investments in the Plan do not charge you commissions or sales loads for purchasing shares or investment units with your Plan account. Many of the investment funds available under the Plan do, however, pay fees and incur expenses that will most likely have an impact on your account balance. These investment fees and other expenses may reduce the returns generated by investment funds in which you invest. For example, investment options (such as mutual funds) pay an investment manager a fee for the management of the fund. In addition, some of the investment options pay "asset-based" fees (that is, fees based on the total assets invested in the fund) to various service providers, which may include the Plan's recordkeeper, for other investment and administrative services provided to the investment fund. In addition, certain funds may assess shareholder-type charges, such as a redemption fee when shares are sold, if they are not held for a minimum specified period). For more information about the fees charged or paid by various investment options, please

review the investment fund prospectus, or if the investment option does not have a prospectus, the information provided to you about the option, such as a Fund Fact Sheet. These documents, and other information about these fees, can be found on the Participant Website or by contacting your Plan administrator. Information about investment fund expenses and shareholder-type charges may also be found in the "Comparative Chart" section of the Participant Fee Disclosure Statement, which is provided to you separately and incorporated herein by reference.

ADDITIONAL ITEMS

A. BENEFIT CLAIMS PROCEDURES

Under the Plan, you generally will receive your benefit as a matter of course. However, in certain cases, you or your beneficiary may wish to request Plan benefits that you believe you are entitled to (all references herein to "you" shall include your beneficiaries). Any such request must be made by you or your authorized representative in writing, and it should be filed with the Administrative Committee. If you or your authorized representative file a claim under the Plan, you will be referred to as the "Claimant". *Note: If your Plan is subject to a collective bargaining agreement and the agreement contains certain provisions, then the procedures for resolution of claims set forth in that collective bargaining agreement will take the place of this claims procedure as permitted by Department of Labor regulations. Please contact your Plan administrator if you have questions regarding whether a collective bargaining agreement's claims procedures apply to you.*

General Claims Procedures

If the Claimant's claim is denied in whole or in part, the Administrative Committee will provide a written notice of denial to the Claimant or the Claimant's authorized representative within a reasonable period of time, but no later than 90 days after the Administrative Committee receives the claim. The 90-day period will begin to run once a claim is filed, without regard to whether the Claimant has provided all the information necessary to make the benefit determination. If the Administrative Committee determines that special circumstances require an extension beyond the initial 90-day period, the Administrative Committee will notify the Claimant or the Claimant's authorized representative in writing of the special circumstances that make the extension necessary and the date by which a decision may be expected before the end of the initial 90-day period. Any such extension may not exceed 90 days from the end of the initial 90-day period.

The Administrative Committee's notice of denial will explain the reason for the denial, refer to the specific Plan provisions on which the denial is based, describe any additional information or material needed from the Claimant to perfect his or her claim and why this information or material is necessary, and describe the Plan's claims review procedures and time limits.

Within 60 days after receiving the notice of denial, the Claimant or the Claimant's authorized representative may submit a written appeal of the denial to the Administrative Committee. The Claimant or the Claimant's authorized representative may, free of charge, review and request

copies of relevant documents, records, and other information relevant to the claim. The Claimant's appeal may include written comments, documents, records, and other information relating to the claim, regardless of whether the information was submitted or considered as part of the Claimant's initial claim for benefits.

The Administrative Committee will review the appeal and make a determination within a reasonable period of time, but no more than 60 days after the Administrative Committee receives the appeal. If the Administrative Committee determines that special circumstances require an extension, the Administrative Committee will notify the Claimant or the Claimant's authorized representative in writing of the special circumstances that make the extension necessary and the date by which a decision may be expected before the end of the initial 60-day period. Any such extension may not exceed 60 days from the end of the initial review period.

The Administrative Committee will provide a written determination on appeal which will explain the reasons for the decision, refer to the provisions of the Plan on which the decision is based, and inform the Claimant or the Claimant's authorized representative of any additional rights the Claimant may have. The determination on appeal by the Administrative Committee is the final determination under this claims procedure.

