DIGITAL PROSPECTORS

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SUMMARIES OF BENEFITS & COVERAGES

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Should you have any questions about these benefits.
Please contact Human Resources at hr@digitalprospectors.com.

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Digital Prospectors Corporation
Open Access Plus Plan
Effective May 1, 2019

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.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated	
Plan Coinsurance	Plan pays 80%	Plan pays 60%
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, plan pays 80% after the out-of-network deductible is met	
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual: $2,000 Family: $6,000	Individual: $3,000 Family: $9,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $6,500 Family: $13,000	Individual: $6,500 Family: $13,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services		
Primary Care Physician (PCP) Services/Office Visit	$20 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$20 copay, and plan pays 100%	Plan pays 60% ^
Surgery Performed in Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Cigna Telehealth Connection Services	$20 copay, and plan pays 100%	Not Covered
• 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)		
Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Plan pays 60% ^
Preventive Services	Plan pays 100%	Plan pays 60% ^
• Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Immunizations	Plan pays 100%	Plan pays 60% ^
Inpatient		
Inpatient Hospital Facility Services	Plan pays 80% ^	Plan pays 60% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services	Plan pays 80% ^	Plan pays 60% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI) • Per visit copay is waived if admitted.	$100 copay, and plan pays 100%	$100 copay, and plan pays 100%
Urgent Care Facility Includes Physician Charges, Lab and Radiology	$50 copay, and plan pays 100%	Plan pays 60% ^
Ambulance Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80% ^	Plan pays 80% ^
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Outpatient Short Term Rehabilitation		
Outpatient Physical Therapy Annual Limits: • Physical Therapy – 30 visits • Limits are not applicable to mental health conditions. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	$20 copay, and plan pays 100%	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy Annual Limits: • Speech, Hearing and Occupational Therapies – 60 visits • Limits are not applicable to mental health conditions for Speech and Occupational Therapies. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	$20 copay, and plan pays 100%	Plan pays 60% ^
Chiropractic Care Annual Limit: • Chiropractic Care – 12 visits	$20 copay, and plan pays 100%	Plan pays 60% ^
Hospice		
Inpatient Facilities	Plan pays 80% ^	Plan pays 60% ^
Outpatient Services **Note:** Includes Bereavement counseling provided as part of a hospice program.	Plan pays 80% ^	Plan pays 60% ^
Medical Specialty Drugs		
Outpatient Facility This benefit applies to the cost of targeted Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan pays 80% ^	Plan pays 60% ^
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.	Plan pays 80% ^	Plan pays 60% ^
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.	Plan pays 80% ^	Plan pays 60% ^
Family Planning		
Women's Services Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	Plan pays 100%	Coverage varies based on Place of Service
Men's Services Includes surgical sterilization services, such as vasectomy (excludes reversals)	Coverage varies based on Place of Service	Coverage varies based on Place of Service

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Abortion		
Abortion Services **Note:** Elective and non-elective procedures	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility		
Infertility Treatment **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)	Plan pays 80% ^	Plan pays 60% ^
Organ Transplants • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. • Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime	Coverage varies based on Place of Service at In-Network cost share	Coverage varies based on Place of Service Bone Marrow - $130,000 Heart - $150,000 Heart/Lung - $185,000 Kidney - $80,000 Kidney/Pancreas - $80,000 Liver - $230,000 Lung - $185,000 Pancreas - $50,000
Durable Medical Equipment and External Prosthetic Appliances • Does accumulate towards the out-of-pocket maximum • Annual Limit: Unlimited	Plan pays 80% ^	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%	Plan pays 60% ^
Note: Services where plan deductible applies are noted with a caret (^).		
Mental Health and Substance Use Disorder		
Inpatient mental health	Plan pays 80% ^	Plan pays 60% ^
Outpatient mental health – Physician's Office	$20 copay, and plan pays 100%	Plan pays 60% ^
Outpatient mental health – all other services	Plan pays 80% ^	Plan pays 60% ^
Inpatient substance use disorder	Plan pays 80% ^	Plan pays 60% ^

Note: Services where plan deductible applies are noted with a caret (^).		
Outpatient substance use disorder – Physician's Office	$20 copay, and plan pays 100%	Plan pays 60% ^
Outpatient substance use disorder – all other services	Plan pays 80% ^	Plan pays 60% ^

Note: Services where plan deductible applies are noted with a caret (^).

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.

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 of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.	**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

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.
- 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.
- 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).
- 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: Essential
Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- 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.

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

Maximum Reimbursable Charge

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 a percentage of a fee schedule (110%) 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 a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges

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

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

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.**

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.

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.

Additional Information

Pre-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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 workers' 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: $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.	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.

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 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 care** **Deductible does not apply	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic care	$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 care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$20 copay/visit for Physical, Speech, Hearing & Occupational therapy** $20 copay/visit for Chiropractic care** **Deductible does not apply	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic care	$250 penalty for failure to precertify speech therapy. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	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.

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		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)
- 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 05-2019 Ben Ver: 14 Plan ID: 8609831

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.
For - Digital Prospectors Corporation
HDHP OAP Plan
Effective May 1, 2019

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.

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated	
Plan Coinsurance	Plan pays 80%	Plan pays 60%
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, plan pays 80% after the in-network deductible is met	
Maximum Reimbursable Charge	Not Applicable	110%

Plan Highlights	In-Network	Out-of-Network
Plan Deductible	Individual: $3,000 Family: $6,000	Individual: $6,000 Family: $12,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Plan deductible always applies before any benefit copay/deductible or coinsurance.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy deductible.

Note: Services where plan deductible applies are noted with a caret (^).

Plan 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

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Physician Services		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Surgery Performed in Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Cigna Telehealth Connection Services	Plan pays 80% ^	Not Covered

- 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)

Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Plan pays 60% ^
Preventive Services	Plan pays 100%	Lab & X-ray: Plan pays 100%; All other services: Plan pays 60% ^

- Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.
- Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.

Immunizations	Plan pays 100%	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 80% ^	Plan pays 60% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Outpatient		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)	Plan pays 80% ^	Plan pays 80% ^
Urgent Care Facility Includes Physician Charges, Lab and Radiology	Plan pays 80% ^	Plan pays 60% ^
Ambulance	Plan pays 80% ^	Plan pays 80% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Outpatient Short Term Rehabilitation		
Outpatient Physical Therapy Annual Limits: • Physical Therapy – 30 visits • Limits are not applicable to mental health conditions. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	Plan pays 80% ^	Plan pays 60% ^
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy Annual Limits: • Speech, Hearing and Occupational Therapies – 60 visits • Limits are not applicable to mental health conditions for Speech and Occupational Therapies. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	Plan pays 80% ^	Plan pays 60% ^
Chiropractic Care Annual Limit: • Chiropractic Care – 12 visits	Plan pays 80% ^	Plan pays 60% ^
Hospice		
Inpatient Facilities	Plan pays 80% ^	Plan pays 60% ^
Outpatient Services	Plan pays 80% ^	Plan pays 60% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Medical Specialty Drugs		
Outpatient Facility This benefit applies to the cost of targeted Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan pays 80% ^	Plan pays 60% ^
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.	Plan pays 80% ^	Plan pays 60% ^
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.	Plan pays 80% ^	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Abortion		
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		
Infertility		
Infertility Treatment **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Other Health Care Facilities/Services		
Home Health Care	Plan pays 80% ^	Plan pays 60% ^
• Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)		
Organ Transplants	Coverage varies based on Place of Service at In-Network cost share	Coverage varies based on Place of Service Bone Marrow - $130,000 Heart - $150,000 Heart/Lung - $185,000 Kidney - $80,000 Kidney/Pancreas - $80,000 Liver - $230,000 Lung - $185,000 Pancreas - $50,000
• Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. • Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime		
Durable Medical Equipment and External Prosthetic Appliances • Does accumulate towards the out-of-pocket maximum • Annual Limit: Unlimited	Plan pays 80% ^	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%	Plan pays 60% ^

Note: Services where plan deductible applies are noted with a caret (^).		
Mental Health and Substance Use Disorder		
Inpatient mental health	Plan pays 80% ^	Plan pays 60% ^
Outpatient mental health – Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Outpatient mental health – all other services	Plan pays 80% ^	Plan pays 60% ^
Inpatient substance use disorder	Plan pays 80% ^	Plan pays 60% ^
Outpatient substance use disorder – Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Outpatient substance use disorder – all other services	Plan pays 80% ^	Plan pays 60% ^

Note: Services where plan deductible applies are noted with a caret (^).

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.

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 of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.	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.
- 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.
- 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).
- 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: Essential
Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- 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.

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

Maximum Reimbursable Charge

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 a percentage of a fee schedule (110%) 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 a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges

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

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

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.**

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.

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.

Additional Information

Pre-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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 workers' 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. Combined medical/behavioral and pharmacy deductible	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	

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% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 20% coinsurance/visit for Chiropractic care	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic care	$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 care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	20% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 20% coinsurance/visit for Chiropractic care	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic care	$250 penalty for failure to precertify speech therapy. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	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.

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		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)
- 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: HDHP OAP 05-2019 Ben Ver: 14 Plan ID: 8609983

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.
For - Digital Prospectors Corporation
Open Access Plus Network Only Plan
Effective May 1, 2019

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.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated
Plan Coinsurance	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, plan pays 80% after the in-network deductible is met
Plan Deductible	Individual: $2,000 Family: $6,000

- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network
Plan Out-of-Pocket Maximum	Individual: $6,500 Family: $13,000

- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Physician Services	
Primary Care Physician (PCP) Services/Office Visit	$25 copay, and plan pays 100%
Specialty Care Physician Services/Office Visit	$50 copay, and plan pays 100%
Surgery Performed in Physician's Office	Plan pays 100% ^
Cigna Telehealth Connection Services	$25 copay, and plan pays 100%

- 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)

Preventive Care	
Preventive Care Office Visit	Plan pays 100%
Preventive Services	Plan pays 100%

- Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.
- Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.

Immunizations	Plan pays 100%
Inpatient	
Inpatient Hospital Facility Services	Plan pays 100% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100% ^
Inpatient Professional Services	Plan pays 100% ^

- For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists

Outpatient	
Outpatient Facility Services Non-surgical treatment procedures are not subject to the facility per visit deductible.	$100 per facility visit deductible, and plan pays 100%
Outpatient Professional Services	Plan pays 100% ^

- For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Emergency Services	
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI) • Per visit copay is waived if admitted.	$250 copay, and plan pays 100%
Urgent Care Facility Includes Physician Charges, Lab and Radiology	$50 copay, and plan pays 100%
Ambulance	Plan pays 100% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 100% ^
Laboratory Services	
Physician's Services/Office Visit	Plan pays 100% ^
Independent Lab	Plan pays 100% ^
Outpatient Facility	Plan pays 100% ^
Radiology Services	
Physician's Services/Office Visit	Plan pays 100% ^
Outpatient Facility	Plan pays 100% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 100% ^
Physician's Services/Office Visit	Plan pays 100% ^
Outpatient Short Term Rehabilitation	
Outpatient Physical Therapy Annual Limits: • Physical Therapy – 30 visits • Limits are not applicable to mental health conditions. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	$50 copay, and plan pays 100%

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy	$50 copay, and plan pays 100%
Annual Limits: • Speech, Hearing and Occupational Therapies – 60 visits • Limits are not applicable to mental health conditions for Speech and Occupational Therapies. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	
Chiropractic Care	$50 copay, and plan pays 100%
Annual Limit: • Chiropractic Care – 12 visits	
Hospice	
Inpatient Facilities	Plan pays 100% ^
Outpatient Services	Plan pays 100% ^
Note: Includes Bereavement counseling provided as part of a hospice program.	
Medical Specialty Drugs	
Outpatient Facility This benefit applies to the cost of targeted Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan pays 100% ^
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.	Plan pays 100% ^
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.	Plan pays 100% ^
Family Planning	
Women's Services	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Abortion	
Abortion Services **Note:** Elective and non-elective procedures	Coverage varies based on Place of Service
Infertility	
Infertility Treatment **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	
Other Health Care Facilities/Services	
Home Health Care • Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)	Plan pays 100% ^
Organ Transplants • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. • Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime	Coverage varies based on Place of Service
Durable Medical Equipment and External Prosthetic Appliances • Does accumulate towards the out-of-pocket maximum • Annual Limit: Unlimited	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%
Note: Services where plan deductible applies are noted with a caret (^).	
Mental Health and Substance Use Disorder	
Inpatient mental health	Plan pays 100% ^
Outpatient mental health – Physician's Office	$50 copay, and plan pays 100%
Outpatient mental health – all other services	Plan pays 100%
Inpatient substance use disorder	Plan pays 100% ^
Outpatient substance use disorder – Physician's Office	$50 copay, and plan pays 100%
Outpatient substance use disorder – all other services	Plan pays 100%

Note: Services where plan deductible applies are noted with a caret (^).

Note: Services where plan deductible applies are noted with a caret (^).

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.

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 of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.	**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.
- 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.
- 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).
- 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: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- 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.