Disability Claims Procedures

If the Claimant's claim for benefits involves a disability determination and the Plan defines disability in a manner that requires the Plan to determine if the Claimant is disabled, the special claims procedures set forth below will apply. If, however, the Plan defines disability by reference to a determination of disability made by the Social Security Administration or pursuant to the Employer's long term disability plan, then the General Claims procedures described above will apply.

If the Claimant's claim is denied in whole or in part, the Administrative Committee will notify the Claimant or the Claimant's authorized representative within a reasonable period of time, but no later than 45 days after the Administrative Committee receives the claim. The 45-day period will begin to run once a claim is filed, without regard to whether the Claimant has provided all the information necessary to make the benefit determination. If the Administrative Committee determines that an extension is needed for reasons beyond the Administrative Committee's control, it may take up to two 30-day extensions for consideration of the claim. If the Administrative Committee takes an extension, the Administrative Committee will notify the Claimant or the Claimant's authorized representative in writing of the reason for the extension and the date by which a decision is expected before the end of the initial 45 day period (or, for a second extension, before the end of the first extension). The notice of extension will include an explanation of the standards on which the entitlement to the benefit claimed is based, the unresolved issues that are preventing a decision, and the additional information needed to resolve the issues. If the Administrative Committee requests additional information, the Claimant or the Claimant's authorized representative will have at least 45 days after receipt of the notice of extension to provide the information. The period during which the Administrative Committee waits for the Claimant or the Claimant's authorized representative to respond to the request for information will not count against the

30-day extension period (i.e. the 30-day extension period will be tolled from the date the notice of extension is sent to the Claimant or the Claimant's authorized representative to the date on which the Claimant or the Claimant's authorized representative responds to the request for additional information).

The Administrative Committee's notice of denial will explain the reason for the denial, refer to the specific Plan provisions on which the denial is based, describe any additional information or material needed from the Claimant to perfect his or her claim and why this information or material is necessary, and describe the Plan's claims review procedures and time limits. Additionally, if the Administrative Committee relies on an internal rule, guideline, or protocol in denying the claim, it will either provide a copy of the rule, guideline or protocol, or indicate that a rule, guideline or protocol was relied upon and is available free of charge to the Claimant or the Claimant's authorized representative on request.

Within 180 days after receiving the notice of denial, the Claimant or the Claimant's authorized representative may submit a written appeal of the denial. The Claimant or the Claimant's authorized representative may review and request copies of relevant documents, records, and other information relevant to the claim free of charge. Further, upon request by the Claimant or the Claimant's authorized representative, the identity of any medical or vocational expert whose advice was obtained in connection with the claim will be disclosed, regardless of whether his or her advice was relied upon in making the determination. The Claimant's appeal may include written comments, documents, records, and other information relating to the claim, regardless of whether it was submitted or considered as part of the initial application.

The Claimant's appeal will be reviewed by an appropriate Plan fiduciary (the "Reviewing Fiduciary") who is neither a member nor a subordinate of the Administrative Committee or its members. The Administrative Committee's initial decision shall not be given any deference. If the initial decision was based in whole or in part on a medical judgment, the Reviewing Fiduciary will consult with a health care professional with appropriate training and experience in the medical field involved. The Reviewing Fiduciary will not consult with a health care professional who was consulted in connection with the initial review of the claim or a subordinate of any such professional.

The Reviewing Fiduciary will review the appeal and make a determination within a reasonable period of time, but no more than 45 days after the Reviewing Fiduciary receives the appeal. If the Reviewing Fiduciary determines that special circumstances require an extension, it will notify the Claimant or the Claimant's authorized representative in writing of the special circumstances and the date by which a decision may be expected before the end of the initial 45-day period. Any such extension may not exceed 45 days from the end of the initial review period.

The Reviewing Fiduciary will provide a written determination on appeal which will explain the reasons for the decision, refer to the provisions of the Plan on which the decision is based, and inform the Claimant or the Claimant's authorized representative of any additional rights the Claimant may have. If the Reviewing Fiduciary relies on an internal rule, guideline, or protocol in denying the claim, the Reviewing Fiduciary will either provide a copy of the rule, guideline or protocol, or indicate that a rule, guideline or protocol was relied upon and is

available free of charge to the Claimant or the Claimant's authorized representative on request. The determination on appeal by the Reviewing Fiduciary is the final determination under this claims procedure.