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

Out-of-Network Emergency Services Charges

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

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

Additional Information

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.**

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.

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.

Pre-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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 workers' 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

Exclusions

- 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: $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	

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	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 care** **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 care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$50 copay/visit for Physical, Speech, Hearing & Occupational therapy** $50 copay/visit for Chiropractic care** **Deductible does not apply	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	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
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)
- 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 05-2019 Ben Ver: 14 Plan ID: 8609949

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Medical coverage

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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.

896375a 05/17

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-are/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Summary of Benefits and Coverage
Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about your health plan option(s). This summary is in a standard format, as regulated by the Patient Protection and Affordable Care Act, to help you compare options. The standard format enables readers to conduct an apples-to-apples comparison.

We are pleased to provide you with the Summary of Benefits and Coverage (SBC) for your plan(s) along with the Health and Human Services uniform glossary that is to be paired with the SBC when distributed to employees.

They are included in this kit.

The glossary can be found here: http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

It is not included in this kit.

A complimentary paper copy is available upon request by calling 603 772 2700 x 209. Participants and beneficiaries may request an electronic SBC from their employer.

The Summary of Benefits and Coverage (SBC) may not be all-inclusive. Arthur J. Gallagher & Co. and Gallagher Benefit Services strives to provide our customers with accurate SBCs but rely on the issuer for accuracy. It is ultimately the responsibility of the issuer and employer to ensure accuracy and furnish to their employees in accordance with the SBC regulations.

Patient Protection Notice
As provided under the Patient Protection and Affordable Care Act

The disclosure is applicable to the following plans

- Open Access Plus IN Network Only
- Open Access Plus
- HSA Open Access Plus

Designation of Primary Care Providers:

Cigna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna at their website www.cigna.com.

Designation of Pediatricians as Primary Care Providers:

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

Access to OBGYN without Referrals:

You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna at their website www.cigna.com.

Disclosure Statement to Employees
Pertaining to Grandfather Status

05/01/19 – 04/30/20 Plan Year

Below you will find the classification of each of the health plans offered by Digital Prospectors Corp as to their "grandfathered" status as defined by the Patient Protection and Affordable Care Act (PPACA):

Open Access Plus IN Network Only	☐ Grandfathered	☒ Non-Grandfathered
Open Access Plus	☐ Grandfathered	☒ Non-Grandfathered
HSA Open Access Plus	☐ Grandfathered	☒ Non-Grandfathered

As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your plan administrator at:

Sabrina Dugas
HR & Office Manager
603.772.2700 x 209

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

HIPAA Notice of Special Enrollment Rights

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 towards 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). You will be required to submit a signed statement when other coverage is the reason for waiving enrollment originally.

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan.

However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Sabrina Dugas, HR & Office Manager at 603.772.2700 x 209.

HIPAA Privacy Rights

Digital Prospectors Corp Health Plan

Protecting Your Health Information Privacy Rights

05/01/19

Digital Prospectors Corp is committed to the privacy of your health information. The administrators of the Digital Prospectors Corp Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting 603.772.2700 x 209.

Notification of Rights under the Women's Health & Cancer Rights Act

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 applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, contact Sabrina Dugas at 603.772.2700 x 209.

Newborn's and Mother's Health Protection Act
Statement of Protection

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from Digital Prospectors Corp About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Digital Prospectors Corp and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1.Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2.Digital Prospectors Corp has determined that the prescription drug coverage offered by the Digital Prospectors Corp Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current [Digital Prospectors Corp] coverage may be affected.

You can keep this coverage if you elect Part D and this plan will coordinate with Part D Coverage.

If you do decide to join a Medicare drug plan and drop your current [Digital Prospectors Corp] coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Digital Prospectors Corp and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call Cigna at # on back of member card. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Insert Name of Entity changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	05/01/2019
Name of Entity/Sender:	Digital Prospectors Corp
Contact--Position/Office:	Sabrina Dugas, Human Resources & Office Manager
Address:	100 Domain Drive Suite 103 Exeter NH 03833
Phone Number:	603-772-2700 x 209

Notice of Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Digital Prospectors Corp, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Sabrina Dugas, HR & Office Manager.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA

continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Digital Prospectors Corp Health Plan

Sabrina Dugas, HR & Office Manager
100 Domain Drive Suite 103
Exeter NH 03833
603-772-2700 x 209
sdugas@digitalprospectors.com

Notices Disclaimer

Please Note: The notices contained in this open enrollment packet may not be all-inclusive. Arthur J. Gallagher & Co. and Gallagher Benefit Services strives to provide your employees current legal notices as they pertain to the employer health plans. It is ultimately the responsibility of the employer to ensure accuracy and furnish to their employees in accordance with the various laws. These notices should not be construed as legal advice. A best practice is for the employer to seek the advice and approval of legal counsel prior to adopting these notices in practice. Arthur J. Gallagher & Co. and Gallagher Benefit Services will not be liable for unintended deficiencies pertaining to the content or distribution of these notices. Responsibility rests with the employer.

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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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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PREVENTIVE HEALTH CARE

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

Why Do You Need Preventive Care?

Your health care plan covers specific preventive care services. Even when you're in the best shape of your life, a serious condition with no symptoms may put your health at risk. Using these services at the right time can help you stay healthier by:

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

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

- What is preventive care
- Preventive care services your plan covers

What's Preventive Care?

Preventive care services are provided when you don't have any symptoms and haven't been diagnosed with a health issue connected with the preventive service. They typically are provided during a wellness exam. You and your doctor will determine what tests and health screenings are right for you based on your:

- Age
- Gender
- Personal health history
- Current health

What's Not Preventive Care?

When your doctor determines that you have a health issue, the additional screenings and tests after this diagnosis are no longer considered preventive. These services are covered under your plan's medical benefits, not your preventive care benefits.

What's Your Share of the Cost?

Many plans cover preventive care services at 100% – no additional cost to you – when you go to a health care professional in your plan's network. Check your plan materials for details about your specific medical plan's coverage and the provider directory for a list of health care professionals and facilities in your plan's network.

Even when your appointment is for preventive care, you may receive other services during that exam that are not preventive. These other services are generally covered under your plan's medical benefits, not your preventive care benefits. This means you may be responsible for paying a portion or all of the cost, depending on your plan's deductible, copay, and coinsurance amounts.

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

Questions?

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

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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 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
Abnormal blood glucose and type 2 diabetes screening/counseling	● ●	Adults ages 40–70 who are overweight or obese
Alcohol misuse/substance abuse screening	● ● ●	All adults; adolescents age 11–21
Aspirin to prevent cardiovascular disease and colorectal cancer; or to reduce risk for preeclampsia[1]	● ●	Adults ages 50–59 with risk factors; Pregnant women at risk for preeclampsia
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Bilirubin screening (effective on or after 1/1/18 as plans renew)	●	Newborns before discharge from hospital
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[1]	● ● ●	• Screening of children and adolescents ages 9–11 years and 17–21 years; children and adolescents with risk factors ages 2–8 and 12–16 years • All adults ages 40-75
Colon cancer screening[1]	● ●	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 • Stool-based deoxyribonucleic acid (DNA) test (i.e., Cologuard) every 3 years
Congenital hypothyroidism screening	●	Newborns
Critical congenital heart disease screening	●	Newborns before discharge from hospital

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Contraception counseling/education. Contraceptive products and services[1,3,4]	●	Women with reproductive capacity
Depression screening	● ● ●	Ages 12–21, All adults, including pregnant and postpartum women
Developmental screening	●	9, 18, 30 months
Developmental surveillance	●	Newborn, 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
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 to age 6 years
Domestic and interpersonal violence screening	●	All women (adolescent/adult)
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 2 months. Ages 4, 5, 6, 8, 10. Adolescents once between ages 11-14, 15-17 and 18-21 (effective on or after 2/1/18 as plans renew)
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
High blood pressure screening (outside clinical setting)[2]	● ●	Adults ages 18 and older without known high blood pressure
HIV screening and counseling	● ● ●	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women (adolescent/adult), 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.
Metabolic/hemoglobinopathies (according to state law)	●	Newborns
Obesity screening/counseling	● ● ●	Ages 6 and older, all adults
Oral health evaluation/assess for dental referral	●	6, 9 months. Ages 12 months, 18 months-6 years for children at risk
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
PKU screening	●	Newborns

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
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
Tuberculosis screening	🔵🔴🟢	Children, adolescents and adults 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, and 15 or as doctor advises

🔵 = Men 🔴 = Women 🟢 = Children/adolescents

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, home blood pressure monitoring supplies, 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 home blood pressure monitoring equipment, breast pump and breast pump supplies, contact CareCentrix at **844.457.9810**.
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.

Some plans choose to supplement the preventive care services listed above with a few additional services, such as other common laboratory panel tests. When delivered during a preventive care visit, these services also may be covered at the preventive level.

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

Make the most of your plan with this quick guide

Your life is busy, but that doesn't mean is has to be complicated. At Cigna, we want to help. That's why we offer you programs and services to help make your life easier – and healthier.

Start by getting to know your plan. The more you take advantage of the many benefits of your plan, the more you'll learn. And the more you learn, the better prepared you can be to make more informed choices about your health and health spending.

myCigna
With the myCigna℠ website or app, you'll find assessment tools, plan management, medical updates and much more.

Cigna Telehealth Connection
Connect with a board-certified doctor via video chat or phone.[1]

Coach by Cigna
We have many ways to help you improve your health wherever you are, whenever you're ready.

Care Management Programs
Get help with a condition from a case manager, or learn how to reach your health goals with My Health Assistant online coaching.

TOGETHER, WE CAN GET YOU ON THE RIGHT PATH TO A HEALTHIER, HAPPIER LIFE.

24/7/365 service
Live customer service is available 24 hours a day, seven days a week, 365 days a year.

Preventive care
Receive eligible preventive care services from an in-network doctor at no additional cost to you.[3]

Specialty medications
We can help you understand, manage and treat more complex conditions that require a specialty medication.

24/7 Health Information Line
Know before you go; talk to a nurse who can help you choose the right care in the right setting at the right time.

In-network care
Using doctors, hospitals and health facilities in your plan's network can help save you money.

Together, all the way.®

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myCigna

On **myCigna.com** you can:

- Find in-network doctors and medical services
- Review coverage
- Manage and track claims
- See cost estimates for medical procedures and prescription drugs
- Compare quality-of-care information for doctors and hospitals
- Compare prescription costs for 30- and 90-day medications – see if a lower-cost drug alternative is available
- You can also find retail pharmacies that offer a 90-day supply
- Access a variety of health and wellness tools and resources
- Sign up to receive alerts when new plan documents are available

To access your health information on the go, make sure you also download the myCigna app.[4]

Coach by Cigna

We have a variety of tools to help you improve your health.

- The mobile apps and **myCigna.com** activities webpage are filled with all sorts of features and a dashboard view lets you see your activities across all of the apps and online tools.
- Our Coach by Cigna app is like having a team of health coaches in the palm of your hand. Using five integrated lifestyle areas – exercise, food, sleep, stress and weight – it helps you focus on what matters to you.

24/7/365 service

When you need us, just call the toll-free number printed on the back of your Cigna ID card for live customer assistance 24 hours a day, seven days a week, 365 days a year. You can:

- Get answers to health, claims and benefit questions
- Order an ID card, update insurance information and check claim status
- Talk with a licensed pharmacist anytime, day or night
- Talk with a nurse for help deciding where and when you should get treatment
- Find a health advocate for help improving specific health issues

Specialty medications

We can help you understand, manage and treat more complex conditions that require a specialty medication. Our therapy management teams, made up of health advocates with nursing backgrounds and pharmacists, are specially trained to deliver the best experience possible. We offer:

- Personalized, 24/7 support
- Condition-specific education on medication therapy and side effects
- Help with medication approval process
- Financial assistance programs if needed

For more information call **800.351.3606**.

Preventive care

Getting and staying healthy is important. That's why eligible preventive care services are covered at no additional cost to you, when you receive them from a doctor who participates in your plan's network. Covered preventive care services include, but are not limited to:[3]

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

Go to **myCigna.com** to see a full list of services covered under preventive care.

24/7 Health Information Line

Know before you go. Speak to a nurse who can help you understand and make informed decisions about health issues you are experiencing, at no extra cost. Get help to choose the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment, or finding the nearest urgent care center in your plan's network. Just call the number on your Cigna ID card. Open 24/7.

In-network care

Save money when you use doctors, hospitals and health facilities that are part of your plan's network. Chances are there's a network doctor or facility right in your neighborhood. And using our online directory can help you find quality, cost-effective care when you need it. Search for doctors and facilities on **myCigna.com** by using the provider search tool.

Care Management Programs

Cigna has many services to help you with your personal health needs. This includes 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.

You also have access to My Health Assistant on myCigna.com. Get help on your journey to better health and wellness:

- Control stress
- Lose weight and eat better
- Enjoy exercise
- Quit tobacco
- Manage Diabetes, COPD, Asthma and other conditions

Enroll online today! Visit **myCigna.com**, select "My Health" tab, then "Programs and Resources," then select "Health Assistant" from the drop down menu.

Cigna Telehealth Connection

MDLIVE and Amwell

Connect with a board-certified doctor via video chat or phone, from your home, office or on-the-go 24/7/365, including weekends and holidays.[1] You can get the care you need – including most prescriptions (when appropriate) – for many minor conditions. Your out-of-pocket cost are typically the same or less than a visit with your primary care provider.[1]

Use an Amwell or MDLIVE doctor for minor conditions:

- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Ear infections
- Headache
- Insect bites
- Joint aches and pains
- Nausea and vomiting
- Pink eye
- Poison ivy
- Rashes
- Respiratory infections
- Sinus infections
- Sore throat

Register today!

Once you do, you'll be ready get care when – and where you need it.

Download the vendor apps[4] or, register online or by phone:

AmwellforCigna.com
855.667.9722

MDLIVEforCigna.com
888.726.3171

Behavioral Health

For mental health and substance use care, get quality care that's convenient too. Our network of providers typically cost the same as an in-office visit. Copays vary by plan.[2]

To access a network of providers and covered services for mental health and substance use care:

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

TIPS TO HELP YOU SAVE MONEY

1

Prescription drugs

- Find the complete list of covered medications on **myCigna.com**
- Generics offer the best value
- Know what brand-name drugs are covered in your plan
- Consider a 90-day supply of prescription drugs you take on a regular basis so you're less likely to miss a dose

2

Know where to go for care

- Use an emergency room for true emergencies
- Don't wait: Locate a convenience care clinic or urgent care center near you, before you need it
- Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area

3

Health care provider choice

- Know which providers are in your network by using the provider search tool on **myCigna.com**
- Visit the health care provider most appropriate for your care
- With Cigna Telehealth Connection, you can connect to a board-certified doctor via video chat or phone, 24/7/365[1]
- Use in-network national labs to help save money

4

Be proactive in your health

- Use the health improvement tools available to you
- Get information on the cost of medications and treatments to avoid surprises
- Use your preventive care benefits, learn your core health numbers and get more information at **Cigna.com/takecontrol**

Find your way to better health.

Get more information on all the programs that are available to you.

Visit **myCigna.com**

Call the 24/7 customer service number on the back of your ID card.

Cigna®

1. 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. Video chat may not be available in all areas or with all providers. AmWell/MDLIVE services are separate from your health plan's provider network and may not be available in all areas. A Primary Care Provider referral is not required for AmWell/MDLIVE services.
2. Plans vary, please check your plan materials for more information on what is covered under your plan.
3. Coverage for preventive care may vary depending on the terms of your specific medical plan. Actual covered services may vary depending on your age, gender, and medical history. Not all preventive care services are covered. For example, immunizations for travel are generally not covered. For a complete list of covered preventive care services, contact your Cigna representative.
4. The downloading and use of any 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.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans have exclusions and limitations. For costs and complete details of coverage, see your plan documents. Providers that participate in the Cigna network are not agents of Cigna and are solely responsible for any treatment provided.

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FINDING A DOCTOR IN OUR DIRECTORY IS EASY

Is your doctor 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 FOUR SIMPLE STEPS

Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "Not a Cigna Customer Yet?" select "Plans through your employer or school."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current network. To search other networks, use the **Cigna.com** directory.)

Step 2

Enter the geographic location you want to search.

Step 3

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

Step 4

Enter a name, specialty or other search word. Click on one of our type ahead suggestions or the magnifying glass icon 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.com** – your one-stop source for managing your health plan, anytime, just about anyplace. On **myCigna.com**, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call **<phone number>**

Together, all the way.®

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 retail 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.®

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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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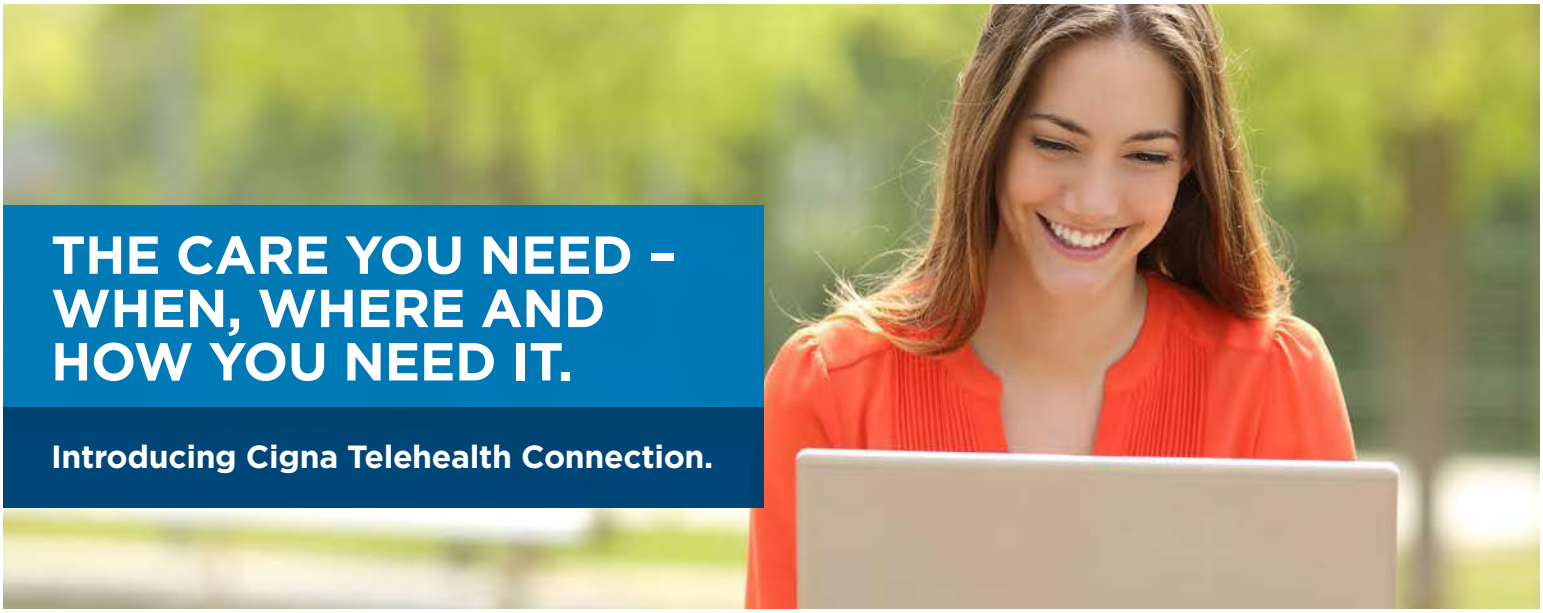

THE CARE YOU NEED – WHEN, WHERE AND HOW YOU NEED IT.

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.®

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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.

CIGNA PERFORMANCE 4-TIER PRESCRIPTION DRUG LIST

As of January 1, 2019

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 03/01/2018.* To see a current list of the medications covered on your plan's drug list, visit:

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

Questions? – Call the toll-free number on the back of your Cigna ID card. We're here to help. If it's easier, you can also chat with us online on the **myCigna** website, Monday–Friday, 9:00 am–8:00 pm EST.

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

Last updated: 03/01/2018, for changes that were effective 07/01/2018

Next planned update: 03/01/2019, for changes that will be effective 07/01/2019

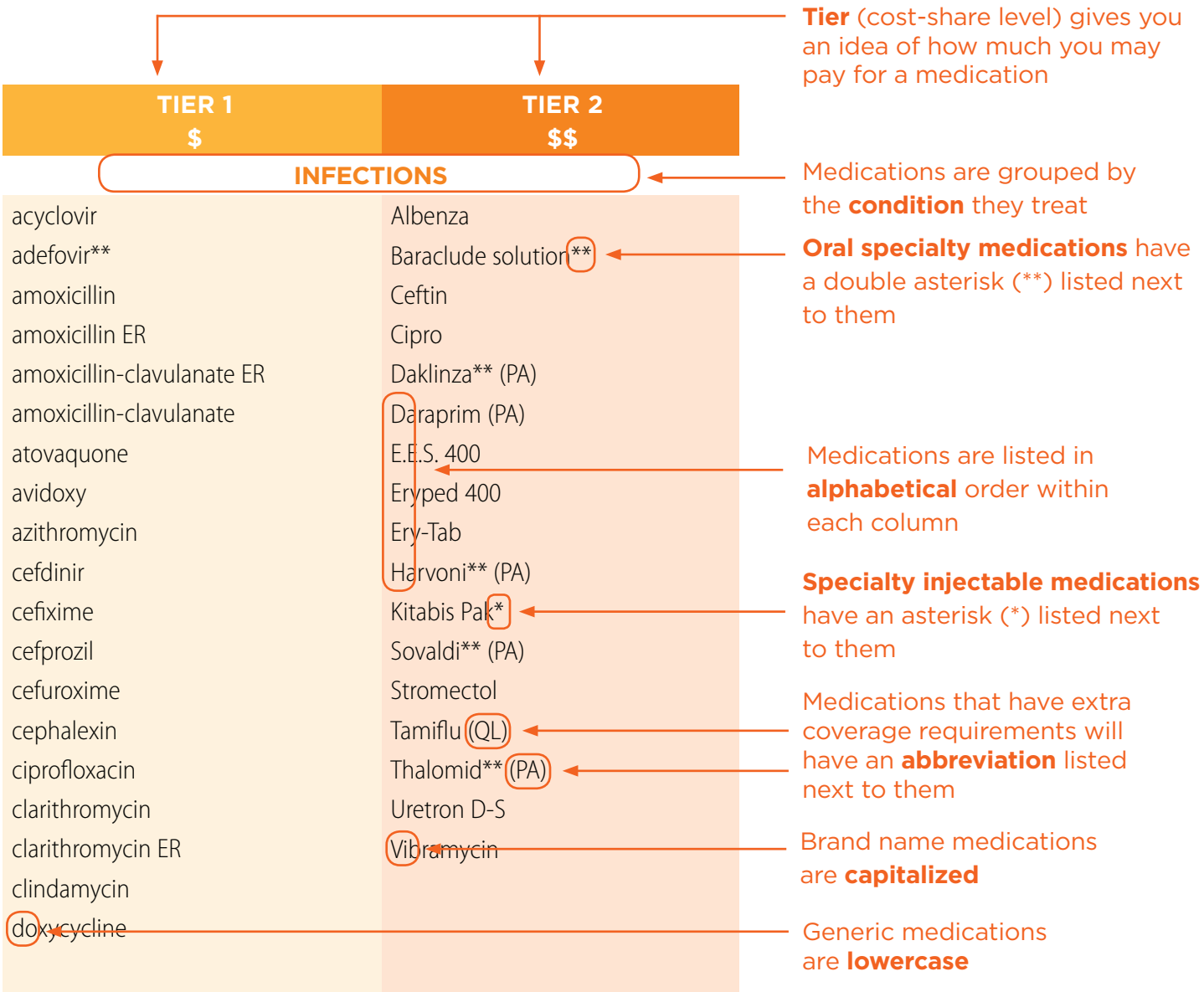
Your prescription drug list

This document shows the most commonly prescribed medications covered on the Performance Prescription Drug List as of January 1, 2019.[1] All of these 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 cost-share levels).

It's important to know that this 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 in to the **myCigna** website or app, 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. **This chart is just an example.** It may not show how these medications are actually covered on the Performance Prescription Drug List.



This chart is just a sample. It may not show how these medications are actually covered on the Legacy Prescription Drug List.

Tiers

Covered medications are divided into tiers, or cost-share levels. Typically, the higher the tier, the higher the price you'll pay to fill the prescription.

› **Tier 1 – Typically Generics**	(Lower-cost medication)	**$**
› **Tier 2 – Typically Preferred Brands**	(Medium-cost medication)	**$$**
› **Tier 3 – Typically Non-Preferred Brands**	(Higher-cost medication)	**$$$**
› **Tier 4 – Specialty Medications**	(Highest-cost medication)	**$$$$**

Abbreviations next to medications

Some medications on your drug list have extra extra requirements before your plan will cover them.* 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** – Cigna will review information provided by your doctor to make sure you meet coverage guidelines for the medication. If approved, your plan will cover the medication.
(ST)	**Step Therapy** – Certain high-cost medications are part of the Step Therapy program. Step Therapy encourages the use of lower-cost medications (typically generics and preferred brands) that can be used to treat the same condition as the higher-cost medication. These conditions include, but are not limited to, depression, high blood pressure, high cholesterol, skin conditions and sleep disorders. Your plan doesn't cover the higher-cost Step Therapy medication until you try one or more alternatives first (unless you receive approval from Cigna).
(QL)	**Quantity Limits** – For some medications, your plan will only cover up to a certain amount over a certain length of time. 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 your plan to cover the medication. Some medications aren't considered clinically appropriate for individuals who aren't within that age range.

* This may not apply to your plan because not all plans have extra coverage requirements like prior authorization, quantity limits, Step Therapy and/or age. Please log in to the myCigna website or app, or check your plan materials, to find out if your plan includes these specific coverage requirements.