B. PENSION BENEFIT GUARANTY CORPORATION

The Pension Benefit Guaranty Corporation does not insure benefits under the Plan. The reason is that plans that provide for individual accounts, such as the Plan, are excluded under the ERISA provisions that provide for such insurance coverage.

C. INVESTMENT INFORMATION

The Plan is called "an individual account plan". This means that you and all other participants have their own account in the Plan. The Plan is intended to satisfy the requirements of Section 404(c) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), .and Department of Labor Regulation Section 2550.404c-1 (29 C.F.R. 2550.404c-1). An ERISA Section 404(c) plan is an individual account plan which is designed to provide you with the opportunity to exercise control over the assets in your individual account, and also provides you with the opportunity to choose, from among a range of investment funds, the manner in which the assets in your account are invested. This means that you will have the responsibility for the investment decisions you make and the Plan's fiduciaries may be relieved of any liability to you under ERISA for any investment losses that are the direct and necessary result of your investment instructions.

Please note that your ability to direct the investment of your Plan account is subject to any restriction or limitation imposed by the underlying investment funds and/or your Plan, in particular, policies with respect to excessive trading (also known as market timing). The Plan's recordkeeper has put into place systematic solutions reasonably designed to assist investment fund companies with enforcing policies on and prohibitions relating to excessive trading. Any and all restrictions that the Plan's recordkeeper is enforcing will be identified to participants on the Plan's participant Web site, as well as through its Voice Response System, and may also be disclosed in materials provided to you describing the Plan's investment procedures and designated investment alternatives. In addition, at any time an investment fund or manager may limit or refuse to honor your investment election if it determines that it would result in excessive trading and/or would otherwise be adverse to the interests of the other shareholders and/or the investment fund, and/or would otherwise violate a policy of the underlying investment fund, and may require the Plan's recordkeeper to impose restrictions upon your ability to engage in transactions in an investment (or multiple investments).

The Company will provide you with the following information at your request:

- Copies of prospectuses (or, alternatively, short-form or summary prospectuses) or similar documents relating to designated investment alternatives under the Plan

- Copies of any financial statements or reports, such as statements of additional information, and any other similar materials relating to designated investments under the Plan to the extent provided to the Plan,

- A list of the assets comprising the portfolio of each designated investment alternative that are "plan assets" and the value of each such asset, and

- Information concerning the share value of each investment and the date of the valuation.

D. ERISA 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:

1) Examine without charge at the office of the Administrative Committee all documents governing the Plan, including collective bargaining agreements, if any, 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;

2) Obtain copies of all documents governing the operation of the Plan, including collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Administrative Committee. A reasonable charge may be made for the copies;

3) Receive a summary of the Plan's annual financial report. The Company is required by law to furnish each participant with a copy of this summary annual report; and

4) Obtain a statement telling you whether you have a right to receive benefits under the Plan and if so, what your benefits would be if you leave the Company. If you do not have a right to Plan benefits, the statement will tell you how many more years you must work to earn a right to benefits. This statement must be requested in writing; it is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who administer 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 (if any), or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit under the Plan 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 may take to enforce the above rights. For instance, if you request materials 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 Administrative Committee to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Administrative Committee. 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, you may file suit in Federal court.

If it should happen that 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 the costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds that your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrative Committee. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Committee, 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.

E. NON-ASSIGNMENT OF BENEFITS

You may not assign the benefits provided for you by the Plan, nor are these benefits subject to the claims of any creditor, unless otherwise provided by law. One exception to this rule is the "Qualified Domestic Relations Order". A Qualified Domestic Relations Order is defined as a judgment, decree or court order, approving property settlement agreements, and/or relating to child support, alimony or marital property rights of a spouse, child or other dependent of a participant. To be binding, a Qualified Domestic Relations Order must specify certain required legal information and cannot alter the amount or form of benefits payable under the Plan. You may obtain a copy of the procedures that the Plan's administrator uses to determine if an order is a Qualified Domestic Relations Order without charge.