Brand name medications are capitalized

In this drug list, brand name medications are capitalized and generic medications are lowercase.

Specialty medications are marked with an asterisk

Specialty medications are used to treat complex conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis. Specialty medications are covered on Tier 4 (see page 16). Injectable specialty medications are marked with an asterisk (*) and oral specialty medications are marked with a double asterisk (**).

Your plan may limit coverage to a 30-day supply and/or require you to use a preferred specialty pharmacy to receive coverage. Please log in to the **myCigna** website or app, 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). Please log in to the **myCigna** website or app, or check your plan materials, to learn more about how your plan covers preventive medications.

Plan exclusions

Your plan excludes certain types of medications or products from coverage. This is known as a "plan (or benefit) exclusion." This means that your plan doesn't cover any prescription medications in the drug class or to treat the specific condition. There's also no option to receive coverage through a medication review process. In this drug list, these medications have a carat (^) next to them. Please log in to the **myCigna** website or app, or check your plan materials, to find out if your plan excludes your medication from coverage.

How to find your medication on the drug list

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

Cigna (Performance) 4-Tier Prescription Drug List

Specialty medications covered on Tier 4 are listed on page 16.

TIER 1 $	TIER 2 $$	TIER 3 $$$
ALLERGY/NASAL SPRAYS		
Adyphren Adyphren Amp azelastine cromolyn cyproheptadine desloratadine epinephrine auto-injector (QL) flunisolide fluticasone hydroxyzine ipratropium mometasone spray (QL) olopatadine spray Phenergan promethazine		Clarinex-D 12 Hour EpinephrineSnap-V EPIsnap Karbinal ER Ryvent Semprex-D
ALZHEIMER'S DISEASE		
donepezil donepezil ODT memantine memantine ER pyridostigmine pyridostigmine ER rivastigmine	Mestinon syrup Namenda Titration Pak	Mestinon tablet Namenda Namenda XR (QL) Namzaric (QL) Regonol
ANXIETY/DEPRESSION/BIPOLAR DISORDER		
amitriptyline bupropion (QL) bupropion SR (QL) bupropion XL (QL) buspirone citalopram (QL) clomipramine desvenlafaxine ER (QL) duloxetine (QL) escitalopram (QL) fluoxetine (QL) fluoxetine DR (QL) paroxetine (QL) paroxetine CR (QL) paroxetine ER (QL) sertraline (QL) trazodone venlafaxine (QL) venlafaxine ER (QL)		Effexor XR (ST, QL) Fetzima (ST, QL) Forfivo XL (ST, QL) Prozac (ST, QL) Sarafem (ST) Trintellix (ST) Viibryd (ST) Wellbutrin SR (ST, QL) Zoloft (ST, QL)

TIER 1 $	TIER 2 $$	TIER 3 $$$
ASTHMA/COPD/RESPIRATORY		
albuterol budesonide solution ipratropium-albuterol montelukast	Advair Diskus Advair HFA Anoro Ellipta Atrovent HFA Breo Ellipta Combivent Respimat Incruse Ellipta ProAir HFA ProAir RespiClick Pulmicort Flexhaler QVAR RediHaler Serevent Diskus Spiriva Stiolto Respimat Striverdi Respimat Symbicort Trelegy Ellipta (ST) Ventolin HFA	Arcapta Neohaler Daliresp (QL) Pulmicort
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
atomoxetine dexmethyl-phenidate dexmethyl-phenidate ER dextroam-phetamine-amphetamine ER dextroam-phetamine-amphetamine guanfacine ER Metadate ER methylphenidate methylphenidate CD methylphenidate ER methylphenidate LA	Vyvanse (PA)	Adderall (ST) Adzenys ER (PA) Adzenys XR-ODT (PA) Daytrana (PA) Dyanavel XR (PA) Evekeo (ST) Focalin (ST) Methylin (ST) Quillichew ER (PA) Quillivant XR (PA) Ritalin (ST)
BLOOD PRESSURE/HEART MEDICATIONS		
amlodipine-benazepril amlodipine-olmesartan amlodipine-valsartan amlodipine-valsartan-HCTZ	Bystolic Byvalson Corlanor (PA) Entresto (PA) Multaq Nitro-Dur 0.3, 0.8mg Tekturna	Azor Bayer Chewable Aspirin+ Benicar (ST) Benicar HCT (ST) BiDil (QL) Cardizem LA Coreg CR

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
BLOOD PRESSURE/HEART MEDICATIONS *(cont)*		
Aspir 81+	Tekturna HCT	Cozaar (ST)
Aspir-Low+		Diovan (ST)
aspirin EC+		Diovan HCT (ST)
aspirin+		Edarbi (ST)
atenolol		Edarbyclor (ST)
atenolol-chlorthalidone		Epaned (ST)
benazepril		Hemangeol
benazepril-HCTZ		Inderal LA
bisoprolol		Inderal XL
Bufferin+		Innopran XL
candesartan		Nitro-Dur 0.1, 0.2, 0.4, 0.6mg
Cartia XT		Nitrolingual
carvedilol		Nitromist
carvedilol ER		Nitrostat
clonidine		Norvasc
Digitek		Ranexa (ST, QL)
Digox		Tiazac
digoxin		Tikosyn (QL)
Dilt-XR		Toprol XL
diltiazem		Tribenzor
diltiazem CD		Vasotec (ST)
diltiazem ER		
dofetilide (QL)		
doxazosin		
Ecotrin+		
EcPirin+		
enalapril		
flecainide		
hydralazine		
irbesartan		
isosorbide		
isosorbide ER		
labetalol		
lisinopril		
lisinopril-HCTZ		
losartan		
losartan-HCTZ		
Matzim LA		
metoprolol		
nadolol		
nifedipine		
nifedipine ER		
olmesartan		
olmesartan-amlodipine-HCTZ		
olmesartan-HCTZ		
propafenone		
propafenone ER		
propranolol		
propranolol ER		
quinapril		

TIER 1 $	TIER 2 $$	TIER 3 $$$
BLOOD PRESSURE/HEART MEDICATIONS *(cont)*		
ramipril		
Taztia XT		
telmisartan		
telmisartan-HCTZ		
tri-buffered aspirin+		
valsartan		
valsartan-HCTZ		
verapamil		
verapamil ER		
verapamil SR		
BLOOD THINNERS/ANTI-CLOTTING		
aspirin-dipyridamole ER	Brilinta	Bevyxxa (QL)
clopidogrel	Eliquis	Coumadin
Jantoven	Xarelto	Effient
prasugrel		Pradaxa
warfarin		Savaysa
		Zontivity
CANCER		
anastrozole		Arimidex
letrozole		Fareston (QL)
mercaptopurine		
tamoxifen+		
CHOLESTEROL MEDICATIONS		
atorvastatin 10mg, 20mg+		Crestor (ST)
ezetimibe		Vascepa
ezetimibe-simvastatin		Vytorin (ST)
fenofibrate		Zetia
fenofibric acid		
fluvastatin 20mg, 40mg+		
fluvastatin ER 80mg+		
lovastatin 20mg, 40mg+		
niacin ER		
Niacor		
omega-3 acid ethyl esters		
pravastatin 10mg, 20mg, 40mg, 80mg+		
rosuvastatin 5mg, 10mg+		
simvastatin (QL)		
simvastatin 10mg, 20mg, 40 mg (QL)+		
Triklo		

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
CONTRACEPTIVE PRODUCTS		
Aftera+	Lo Loestrin FE	Beyaz
Altavera+	NuvaRing	Caya Contoured+
Alyacen+	Taytulla	Ella+
Amethia Lo+		Estrostep FE
Amethia+		FC2 Female Condom+
Amethyst+		Femcap+
Apri+		Loestrin FE
Aranelle+		LoSeasonique
Ashlyna+		Microgestin+
Aubra+		Minastrin 24 FE
Aviane+		Seasonique
Azurette+		Today Contraceptive Sponge+
Balziva+		Wide Seal Diaphragm+
Bekyree+		
Blisovi 24 FE+		
Blisovi FE+		
Briellyn+		
Camila+		
Camrese Lo+		
Camrese+		
Caziant+		
Chateal+		
Cryselle+		
Cyclafem+		
Cyred+		
Dasetta+		
Daysee+		
Deblitane+		
Delyla+		
desogestrel-ethinyl estradiol+		
drospirenone-ethinyl estradiol-levomefibrate+		
drospirenone-ethinyl estradiol+		
Econtra EZ+		
Econtra One-Step+		
Elinest+		
Emoquette+		
Enpresse+		
Enskyce+		
Errin+		
Estarylla+		
ethynodiol-ethinyl estradiol+		
Falmina+		
Fayosim+		

TIER 1 $	TIER 2 $$	TIER 3 $$$
CONTRACEPTIVE PRODUCTS *(cont)*		
Femynor+		
Gianvi+		
Heather+		
Introvale+		
Isibloom+		
jencycla+		
Jolessa+		
Jolivette+		
Juleber+		
Junel FE 24+		
Junel FE+		
Junel+		
Kaitlib FE+		
Kariva+		
Kelnor 1-35+		
Kelnor 1-50+		
Kimidess+		
Kurvelo+		
Larin 24 FE+		
Larin FE+		
Larin+		
Larissia+		
Leena+		
Lessina+		
Levonest+		
levonorgestrel-ethinyl estradiol+		
Levora-28+		
Lillow+		
Loryna+		
Low-Ogestrel+		
Lutera+		
Lyza+		
Marlissa+		
medroxyprogesterone 150mg/ml+		
Melodetta 24 FE+		
Mibelas 24 FE+		
Microgestin FE+		
Mili+		
Mono-Linyah+		
Mononessa+		
My Choice+		
My Way+		
Myzilra+		
Necon 0.5/35+		
Necon 7/7/7+		
Nikki+		
Nora-BE+		

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
CONTRACEPTIVE PRODUCTS *(cont)*		
norethindrone-ethinyl estradiol-iron+		
norethindrone-ethinyl estradiol+		
norethindrone+		
norgestimate-ethinyl estradiol+		
Norlyda+		
Norlyroc+		
Nortrel+		
Ocella+		
Opcicon One-Step+		
Option 2+		
Orsythia+		
Philith+		
Pimtrea+		
Pirmella+		
Portia+		
Previfem+		
Quasense+		
Rajani+		
Reclipsen+		
Rivelsa+		
Setlakin+		
Sharobel+		
Sprintec+		
Sronyx+		
Syeda+		
Tarina FE+		
Tilia FE+		
Tri-Mili+		
Tri-Previfem+		
Tulana+		
Tydemy+		
VCF+		
Velivet+		
Viorele+		
Vyfemia+		
Wera+		
Wymzya FE+		
Xulane+		
Zenchent+		
Zovia 1-35e+		
Zovia 1-50e+		

TIER 1 $	TIER 2 $$	TIER 3 $$$
COUGH/COLD MEDICATIONS		
benzonatate		Tessalon Perle
Bromfed DM		Tussionex (QL)
brompheniramine-pseudoephedrine-DM		Tuzistra XR (QL)
hydrocodone-chlorpheniramine ER (QL)		
hydrocodone-homatropine (QL)		
Hydromet (QL)		
DENTAL PRODUCTS		
chlorhexidine rinse	Prevident 5000 paste, gel	Clinpro 5000
Denta 5000 Plus		Prevident
Dentagel		Prevident 5000 cream
doxycycline		
Fluoridex		
Oralone		
Paroex		
Peridex		
Periogard		
sodium fluoride		
SF 5000 plus		
triamcinolone paste		
DIABETES		
glimepiride	Basaglar	Cycloset
glipizide	Bydureon (QL)	Glucophage
glipizide ER	Byetta (QL)	Glucophage XR
glipizide XL	Farxiga	Riomet
metformin	GlucaGen HypoKit(QL)	VGo
metformin ER	Glucagon Emergency Kit (QL)	
	Glyxambi	
	Humalog	
	Humulin	
	Janumet	
	Janumet XR	
	Januvia	
	Jardiance	
	Kombiglyze XR	
	Levemir	
	OneTouch test strips and meters	
	Onglyza	
	Qtern	

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
DIABETES *(cont)*		
	Soliqua SymlinPen Synjardy Synjardy XR Tresiba Trulicity (QL) Victoza (QL) Xigduo XR Xultophy	
DIURETICS		
acetazolamide chlorthalidone eplerenone furosemide hydrochlorothiazide spironolactone triamterene-HCTZ	Diuril Dyrenium	Aldactone Carospir Lasix
EAR MEDICATIONS		
neomycin-polymyxin-HC ofloxacin drops	Cipro HC Ciprodex	Coly-Mycin S Dermotic Otovel
ERECTILE DYSFUNCTION		
sildenafil (PA, QL)	Cialis (PA, QL) Muse (PA, QL)	Viagra (PA, ST, QL)
EYE CONDITIONS		
azelastine brimonidine ciprofloxacin drops dorzolamide-timolol erythromycin ointment fluorometholone gatifloxacin ketorolac solution latanoprost moxifloxacin drops neomycin-polymyxin-dexamethasone ofloxacin drops olopatadine drops polymyxin B-TMP prednisolone drops timolol tobramycin drops tobramycin-dexamethasone	Alphagan P 0.1% Azasite Azopt Betimol Betoptic S Lotemax drops, gel Moxeza Pazeo Restasis Simbrinza Tobradex ointment Travatan Z Xiidra	Acuvail Alphagan P 0.15% Alrex Bepreve Besivance Bromsite Combigan Cosopt PF Durezol Ilevro Lotemax ointment Lumigan Nevanac Pataday Patanol Prolensa Tobradex drops Tobradex ST Vigamox Zioptan (ST, QL) Zirgan Zylet

TIER 1 $	TIER 2 $$	TIER 3 $$$
FEMININE PRODUCTS		
Fem pH Gynazole 1 miconazole 3 terconazole		AVC Relagard
GASTROINTESTINAL/HEARTBURN		
Alophen+ Anucort-HC balsalazide Bisa-Lax+ bisacodyl+ chlordiazepoxide-clidinium Clearlax+ dicyclomine diphenoxylate-atropine dronabinol Ducodyl+ esomeprazole (QL) famotidine Gavilax+ Gavilyte-C+ Gavilyte-G+ Gavilyte-n+ GentleLax+ Glycolax+ HealthyLax+ Hemmorex-HC hydrocortisone suppository lansoprazole (QL) lansoprazole-amoxicillin-clarithromycin LaxaClear+ mesalamine metoclopramide metoclopramide ODT Natura-Lax+ omeprazole (QL) ondansetron ondansetron ODT pantoprazole (QL) PEG 3350-electrolyte PEG 3350-electrolytes+ PEG-Prep+	Amitiza Apriso Canasa Carafate suspension Creon Dexilant (QL) GoLytely powder Linzess Pentasa Zenpep	Aciphex (ST, QL) Aciphex Sprinkle (QL) Bonjesta Carafate tablet Clenpiq CoLyte With Flavor Packets+ Correctol+ Diclegis Donnatal Dulcolax+ Gialax+ GoLytely solution+ Lialda (ST) Miralax+ Movantik (PA) MoviPrep+ Nulytely with flavor packets+ OsmoPrep+ Pancreaze Pertzye Prepopik+ Prevacid 30mg (ST, QL) Rectiv Relistor (PA) Sancuso (PA, QL) sfRowasa Suprep+ Sustol (PA) Symproic (PA) Transderm Scop Viberzi Viokace

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
GASTROINTESTINAL/HEARTBURN *(cont)*		
Phenadoz		
Powderlax+		
promethazine		
Promethegan		
Purelax+		
rabeprazole (QL)		
ranitidine		
scopolamine		
Smooth LAX+		
sucralfate		
TriLyte with flavor packets+		
ursodiol		
HORMONAL AGENTS		
Amabelz	Androderm (PA, QL)	Activella
budesonide EC	AndroGel 1.62% (PA, QL)	Alora (QL)
cabergoline (QL)	Armour Thyroid	AndroGel 1.0% (PA, QL)
Covaryx	Cytomel 50mcg	Angeliq
Covaryx H.S.	Divigel	Climara
Decadron	Duavee	Climara Pro
desmopressin	Estring (QL)	Combipatch
dexamethasone	Premarin	Cytomel 5, 25mcg
dexamethasone intensol	Premphase	Depo-Testosterone
EEMT	Prempro	Elestrin
EEMT H.S.	Synthroid	Entocort EC
estradiol (QL)		Estrace
estradiol-norethindrone		Estrogel
estrogen-methyltestosterone		Evamist
levothyroxine		Femring
Levoxyl		Intrarosa
liothyronine		Levo-T
medroxy-progesterone		Menostar (QL)
methimazole		Minivelle (QL)
methylprednisolone		Osphena
Mimvey		Rayaldee
Mimvey Lo		Striant (PA, QL)
Nature-Throid		Testopel (PA)
NP Thyroid		Tirosint
prednisolone		Triostat
prednisolone ODT		Unithroid
prednisone		Vagifem (QL)
prednisone intensol		Vivelle-Dot (QL)
progesterone		

TIER 1 $	TIER 2 $$	TIER 3 $$$
HORMONAL AGENTS *(cont)*		
testosterone (PA, QL)		
testosterone cypionate		
thyroid		
Unithroid 75mcg		
Westhroid		
WP Thyroid		
Yuvafem (QL)		
INFECTIONS		
acyclovir	Albenza	Alinia
amoxicillin	Cipro	Bactrim
amoxicillin-clavulanate ER		Bactrim DS
amoxicillin-clavulanate		Cleocin
atovaquone		Clindesse
atovaquone-proguanil		Cresemba vial
Avidoxy		Cresemba capsule (PA)
azithromycin		Dificid (QL)
cefdinir		E.E.S. 400
cefixime		EryPed 200
cefuroxime		Ery-Tab
cephalexin		Minocin vial
ciprofloxacin		Monurol
clarithromycin		Noxafil
clarithromycin ER		Plaquenil
clindamycin		Sulfatrim
Coremino		Suprax
dapsone		Tamiflu (QL)
Doxy 100		Uretron D-S
doxycycline		Uribel
doxycycline IR-DR		Urogesic Blue
Emverm		UTA
erythromycin		Valtrex
famciclovir		Vibramycin suspension, syrup
fluconazole		Xifaxan
hydroxychloroquine		
itraconazole		
levofloxacin		
metronidazole		
minocycline		
minocycline ER		
Mondoxyne NL		
Morgidox		
nitrofurantoin		
Okebo		

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
INFECTIONS *(cont)*		
oseltamivir (QL) penicillin Soloxide sulfamethoxazole-trimethoprim terbinafine tinidazole valacyclovir valganciclovir vancomycin Vandazole voriconazole (PA)		
INFERTILITY		
clomiphene^	Crinone^ Endometrin^	
MISCELLANEOUS		
NebuSal 3% PulmoSal sodium chloride	TechLITE lancets	Addyi (QL) NebuSal 6% Nuedexta (QL)
NUTRITIONAL/DIETARY		
B-12 Compliance calcitriol calcium cyanocobalamin injection FA-8+ fluoride+ Fluoritab+ Flura-Drops+ folic acid+ Klor-Con Klor-Con M10 Klor-Con M20 lanthanum levocarnitine Ludent Fluoride+ multivitamin-iron-fluoride+ PNV-DHA polyvitamins-fluoride+ potassium chloride Prena1 Pearl prenatal vitamin+ Prenatal+ Right Step+ sevelamer	CitraNatal 90 DHA Klor-Con M15 OB Complete Poly-Vi-Flor+ Prefera OB Prenate Tri-Vi-Flor+ Tristart DHA Vitafol vitaMedMD One Rx vitaPearl VP-PNV-DHA	Auryxia (QL) Concept DHA Escavite D+ Escavite+ Floriva+ Fluorabon+ K-Tab ER Klor-Con 10 Klor-Con 8 KPN+ Mephyton MVC-fluoride+ Nascobal Perry Prenatal+ Phoslyra Physicians EZ Use B-12 Poly-Vi-Flor With Iron+ Quflora+ Renagel Renvela Urosex+ Velphoro Veltassa

TIER 1 $	TIER 2 $$	TIER 3 $$$
NUTRITIONAL/DIETARY *(cont)*		
sodium fluoride+ tri-vitamin with fluoride-iron+ tri-vitamin with fluoride+ Virt-PN DHA vitamin D2 Zatean-PN DHA		
OSTEOPOROSIS PRODUCTS		
alendronate (QL) calcitonin-salmon raloxifene+ risedronate risedronate DR		Evista Fosamax Plus D (ST)
PAIN RELIEF AND INFLAMMATORY DISEASE		
acetaminophen-codeine (PA, QL) allopurinol baclofen buprenorphine (QL) butalbital-acetaminophen-caffeine-codeine (PA, QL) carisoprodol celecoxib (QL) colchicine cyclobenzaprine DermacinRx Empricaine DermacinRx Prizopak diclofenac (QL) diclofenac ER dihydroergotamine (QL) eletriptan (QL) Endocet (PA, QL) etodolac etodolac ER fenoprofen Fenortho fentanyl (PA, QL) Fioricet (QL) frovatriptan (QL) Glydo hydrocodone-acetaminophen (PA, QL)	Embeda (PA, QL) Hysingla ER (PA, QL) Nucynta (PA, QL) Proctofoam-HC Savella Subsys (PA, QL) Uloric Xtampza ER (PA, QL)	Abstral (PA, QL) Actiq (PA, QL) Analpram HC Arymo ER (PA, QL) Buprenex Butrans (QL) Celebrex (ST, QL) Colcrys Duragesic (PA, QL) Fentora (PA, QL) Flector (ST, QL) Kadian (PA, QL) Lazanda (PA, QL) Mitigare Morphabond ER (PA, QL) MS Contin (PA, QL) Nucynta ER (PA, QL) Onzetra Xsail (QL) Oxaydo (PA, QL) Pennsaid (ST) Percocet (PA, QL) Procort Synera Voltaren (ST, QL) Zohydro ER (PA, QL)

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
PAIN RELIEF AND INFLAMMATORY DISEASE *(cont)*		
hydromorphone tablet, solution (PA, QL)		
hydromorphone syringe, vial (QL)		
hydromorphone ER (PA, QL)		
IBU		
ibuprofen		
indomethacin		
indomethacin ER		
ketorolac (QL)		
leflunomide		
lidocaine (QL)		
lidocaine viscous		
lidocaine-prilocaine		
Lidopril		
Lidopril XR		
Lido-Prilo Caine Pack		
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)		
naproxen		
naproxen DS		
oxycodone (PA, QL)		
oxycodone ER (PA, QL)		
oxycodone-acetaminophen (PA, QL)		
oxymorphone (PA, QL)		
oxymorphone ER (PA, QL)		
Phrenilin Forte (QL)		
Prilolid		

TIER 1 $	TIER 2 $$	TIER 3 $$$
PAIN RELIEF AND INFLAMMATORY DISEASE *(cont)*		
Primlev (PA, QL)		
Profeno		
Relador Pak		
Relador Pak Plus		
rizatriptan (QL)		
sumatriptan (QL)		
sumatriptan-naproxen (QL)		
tizanidine		
tramadol (QL)		
tramadol ER (QL)		
Verdrocet (PA, QL)		
Vicodin (PA, QL)		
Vicodin ES (PA, QL)		
Vicodin HP (PA, QL)		
PARKINSON'S DISEASE		
amantadine		Azilect
bromocriptine		Neupro
carbidopa-levodopa		Rytary
carbidopa-levodopa ER		Sinemet
pramipexole		Sinemet CR
pramipexole ER		Tasmar
rasagiline		Xadago
ropinirole ER		
SCHIZOPHRENIA/ANTI-PSYCHOTICS		
aripiprazole		Abilify Maintena (QL)
aripiprazole ODT		Aristada (QL)
chlorpromazine		Fanapt (ST, QL)
haloperidol		Invega Sustenna (QL)
olanzapine		Invega Trinza (QL)
olanzapine ODT		Latuda (ST)
paliperidone ER		Rexulti (ST)
quetiapine		Saphris (ST)
quetiapine ER		Seroquel (ST)
risperidone		Seroquel XR (ST)
risperidone ODT		Vraylar (ST)
ziprasidone		
SEIZURE DISORDERS		
carbamazepine	Keppra vial	Aptiom (PA)
carbamazepine ER	Lyrica	Banzel (PA, QL)
divalproex ER	Vimpat tablet, solution (PA)	Briviact (PA)
Epitol		Carbatrol
gabapentin		Depakote
lamotrigine		Depakote ER
		Dilantin

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
SEIZURE DISORDERS *(cont)*		
lamotrigine (blue, green, orange)		Fycompa (PA)
lamotrigine ER		Oxtellar XR (PA)
lamotrigine ODT		Phenytek
lamotrigine ODT (blue, green, orange)		Spritam (PA)
levetiracetam		Tegretol
levetiracetam ER		Tegretol XR
oxcarbazepine		Vimpat vial
Roweepra		
Roweepra XR		
topiramate		
topiramate ER		
SKIN CONDITIONS		
adapalene cream, lotion, 3% gel (PA age)	Eucrisa	Benzamycin
adapalene-benzoyl peroxide	Finacea	Celacyn gel
Ala-Cort 2.5%	Naftin gel	Desonate (ST)
Amnesteem (QL)	Santyl (QL)	Desowen (ST)
Avar		Dovonex
Avar-E		Drysol
BenzePrO		Ecoza
BP 10-1		Elidel
calcipotriene		Enstilar
calcipotriene-betamethasone DP		Naftin cream
calcitrene		Picato
Claravis (QL)		Sklice
Clindacin ETZ		Soolantra
Clindacin P		Sorilux
clindamycin		Taclonex
clindamycin-benzoyl peroxide		Topicort (ST)
clindamycin-tretinoin		Tridesilon (ST)
clobetasol		
Clodan shampoo		
clotrimazole-betamethasone		
dapsone		
desonide		
fluocinonide		
fluorouracil		
flurandrenolide		
hydrocortisone		