F. RIGHTS TO EMPLOYMENT

The existence of the Plan does not affect the employment rights of any employee or the rights of the Company to discharge an employee.

G. FUTURE OF THE PLAN

While the Company hopes and expects to continue the Plan indefinitely, it reserves the right to terminate, discontinue making contributions to, amend or modify the Plan at any time, acting through written resolution of the controlling entity of the Company. Upon termination of the Plan, you will become 100% vested in your total Account Balance. The Company will arrange for distributions upon Plan termination as soon as administratively feasible.

H. VETERAN'S RIGHTS

If you are a returning veteran, special rules apply to your Elective Deferrals made to the Plan. In general, re-employed veterans are permitted to make additional Elective Deferrals with respect to their period of military service during a period which begins on their date of reemployment and has the same length as the lesser of (a) the period of their absence due to uniformed service, multiplied by 3 or (b) 5 years. If you are a returning veteran and believe you may be entitled to contribute under these special provisions, please contact the Company.

I. MISCELLANEOUS ITEMS

Plan Name:	Digital Prospectors 401(k) Retirement Plan
Plan Sponsor:	Digital Prospectors Corporation 100 Domain Drive Suite 103 Exter, NH 03833 (603) 772-2700
Participating Affiliates:	
Original Effective Date:	January 01, 2014
Amendment and Restatement Date:	This Summary Plan Description describes the Plan as of May 01, 2015.
Employer I.D. Number:	020505745
Plan Number:	001
Type of Plan:	401(k)/profit sharing plan
Plan Year:	Calendar Year
Year on which Plan's Records are Kept	Calendar Year
Administrative Committee or committee designated by Digital Prospectors Corporation to administer the Plan.	Consult your Human Resources Department or Office Manager: Digital Prospectors Corporation 100 Domain Drive Suite 103 Exter, NH 03833 (603) 772-2700
Trustee:	Reliance Trust Company 1100 Abernathy Road 500 Northpark, Suite 400 Atlanta, GA 30328 Attn: Sharon H. Ennis
Service of Process:	Either the Trustee at the Trustee's address listed above or the Plan administrator at the Digital Prospectors Corporation's address listed above

If your Plan is maintained pursuant to a Collective Bargaining Agreement, a copy of the Collective

Bargaining Agreement may be obtained upon written request to the Plan's administrator, and is available for examination.

1 SAFE HARBOR EMPLOYEE NOTICE

If notice has been delivered electronically, the employee may request a written paper notice that must be provided at no charge.

To: **All employees of Digital Prospectors Corporation (the "Company") and participating affiliates, if any eligible for the Digital Prospectors 401(k) Retirement Plan (the "Plan")**

From: **Digital Prospectors Corporation**

Subject: **Safe Harbor Matching Contributions**

During the Plan Year that begins 1/1/2018, the employer matching contribution formula described below will be offered under the Plan and the Plan will be a "safe harbor 401(k) plan" under the Internal Revenue Code.

Election to Make Elective Deferral Contributions

If you are not already making Elective Deferral contributions, you may make an initial election to defer a portion of your compensation into the Plan by either completing and filing the election form with the Company or through ADP's automated voice response system (or through the ADP participant web site if it is available under our Plan). If you are already making Elective Deferral contributions, you may change the deferral percentage you previously elected by calling the ADP automated voice response system (or through the ADP participant web site if it is available under our Plan). Any initial election or change of election by an eligible employee may be made at any time and will be effective as soon as administratively feasible after receipt and processing of your election.

Safe Harbor Matching Contributions

The Company will make a Safe Harbor Matching Contribution equal to 100% on the first 3% of your compensation that you defer as an Elective Deferral and an additional 50% on the next 2% of your compensation that you defer as an Elective Deferral.

Safe Harbor Matching Contributions will be made on a payroll-by-payroll basis.

Vesting and Withdrawal Provisions

You are always 100% vested in your employee Elective Deferral and Safe Harbor Matching Contributions accounts. A description of the Plan's vesting and withdrawal provisions that apply to contributions under the Plan is attached as part of this Notice.