TIER 1 $	TIER 2 $$	TIER 3 $$$
SKIN CONDITIONS *(cont)*		
imiquimod		
isotretinoin (QL)		
ketoconazole		
metronidazole		
mupirocin		
Myorisan (QL)		
Neuac gel		
Nolix		
nystatin-triamcinolone		
oxiconazole		
permethrin		
Procto-Med HC		
Procto-Pak		
Proctosol-HC		
Proctozone-HC		
Rosadan		
Rosanil		
Scalacort		
sodium sulfacetamide-sulfur		
SSS 10-5		
SulfaCleanse 8-4		
tacrolimus		
tazarotene		
tretinoin (PA age)		
triamcinolone		
Triderm		
Zenatane (QL)		
SLEEP DISORDERS/SEDATIVES		
armodafinil (PA)	Belsomra (ST)	Rozerem (ST, QL)
eszopiclone	Silenor (ST)	
modafinil (PA)		
zolpidem		
zolpidem ER		
SMOKING CESSATION		
bupropion SR 150mg+	Chantix	Nicorette+
NicoDerm CQ+	Nicotrol	Zyban
Nicorelief+		
nicotine gum+		
nicotine lozenge+		
nicotine patch+		
Quit 2+		
Quit 4+		

Cigna (Performance) 4-Tier Prescription Drug List

TIER 1 $	TIER 2 $$	TIER 3 $$$
SUBSTANCE ABUSE		
buprenorphine	Bunavail	
buprenorphine-naloxone	Narcan	
naloxone	Probuphine	
naltrexone (QL)	Suboxone	
	Zubsolv	
URINARY TRACT CONDITIONS		
darifenacin ER	Elmiron	Avodart
dutasteride	K-Phos Original	Pyridium
finasteride 5mg		Rapaflo
oxybutynin		
oxybutynin ER		
phenazopyridine		
potassium ER		
tamsulosin		
tolterodine		
tolterodine ER		
trospium		
trospium ER		

Specialty medications

The specialty medications listed below are covered on Tier 4. All of these medications require approval from Cigna before your plan will cover them.

MEDICATION NAME	DRUG CLASS
abacavir-lamivudine**	AIDS/HIV
Actemra* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Actimmune* (PA)	CANCER
Adcirca** (PA)	ASTHMA/COPD/RESPIRATORY
Adempas** (PA)	ASTHMA/COPD/RESPIRATORY
Afinitor Disperz** (PA)	CANCER
Afinitor** (PA)	CANCER
Akynzeo** (PA, QL)	GASTROINTESTINAL/HEARTBURN
Alecensa** (PA)	CANCER
alosetron**	GASTROINTESTINAL/HEARTBURN
Ampyra** (PA)	MULTIPLE SCLEROSIS
Apokyn* (PA)	PARKINSON'S DISEASE
Aralast NP* (PA)	ASTHMA/COPD/RESPIRATORY
Aranesp* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Astagraf XL**	TRANSPLANT MEDICATIONS
atazanavir**	AIDS/HIV
Atripla**	AIDS/HIV
Aubagio** (PA)	MULTIPLE SCLEROSIS
Austedo** (PA)	MISCELLANEOUS
Avastin* (PA)	CANCER
Aveed* (PA)	HORMONAL AGENTS
Avonex* (PA)	MULTIPLE SCLEROSIS
azathioprine**	TRANSPLANT MEDICATIONS
Baraclude**	INFECTIONS
Bebulin* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Benlysta* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Berinert* (PA)	BLOOD PRESSURE/HEART MEDICATIONS
Betaseron* (PA)	MULTIPLE SCLEROSIS
bexarotene** (PA)	CANCER
Biktarvy**	AIDS/HIV
Bosulif** (PA)	CANCER
Botox* (PA)	MISCELLANEOUS
Cabometyx** (PA)	CANCER
capecitabine** (PA)	CANCER
Cayston*	INFECTIONS
Cellcept**	TRANSPLANT MEDICATIONS
Ceprotin* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Cerdelga** (PA)	MISCELLANEOUS

MEDICATION NAME	DRUG CLASS
Cerezyme* (PA)	MISCELLANEOUS
Cholbam** (PA)	GASTROINTESTINAL/HEARTBURN
Cimzia* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Cinryze* (PA)	BLOOD PRESSURE/HEART MEDICATIONS
Cometriq** (PA)	CANCER
Complera**	AIDS/HIV
Cosentyx* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Cotellic** (PA)	CANCER
Cuprimine** (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Cystagon**	URINARY TRACT CONDITIONS
Cystaran** (QL)	EYE CONDITIONS
Daraprim** (PA)	INFECTIONS
Depen** (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Descovy**	AIDS/HIV
desmopressin*	HORMONAL AGENTS
Durolane* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Dysport* (PA)	MISCELLANEOUS
Egrifta* (PA)	HORMONAL AGENTS
Elaprase* (PA)	MISCELLANEOUS
Emflaza** (PA)	HORMONAL AGENTS
Enbrel* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
enoxaparin* (QL)	BLOOD THINNERS/ANTI-CLOTTING
entecavir**	INFECTIONS
Entyvio* (PA)	GASTROINTESTINAL/HEARTBURN
Envarsus XR**	TRANSPLANT MEDICATIONS
Epclusa** (PA)	INFECTIONS
Epogen* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Erivedge** (PA)	CANCER
Erleada* (PA)	CANCER
Esbriet** (PA)	MISCELLANEOUS
Euflexxa* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Evotaz**	AIDS/HIV
Exjade**	MISCELLANEOUS
Extavia* (PA)	MULTIPLE SCLEROSIS
Eylea* (PA)	EYE CONDITIONS
Fasenra* (PA)	ASTHMA/COPD/RESPIRATORY
Firazyr* (PA)	BLOOD PRESSURE/HEART MEDICATIONS
Follistim AQ*^	INFERTILITY
fondaparinux* (QL)	BLOOD THINNERS/ANTI-CLOTTING
Forteo*	HORMONAL AGENTS
Fragmin* (QL)	BLOOD THINNERS/ANTI-CLOTTING
Ganirelix*^	HORMONAL AGENTS

MEDICATION NAME	DRUG CLASS
Gattex* (PA)	GASTROINTESTINAL/HEARTBURN
Gazyva* (PA)	CANCER
Gelsyn-3* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Genvoya**	AIDS/HIV
Gilenya** (PA)	MULTIPLE SCLEROSIS
Gilotrif* (PA)	CANCER
Glassia* (PA)	ASTHMA/COPD/RESPIRATORY
glatiramer* (PA)	MULTIPLE SCLEROSIS
Glatopa* (PA)	MULTIPLE SCLEROSIS
Gleevec** (PA)	CANCER
Granix*	BLOOD MODIFIERS/BLEEDING DISORDERS
H.P. Acthar* (PA)	HORMONAL AGENTS
Haegarda* (PA)	BLOOD PRESSURE/HEART MEDICATIONS
Harvoni** (PA)	INFECTIONS
Herceptin* (PA)	CANCER
Humatrope* (PA)	HORMONAL AGENTS
Humira* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Hyalgan* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
ibandronate*	OSTEOPOROSIS PRODUCTS
Ibrance** (PA)	CANCER
Iclusig** (PA)	CANCER
Ilaris* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Iluvien*	EYE CONDITIONS
imatinib** (PA)	CANCER
Imbruvica** (PA)	CANCER
Ingrezza* (PA)	MISCELLANEOUS
Inlyta** (PA)	CANCER
Intelence**	AIDS/HIV
Intron A* (PA)	CANCER
Isentress HD**	AIDS/HIV
Isentress**	AIDS/HIV
Jadenu**	MISCELLANEOUS
Jakafi** (PA)	CANCER
Jynarque* (PA)	DIURETICS
Kadcyla* (PA)	CANCER
Kalydeco** (PA, QL)	ASTHMA/COPD/RESPIRATORY
Kevzara* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Kineret* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Kitabis Pak*	INFECTIONS
Korlym** (PA)	CHOLESTEROL MEDICATIONS
Kuvan** (PA)	MISCELLANEOUS
Kyleena*	CONTRACEPTION PRODUCTS

MEDICATION NAME	DRUG CLASS
Kynamro* (PA)	CHOLESTEROL MEDICATIONS
Lemtrada* (PA)	MULTIPLE SCLEROSIS
Lenvima** (PA)	CANCER
Letairis** (PA)	ASTHMA/COPD/RESPIRATORY
Lonsurf** (PA)	CANCER
Lucentis* (PA)	EYE CONDITIONS
Lumizyme* (PA)	MISCELLANEOUS
Lupron Depot* (PA)	HORMONAL AGENTS
Lynparza** (PA)	CANCER
Makena* (PA)	INFERTILITY
Mavyret** (PA)	INFECTIONS
Mekinist** (PA)	CANCER
Menopur*^	INFERTILITY
methotrexate**	CANCER
Mirena*	CONTRACEPTION PRODUCTS
Monovisc* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
mycophenolate**	TRANSPLANT MEDICATIONS
mycophenolic acid**	TRANSPLANT MEDICATIONS
Myfortic**	TRANSPLANT MEDICATIONS
Naglazyme* (PA)	MISCELLANEOUS
Natpara* (PA)	HORMONAL AGENTS
Neoral**	TRANSPLANT MEDICATIONS
Nerlynx* (PA)	CANCER
Neulasta* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Nexavar** (PA)	CANCER
Nexplanon*	CONTRACEPTION PRODUCTS
Ninlaro** (PA)	CANCER
Nityr** (PA)	MISCELLANEOUS
Northera** (PA)	BLOOD PRESSURE/HEART MEDICATIONS
Norvir**	AIDS/HIV
Nucala* (PA)	ASTHMA/COPD/RESPIRATORY
Ocaliva** (PA)	GASTROINTESTINAL/HEARTBURN
Ocrevus* (PA)	MULTIPLE SCLEROSIS
Odefsey**	AIDS/HIV
Ofev** (PA)	ASTHMA/COPD/RESPIRATORY
Opsumit** (PA)	ASTHMA/COPD/RESPIRATORY
Orencia* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Orenitram ER** (PA)	ASTHMA/COPD/RESPIRATORY
Orkambi** (PA, QL)	ASTHMA/COPD/RESPIRATORY
Orthovisc* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Otezla** (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Otrexup* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE

MEDICATION NAME	DRUG CLASS
Ozurdex*	EYE CONDITIONS
PegIntron* (PA)	INFECTIONS
Perjeta* (PA)	CANCER
Plegridy* (PA)	MULTIPLE SCLEROSIS
Pomalyst** (PA)	CANCER
Prezcobix**	AIDS/HIV
Prezista**	AIDS/HIV
Procrit* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Procysbi** (PA)	URINARY TRACT CONDITIONS
Prograf**	TRANSPLANT MEDICATIONS
Prolia* (PA)	OSTEOPOROSIS PRODUCTS
Promacta** (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Pulmozyme** (PA)	ASTHMA/COPD/RESPIRATORY
Rasuvo* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Ravicti** (PA)	GASTROINTESTINAL/HEARTBURN
Rebif* (PA)	MULTIPLE SCLEROSIS
Remicade* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Remodulin* (PA)	ASTHMA/COPD/RESPIRATORY
Repatha* (PA)	CHOLESTEROL MEDICATIONS
Revlimid** (PA)	CANCER
Reyataz**	AIDS/HIV
ritonavir**	AIDS/HIV
Rituxan* (PA)	CANCER
Samsca**	DIURETICS
Sandostatin LAR Depot* (PA)	HORMONAL AGENTS
Selzentry**	AIDS/HIV
Sensipar**	GASTROINTESTINAL/HEARTBURN
Serostim* (PA)	HORMONAL AGENTS
Simponi* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Sinuva* (PA)	ALLERGY/NASAL SPRAYS
sirolimus**	TRANSPLANT MEDICATIONS
Skyla*	CONTRACEPTION PRODUCTS
Soliris* (PA)	BLOOD MODIFIERS/BLEEDING DISORDERS
Somatuline Depot* (PA)	HORMONAL AGENTS
Somavert* (PA)	HORMONAL AGENTS
Sovaldi** (PA)	INFECTIONS
Sprycel** (PA)	CANCER
Stelara* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Stivarga** (PA)	CANCER
Strensiq* (PA)	MISCELLANEOUS
Stribild**	AIDS/HIV
Sublocade*	SUBSTANCE ABUSE

MEDICATION NAME	DRUG CLASS
Sucraid**	GASTROINTESTINAL/HEARTBURN
Supprelin LA* (PA)	HORMONAL AGENTS
Sutent** (PA)	CANCER
Sylatron* (PA)	CANCER
Symdeko* (PA, QL)	ASTHMA/COPD/RESPIRATORY
Synagis* (PA)	INFECTIONS
Synvisc* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Synvisc-One* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Syprine** (PA)	MISCELLANEOUS
tacrolimus**	TRANSPLANT MEDICATIONS
Tafinlar** (PA)	CANCER
Tagrisso** (PA)	CANCER
Taltz* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Tarceva** (PA)	CANCER
Targretin** (PA)	CANCER
Tasigna** (PA)	CANCER
Tecentriq** (PA)	CANCER
Tecfidera** (PA)	MULTIPLE SCLEROSIS
temozolomide** (PA)	CANCER
tenofovir**	AIDS/HIV
tetrabenazine** (PA)	MISCELLANEOUS
Thalomid** (PA)	INFECTIONS
Thiola**	URINARY TRACT CONDITIONS
Thyrogen*	HORMONAL AGENTS
Tivicay**	AIDS/HIV
Tobi Podhaler**	INFECTIONS
tobramycin*	INFECTIONS
Tracleer** (PA)	ASTHMA/COPD/RESPIRATORY
tranexamic acid**	BLOOD MODIFIERS/BLEEDING DISORDERS
Tremfya* (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Trexall*	CANCER
Triumeq*	AIDS/HIV
Truvada**	AIDS/HIV
Tymlos*	OSTEOPOROSIS PRODUCTS
Tysabri* (PA)	MULTIPLE SCLEROSIS
Tyvaso** (PA)	ASTHMA/COPD/RESPIRATORY
Uptravi** (PA)	ASTHMA/COPD/RESPIRATORY
Valstar*	CANCER
Varubi** (PA, QL)	GASTROINTESTINAL/HEARTBURN
Vemlidy**	INFECTIONS
Verzenio** (PA)	CANCER
Vimizim* (PA)	MISCELLANEOUS

MEDICATION NAME	DRUG CLASS
Viread**	AIDS/HIV
Vivitrol**	MISCELLANEOUS
Vosevi** (PA)	INFECTIONS
Votrient** (PA)	CANCER
VPRIV* (PA)	MISCELLANEOUS
Xalkori** (PA)	CANCER
Xeljanz XR** (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Xeljanz** (PA)	PAIN RELIEF AND INFLAMMATORY DISEASE
Xenazine** (PA)	MISCELLANEOUS
Xeomin* (PA)	MISCELLANEOUS
Xgeva* (PA)	OSTEOPOROSIS PRODUCTS
Xolair* (PA)	ASTHMA/COPD/RESPIRATORY
Xtandi** (PA)	CANCER
Xyrem** (PA)	SLEEP DISORDERS/SEDATIVES
Zarxio*	BLOOD MODIFIERS/BLEEDING DISORDERS
Zelboraf** (PA)	CANCER
Zepatier** (PA)	INFECTIONS
Zorbtive* (PA)	HORMONAL AGENTS
Zortress**	TRANSPLANT MEDICATIONS
Zytiga** (PA)	CANCER

Medications that are not covered

The medications listed below aren't covered on your plan's drug list.^^ This means that if you fill a prescription for any of these medications, you'll pay its full cost out-of-pocket. **We want you to know your plan covers other medications that are used to treat the same condition.^^** We've listed some below for you and your doctor to consider. **You should call your doctor's office to talk about your options.**

DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
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	Anafranil	clomipramine
	Aplenzin Wellbutrin XL	bupropion XL
	Ativan	lorazepam
	Cymbalta	duloxetine
	Lexapro	escitalopram
	Pamelor	nortriptyline
	Parnate	tranylcypromine
	Pexeva	paroxetine CR/ER
	Tofranil	imipramine
ASTHMA/COPD/RESPIRATORY	Alvesco ArmonAir RespiClick Arnuity Ellipta Asmanex Asmanex HFA Flovent Diskus Flovent HFA	QVAR RediHaler Pulmicort Flexhaler
	Bevespi Utibron Neohaler	Anoro Ellipta Stiolto Respimat
	Dulera	Advair Diskus Advair HFA Breo Ellipta Symbicort
	Elixophyllin	theophylline oral solution
	Proventil HFA Xopenex HFA	ProAir HFA ProAir RespiClick Ventolin

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
ASTHMA/COPD/RESPIRATORY *(cont)*	Seebri Neohaler Tudorza Pressair	Incruse Ellipta Spiriva
	Zyflo	montelukast zafirlukast
	Zyflo CR	zileuton ER
ATTENTION DEFICIT HYPERACTIVITY DISORDER	Cotempla XR-ODT	dexmethylphenidate ER methylphenidate ER/CD/LA dextroamphetamine-amphetamine ER Vyvanse
	Desoxyn	methamphetamine
	Dexedrine	dextroamphetamine
	Mydayis	dextroamphetamine-amphetamine ER dexmethylphenidate ER methylphenidate ER/CD/LA Vyvanse
BLOOD PRESSURE/HEART MEDICATIONS	Betapace	sotalol
	Cardizem	diltiazem
	Cardizem CD	Cartia XT diltiazem CD/ER
	Isordil Isordil Titradose	isosorbide dinitrate
	Lanoxin	Digitek digoxin
BLOOD THINNERS/ANTI-CLOTTING	Yosprala	IR or EC aspirin
CANCER	Nilandron	nilutamide
CHOLESTEROL MEDICATIONS	Antara Fenoglide	fenofibrate
	Lipitor	atorvastatin
	Zypitamag	atorvastatin fluvastatin lovastatin pravastatin rosuvastatin simvastatin
COUGH/COLD MEDICATIONS	Tussicaps	hydrocodone-chlorpheniramine ER
DIABETES	Accu-Chek, Contour, Freestyle, all other test strips and meters	OneTouch test strips and meters
	Adlyxin Tanzeum	Byetta Bydureon Ozempic Trulicity Victoza

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
DIABETES *(cont)*	Admelog Afrezza Apridra Apridra SoloStar Fiasp Novolin, Novolog	Humalog Humulin
	Fortamet Glumetza metformin ER (generic Fortamet and Glumetza)	metformin ER (generic Glucophage XR)
	Invokamet Invokamet XR Segluromet	Synjardy, Synjardy XR, Xigduo XR
	Invokana	Farxiga Jardiance
	Jentadueto Jentadueto XR Kazano	alogliptin-metformin Janumet, Janumet XR Kombiglyze XR
	Nesina Tradjenta	alogliptin Januvia Onglyza
	Oseni	alogliptin-pioglitazone Januvia + pioglitazone
	Lantus Toujeo SoloStar	Basaglar, Levemir, Tresiba
	Steglatro	Farxiga Jardiance
DIURETICS	Edecrin ethacrynic acid	bumetanide furosemide torsemide
EYE CONDITIONS	Vyzulta	bimatoprost latanoprost Travatan Z
GASTROINTESTINAL/HEARTBURN	Anusol-HC suppository Cortifoam Uceris foam	Anucort-HC Hemmorex-HC hydrocortisone suppository
	Asacol-HD Colazal Delzicol Dipentum Giazo mesalamine 800mg tablet	Apriso balsalazide Lialda Pentasa sulfasalazine sulfasalazine DR
	Librax	chlordiazepoxide-clidinium
	Lotronex	alosetron
	Marinol	dronabinol

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
GASTROINTESTINAL/HEARTBURN *(cont)*	Nexium	esomeprazole
	Omeclamox-Pak Prevpac Pylera	lansoprazole-amoxicillin-clarithromycin (combo pak)
	OmePPI	omeprazole
	Pepcid	famotidine
	Prevacid SoluTab	lansoprazole
	Rowasa	mesalamine enema
	Syndros	dronabinol
	Trulance	Amitiza, Linzess
	Zegerid	omeprazole
	Zofran	ondansetron
	Zofran ODT	ondansetron ODT
	Zuplenz	ondansetron ondansetron ODT
HORMONAL AGENTS	Cortrosyn	cosyntropin
	DDAVP	desmopressin
	Dexpak TaperDex	dexamethasone
	Fortesta Natesto Testim Vogelxo	AndroGel 1.62% testosterone
	Genotropin Norditropin Nutropin AQ Omnitrope Saizen Zomacton	Humatrope (PA)
	Hectorol	doxercalciferol
	Rayos	prednisone prednisone intensol
	Uceris tablet	dexamethasone hydrocortisone methylprednisolone prednisone prednisolone
INFECTIONS	Acticlate Doryx Minocin capsule Oracea Solodyn Vibramycin capsule Ximino	Generic products (e.g., doxycycline; minocycline)

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
INFECTIONS *(cont)*	Augmentin/ES/XR	amoxicillin-clavulanate ER
	Bethkis Tobi	Kitabis Pak tobramycin
	Diflucan	fluconazole
	E.E.S. 200 Eryped 400	erythromycin ethylsuccinate
	Mepron	atovaquone
	Mycobutin	rifabutin
	Onmel	itraconazole terbinafine
	Sitavig	acyclovir (oral) famciclovir valacyclovir
	Sporanox	itraconazole
	Targadox	doxycycline
	Valcyte	valganciclovir
	Vancocin	vancomycin
	Zovirax	acyclovir (oral) famciclovir valacyclovir
INFERTILITY	Bravelle Gonal-F	Follistim AQ (PA)
MISCELLANEOUS	Horizant	gabapentin
MULTIPLE SCLEROSIS	Copaxone	Aubagio, Avonex, Betaseron, Extavia, Gilenya, glatiramer, Glatopa, Plegridy, Rebif, Tecfidera
PAIN RELIEF AND INFLAMMATORY DISEASE	Amrix	cyclobenzaprine Other generic muscle relaxants
	Belbuca	buprenorphine
	Bupap	butalbital-acetaminophen tablet Tencon
	Cambia diclofenac 1.5% solution Duexis Naprelan naproxen CR naproxen ER Pennsaid Tivorbex Vimovo Vivlodex Zipsor Zorvolex	Generic prescription NSAIDs (e.g., celecoxib, meloxicam)

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
PAIN RELIEF AND INFLAMMATORY DISEASE *(cont)*	Conzip	tramadol tramadol ER
	D.H.E. 45	dihydroergotamine
	Duzallo	allopurinol, probenecid
	Gralise	gabapentin
	Imitrex Zembrace SymTouch	sumatriptan
	Siliq	Enbrel (PA) Humira (PA) Remicade (PA) Stelara (PA)
	levorphanol	Generic products (e.g., acetaminophen-codeine, hydromorphone, oxycodone)
	Lido-K Lidozion	lidocaine cream
	Lorzone	chlorzoxazone
	Migranal	dihydroergotamine
	OxyContin	Xtampza ER (PA) Embeda ER (PA) Hysingla ER (PA)
	Roxicodone	oxycodone
	Soriatane	acitretin
	Sprix	ketorolac
	Treximet	Generic NSAIDs Generic triptans (e.g., sumatriptan, naratriptan)
	Vanatol LQ	butalbital-acetaminophen-caffeine
	Zomig	zolmitriptan sumatriptan
	Zomig ZMT	zolmitriptan ODT
PARKINSON'S DISEASE	Gocovri	amantadine
	Lodosyn	carbidopa
	Requip XL	ropinirole ER
SCHIZOPHRENIA/ANTI-PSYCHOTICS	Abilify	aripiprazole
	Fazaclo	clozapine
	Versacloz	clozapine ODT
	Geodon	ziprasidone
	Zyprexa	olanzapine
	Zyprexa Zydis	olanzapine ODT
SEIZURE DISORDERS	Lyrica CR	duloxetine gabapentin lidocaine 5% patch Lyrica
	Mysoline	primidone

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
SKIN CONDITIONS	Absorica	Claravis Myorisan Zenatane
	Aldara	imiquimod cream
	Anusol-HC cream	hydrocortisone Procto-Med HC Proctosol-HC Proctozone-HC
	Bensal HP Salex	salicylic acid
	Benzaclin Duac Neuac Kit	clindamycin-benzoyl peroxide Neuac gel
	Carac	fluorouracil
	Clindagel	clindamycin
	Clobex	clobetasol
	Cutivate	Generic topical steroid (e.g. betamethasone)
	diclofenac 3% gel	Fluoroplex fluorouracil imiquimod Picato (NPB)
	Ertaczo Extina Luzu Vusion	ketoconazole
	Halog Ultravate X	clobetasol halobetasol
	Jublia	Ciclodan
	Kerydin	ciclopirox itraconazole terbinafine
	Kenalog	triamcinolone
	Locoid Locoid Lipocream	hydrocortisone
	Loprox cream, kit	ciclopirox
	Noritate	metronidazole Rosadan
	Oxistat	clotrimazole econazole ketoconazole
	Penlac	Ciclodan ciclopirox
	Plexion	sodium sulfacetamide-sulfur

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DRUG CLASS	MEDICATION NOT COVERED^^	GENERIC AND/OR PREFERRED BRAND ALTERNATIVE(S)
SKIN CONDITIONS *(cont)*	Prudoxin Zonalon	Generic topical steroid (e.g., betamethasone tacrolimus (topical)
	Sernivo	betamethasone fluocinonide hydrocortisone
	Soriatane	acitretin
	Trianex	triamcinolone Triderm
	Ultravate lotion	clobetasol
	Vanos	fluocinonide
	Verdeso	desonide
	Xerese	acyclovir (oral) + hydrocortisone famciclovir + hydrocortisone valacyclovir + hydrocortisone
	Ziana	tretinoin clindamycin-benzoyl peroxide
	Zyclara	imiquimod
SLEEP DISORDERS/SEDATIVES	Ambien Ambien CR Edluar Intermezzo	zolpidem zolpidem ER
	Nuvigil	armodafinil
	Provigil	modafinil
	Restoril	temazepam
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

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Prescription drug list FAQs

Understanding your prescription medication coverage can be confusing. Below are answers to some commonly asked questions.