Please refer to your Plan's Summary Plan Description for information about the Plan's provisions including any other contributions that may be made and the conditions under which they are made, and the type and amount of compensation you may defer.

The Company reserves the right to suspend the Safe Harbor Contribution under our Plan during the Plan Year. You will receive a supplemental notice if this occurs. Any such change would not take effect until after the plan is amended to suspend the Safe Harbor Contribution, but no earlier than 30 days after the supplemental notice is provided to you.

For additional information (including requesting a copy of the Plan's Summary Plan Description) please contact:

Name of Company Contact:	Janet Walsh
Mailing Address:	100 Domain Drive, Suite 103
	Exter, NH 03833
E-mail Address (if applicable):	jwalsh@digitalprospectors.com
Phone Number:	603-215-7065

SAFE HARBOR EMPLOYEE NOTICE

VESTING AND WITHDRAWAL PROVISIONS

WHAT DOES VESTING MEAN?

Vesting is your right to the contributions in your total Account Balance. In other words, to be vested refers to that portion of your Account Balance that is yours and which cannot be forfeited. Upon termination of Employment, you are entitled to the entire vested portion of your Account Balance.

You are always 100% fully vested in your Elective Deferral and Rollover (if any) Contribution Accounts.

In some circumstances, the Company may need to make special contributions on your behalf called Qualified Matching Contributions or Qualified Nonelective Contributions. If made, you are always 100% vested in these contribution accounts.

If you terminate Employment due to death, Disability or attainment of age 65, the Plan's Normal Retirement Age, you will also be 100% fully vested in your total Account Balance. If you die on or after January 1, 2007, while performing qualified military service, you will be treated for vesting purposes as if you resumed employment with the Company and then terminated Employment due to death. Qualified military service means any service in the uniformed services (as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")) that entitles an employee to reemployment rights under USERRA.

If you leave the Company for any other reason, you will be vested in your Nonelective Contributions Account according to the following schedule:

Years of Service	**Vested %**
Less than 2 years	0%
At least 2 years, but less than 3	20%
At least 3 years, but less than 4	40%
At least 4 years, but less than 5	60%
At least 5 years, but less than 6	80%
6 Years or more	100%

For information about how Years of Service are calculated under the Plan, please review the Section entitled "What Does Vesting Mean?" in the Plan's Summary Plan Description (SPD).

WHAT HAPPENS IF I BECOME PERMANENTLY DISABLED?

If you become Disabled under the Plan while you were employed by the Employer, you become 100% vested in all your total Account Balance. Please see the Plan SPD section entitled "What Happens If I Become Permanently Disabled?" to learn how the Plan defines Disabled for this purpose.

WHEN CAN I RECEIVE PLAN BENEFITS?

Benefits are payable to you after you leave the Company for any reason (retirement, termination, Disability or death). There is generally an extra 10% tax on distributions before age 59-1/2, with certain exceptions. You can learn more about the extra 10% tax in IRS Publication 575, Pension and Annuity Income.

If you are performing service in the uniformed services while on active duty for a period of more than 30 days, you may be eligible to obtain a distribution from your Elective Deferral account(s). If you elect to receive such a distribution, you will be suspended from making Elective Deferrals for 6 months beginning on the date of the distribution. If you are eligible for both this distribution and a qualified reservist distribution (see below), your distribution will be processed as a qualified reservist distribution. Please consult your Plan's administrator if you have any questions regarding this provision.

MAY I WITHDRAW FUNDS WHILE STILL EMPLOYED?

You may withdraw all or part of your vested Account Balance once you reach age 59½. You may also withdraw any or part of your Rollover Contribution Account in the Plan at any time and at any age.

In the event of a financial hardship you may withdraw your own Elective Deferrals (excluding earnings on your Elective Deferrals) as well as any vested or Nonelective Contributions. Safe Harbor Contributions are not permitted to be withdrawn in the event of a financial hardship.

To make a hardship withdrawal under current Internal Revenue Service rules, you must be able to show that you are suffering an immediate and heavy financial hardship and that the money cannot be obtained from any other source. You must take any non-hardship

in-service withdrawals that may be available to you under the Plan before you may obtain a hardship withdrawal. You also must first obtain the maximum available loan under the Plan. You will not be required to take the maximum available loan before receiving a hardship withdrawal to the extent that repaying the loan would increase the amount of your hardship. Please see the Section of the Plan's SPD entitled "May I Withdraw Funds While Still Employed?" for more information about hardship withdrawals.

Circumstances that qualify as an immediate and heavy financial hardship are (1) expenses for medical care (described in Section 213(d) of the Internal Revenue Code) previously incurred by you, your spouse, your dependent or your primary beneficiary under the Plan or necessary for you, your spouse, your dependent, or your primary beneficiary under the Plan to obtain medical care; (2) costs directly related to the purchase of your principal residence (excluding mortgage payments); (3) tuition, related educational fees, and room and board expenses for the next twelve (12) months of post secondary education for yourself, your spouse or dependent or your primary beneficiary under the Plan; (4) amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence; (5) payments for burial or funeral expenses for your deceased parent, spouse, children or other dependents or your primary beneficiary under the Plan; or (6) expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code. For this purpose, a "primary beneficiary under the Plan" is an individual who is named as your beneficiary under the Plan and has an unconditional right to all or a portion of your account balance if you die.

In addition, the amount of your hardship withdrawal must be no more than the amount necessary to satisfy your immediate and heavy financial need, plus any income taxes or penalties which are expected to result from the distribution. The minimum permitted hardship withdrawal is $500. The hardship withdrawal may be subject to a 10% excise tax imposed by the IRS. You will be suspended from making elective contributions for 6 months after you receive a hardship withdrawal that includes Elective Deferrals.

If you are a qualified member of the reserves, you also may be eligible to request a *qualified reservist distribution*. A *qualified reservist distribution* is an exception to Plan restrictions on withdrawal of elective deferrals. Further, the extra 10% tax on a payout before age 59½ doesn't apply to a qualified reservist distribution. For more information, see the Section in the Plan's SPD entitled "My I Withdraw Funds While Still Employed?". A qualified reservist distribution may be taken from your Elective Deferral accounts.

HOW DO LOANS WORK?

You may borrow certain amounts from the vested portion of your Account. You can learn more about the Plan's loan rules in SPD section entitled "How Do Loans Work?".

ROTH ELECTIVE DEFERRALS

Under our Plan you are able to make two kinds of Elective Deferrals. You may make Pre-Tax Elective Deferrals, or you may make Roth Elective Deferrals. There are a number of ways to contribute Roth Elective Deferrals to the Plan. The first is by electing to contribute Roth Elective Deferrals directly to the Plan. (Roth Elective Deferrals contributed directly to the Plan will be recorded in a Roth Elective Deferral Account.) The second is by making a Roth Rollover Contribution to the Plan. Please see the sections of the Plan's SPD entitled "What Contributions Are Made to the Plan?" and "If I Received a Distribution From Another Eligible Retirement Plan, May I Contribute That Amount to the Plan?" for more information about Pre-Tax Elective Deferrals, Roth Elective Deferrals, and Roth Rollover Contributions.

Roth Elective Deferrals are generally treated in the same manner as Pre-Tax Elective Deferrals. This means that your Roth Elective Deferral sub-account is always fully vested and is subject to the distribution restrictions and provisions discussed elsewhere in this Safe Harbor Notice. Your Roth Rollover Contribution sub-account is also fully vested and subject to the distribution restrictions and provisions discussed elsewhere in this Safe Harbor Notice. Loans are available from your Roth Elective Deferral, and Roth Rollover Contribution sub-accounts.You are also permitted to:

- take a hardship distribution from your Roth Elective Deferral sub-account (excluding earnings);
- take an in-service distribution from your Roth Elective Deferral sub-account once you reach age 59-1/2; and
- take an in-service distribution from your Roth Rollover Contribution sub-accounts at any time.

Roth Elective Deferrals and Roth Rollover Contributions are taxed differently than Pre-Tax Elective Deferrals upon distribution. You can learn more about how distributions are taxed in the section of the Plan's SPD entitled "How Are My Distributions From The Plan Taxed?".