Why do you make changes to the drug list?

Cigna regularly reviews and updates the prescription drug list. We make changes for many reasons – like when new medications become available or are no longer available, or when medication prices change. We try to give you many options to choose from to treat your health condition. These changes may include:[1]

- Moving a medication to a lower cost tier. This can happen at any time during the year.
- Moving a brand 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. This typically happens twice a year on January 1st and July 1st.
- Adding requirements to a medication. For example, requiring approval from Cigna before a medication may be covered or adding a quantity limit to a medication.

When a medication changes tiers, you may pay a different amount to fill that medication. It's important to know that when we make a change that affects the coverage of a medication you're taking, we let you know before it begins so you have time to talk with your doctor.

Why doesn't my plan cover certain medications?

To help lower your overall health care costs, your plan doesn't cover certain high-cost brand medications because they have lower-cost, covered alternatives which are used to treat the same condition. Meaning, the alternative works the same or similar to the non-covered medication. If you're taking a medication that your plan doesn't cover and your doctor feels an alternative isn't right for you, he or she can ask Cigna to consider approving coverage of your medication.

Your plan may also exclude certain medications or products from coverage. This is known as a "plan (or benefit) exclusion." For example, your plan excludes medications that aren't approved by the U.S. Food and Drug Administration (FDA).

How do you decide which medications are covered?

The Cigna Prescription Drug List is developed with the help of Cigna's Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals medications about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market. The Cigna Pharmacy Management® Business Decision Team then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

Which medications are covered under the health care reform law?

The Patient Protection and Affordable Care Act (PPACA), 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. Please log in to the **myCigna** website or app, or check your plan materials, to learn more about how your plan covers preventive medications. You can also view the PPACA 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

Prescription drug list FAQs *(cont)*

supplies or devices covered under standard pharmacy benefit plans. We review all newly approved medications to determine if they 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?

You can use the Drug Cost tool on the **myCigna** website to estimate how much your medication may cost[2] 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 medication that's on a lower tier (ex. generic or preferred brand) or by filling a 90-day supply, if your plan allows. You should talk with your doctor to find out if one of these options, may work for you.

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

The FDA requires generic medications to provide the same clinical benefit as its brand name versions.[3] The FDA also requires generic makers to prove that the generic works in the same way as the brand name medication. This means that generic equivalent medications must:[3]

- Have the same active ingredient, strength and dosage form as the brand name medication
- Deliver the same amount of active ingredients into the bloodstream in the same amount of time as the brand name medication
- Be used in the same way as the brand name medication

Generics typically cost much less than brand name medications – in some cases, up to 85% less.[3] 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 can help you manage your health and prescription needs.[4] Their team of medical condition experts provide personalized, 24/7 support. They'll help you get approval for coverage of your medication, answer any questions you have about your medication and its cost, help you work through any side effects and make sure you have any supplies you need (at no extra cost). They'll also help you set up home delivery of your medication and give you information about financial assistance programs (if you need help paying for your medication). To learn more about the services they provide, please call **800.351.3606** or go to **Cigna.com/specialty-pharmacyservices**.

Can I fill my prescriptions by mail?

Yes, as long as your plan offers home delivery.[4]

- If you're taking a medication every day to treat an ongoing health condition like diabetes, high blood pressure, high cholesterol or asthma, you can order up to a 90-day supply through Cigna Home Delivery Pharmacy.[SM] To learn more, call **800.835.3784** or go to **Cigna.com/home-delivery-pharmacy**.
- If you're taking a specialty medication to treat a complex condition like multiple sclerosis, hepatitis C and rheumatoid arthritis, you can fill your prescription through Cigna Specialty Pharmacy (our home delivery pharmacy). To learn more, call **800.351.3606** or go to **Cigna.com/specialty-pharmacy-services**.

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

You can use the online tools and resources on the **myCigna** website or app to help you better understand your pharmacy benefits. You can view your drug list or search for a specific medication, use the Drug Cost tool to estimate how much your medications may cost, find an in-network pharmacy near you, review your pharmacy claims and payment history, and track Cigna Home Delivery Pharmacy[4] orders and request refills.

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) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines;
- prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative;
- doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved 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 medications used for purposes other than those approved by the FDA unless the medications are 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 products;
- 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 medications and related supplies due to loss or theft;
- medications 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
- coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication 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 approved 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 may 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, these changes may not begin 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. Prices are not guaranteed, and even though a price is displayed in the Drug Cost tool, it's not a guarantee of coverage. Your costs and coverage may change by the time you fill your prescription at the pharmacy, and medication costs at individual pharmacies can vary. Coverage and pricing may change. For example, your pharmacy's retail cash price for a specific medication may be less than the price shown in the Drug Cost tool.
3. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Last updated 06/04/18.
4. Not all plans are the same, so some plans may not include Cigna Home Delivery Pharmacy or Cigna Specialty Pharmacy. Please log in to the myCigna website or app, or check your plan materials, to learn more about the pharmacies in your plan's network.
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.

891394 g Performance 4-Tier 08/18

Cigna Healthcare Financial Exhibit for:

Digital Prospectors Corporation - High

Effective Date: May 01, 2019

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum		
(Class I, II, III, IX Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$25	$25
Per Family	$75	$75
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Surgical Extraction of Impacted Teeth Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children Only Lifetime Maximum	50%, No Ortho Deductible $1500	50%, No Ortho Deductible $1500
Class IX Expenses - Implants		
Plan Calendar Year Max	50%, After Deductible $1500	50%, After Deductible $1500
Dental Plan Reimbursement Levels	Based on Contracted Fees	95th Percentile
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

P0002 (NS001) Network. Prepared by Underwriting.

Cigna Healthcare Financial Exhibit for:

Digital Prospectors Corporation - High

Effective Date: May 01, 2019

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 per 36 consecutive months. Panorex: 1 per 36 consecutive months
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	1 per 60 consecutive months
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	1 per 60 consecutive months
Dentures and Partials	1 per 60 consecutive months
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	For dependent children, up to age 19
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for a specified time period; thereafter, considered a Class III expen
Late Entrant Limit	50% coverage on Class III, IV and IX (if applicable), for a specified time period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

Cigna Healthcare Financial Exhibit for:

Digital Prospectors Corporation - Low

Effective Date: May 01, 2019

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum		
(Class I, II, III, IX Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$50	$50
Per Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Surgical Extraction of Impacted Teeth Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
	Not Covered	Not Covered
Class IX Expenses - Implants		
	50%, After Deductible	50%, After Deductible
Plan Calendar Year Max	$1500	$1500
Dental Plan Reimbursement Levels	Based on Contracted Fees	95th Percentile
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

P0002 (NS001) Network. Prepared by Underwriting.

Cigna Healthcare Financial Exhibit for:

Digital Prospectors Corporation - Low

Effective Date: May 01, 2019

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 per 36 consecutive months. Panorex: 1 per 36 consecutive months
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	1 per 60 consecutive months
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	1 per 60 consecutive months
Dentures and Partials	1 per 60 consecutive months
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for a specified time period; thereafter, considered a Class III expen
Late Entrant Limit	50% coverage on Class III, IV and IX (if applicable), for a specified time period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
Digital Prospectors Corporation - 5/1/2019
C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit**	**Out-of-Network Benefit**	**Frequency Period ****
Exam Copay	$20	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Progressives Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $40 Up to $65 Up to $75 Up to $75 Up to $100	 12 months 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 $150 Covered 100%	 Up to $120 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $150	Up to $83	24 months
** Your Frequency Period begins on January 1 (Calendar year basis)			

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 19 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com,"Review My Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.

3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
• Go to **Cigna.com** and go to Forms, Vision Forms
• Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

DISCRIMINATION IS AGAINST THE LAW

Vision 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.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. Call 1.877.478.7557 (TTY: 800.428.4833).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.877.478.7557 (TTY: 800.428.4833).

Chinese – 注意：我們可為您免費提供語言協助服務。請致電 1.877.478.7557 （聽障專線：800.428.4833）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.877.478.7557 (TTY: 800.428.4833).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.478.7557 (TTY: 800.428.4833)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.877.478.7557 (TTY: 800.428.4833).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.478.7557 (линия TTY телетайп: 800.428.4833).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.478.7557 (رقم هاتف الصم والبكم: 800.428.4833).

French Creole – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.478.7557 (TTY: 800.428.4833).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.877.478.7557 (ATS: 800.428.4833).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.877.478.7557 (TTY: 800.428.4833).

Polish – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 877 478 7557 (TTY: 800.428.4833).

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.877.478.7557 (TTY: 800.428.4833) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.478.7557 (TTY: 800.428.4833).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.478.7557 (TTY: 800.428.4833).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. با شماره 1.877.478.7557 تماس بگیرید (شماره تلفن ویژه ناشنوایان: 800.428.4833).

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Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
SHORT-TERM DISABILITY INSURANCE

SUMMARY OF BENEFITS

Prepared for: Digital Prospectors Corporation

Disability insurance pays a portion of your salary if you're unable to work due to a covered disability. When reviewing this coverage, consider how long you can personally go without receiving a paycheck.

Who Is Eligible For Coverage?:

You: All active, Full-Time Staff & Salaried Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage the first of the month following date of hire.

Available Coverage:

Gross Weekly Benefit[1]	Maximum Gross Weekly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of your weekly covered earnings	$2,000	7 Days for accident 7 Days for sickness	13 Weeks for accident 13 Weeks for sickness

Important Definitions and Policy Provisions:

Disability - "Disability" or "Disabled" means if solely because of a covered injury or sickness, you are unable to perform the material duties of your regular job and you are unable to earn 80% or more of your covered earnings from working in your regular job. We will require proof of earnings and continued disability.

Covered Earnings - "Covered Earnings" means your wages or salary, not including overtime pay, bonuses, commissions, and other extra compensation.

When Benefits Begin - You must be continuously Disabled for 7 Days for an accident and 7 Days for a sickness before benefits will be paid for a covered Disability.

How Long Benefits Last - Once you qualify for benefits under this plan, the maximum number of weekly Disability benefits is 13 Weeks for an accident and 13 Weeks for a sickness. Disability benefits will end sooner if you no longer qualify for benefits.

When Coverage Takes Effect - Your coverage takes effect on the later of the policy's effective date, the date you become eligible, the date we receive your completed enrollment form if required, or the date you authorize any necessary payroll deductions if applicable. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit proof of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Benefit Reductions, Conditions, Limitations and Exclusions:

Effects of Other Income Benefits - This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your Certificate of Insurance.

Termination of Disability Benefits - Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date you refuse to participate in rehabilitation services.

Exclusions - This plan does not pay benefits for a Disability which results, directly or indirectly, from any of the following:

- Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane.
- war or any act of war, whether or not declared.
- active participation in a riot;
- commission of a felony;
- the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
- any cosmetic surgery or surgical procedure that is not Medically Necessary.
- an Injury or Sickness for which the Employee is entitled to benefits from Workers' Compensation or occupational disease law.
- an Injury or Sickness that is work related.

In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.

1. Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.
2. Costs are subject to change.

Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
LONG-TERM DISABILITY INSURANCE

SUMMARY OF BENEFITS

Prepared for: Digital Prospectors Corporation

If you had an unexpected illness or injury and were unable to work, how long would you be able to pay your bills? Long-term disability pays a portion of your salary if you're unable to work due to a covered disability.

Who Is Eligible For Coverage?:

You: All active, Full-Time Staff & Salaried Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage the first of the month following date of hire.

Available Coverage:

Gross Monthly Benefit[1]	Maximum Gross Monthly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of your monthly covered earnings	$10,000	90 Days	Please refer to the "How Long Benefits Last" section below for more details.

Additional Features
Family Survivor Benefit – If you die while receiving benefits, we will pay a survivor benefit to your lawful spouse, eligible children, or estate. The plan will pay a single lump sum equal to 3 months of benefits.

Important Definitions and Policy Provisions:

Disability - "Disability" or "Disabled" means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation/regular job and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation/regular job. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your indexed earnings. We will require proof of earnings and continued disability.

Covered Earnings - "Covered Earnings" means your wages or salary, not including overtime pay, bonuses, commissions, and other extra compensation.

When Benefits Begin - You must be continuously Disabled for 90 Days before benefits will be paid for a covered Disability.

How Long Benefits Last - Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to the later of your Social Security Normal Retirement Age, or the following schedule, depending on your age at the time you become Disabled.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payments (months)	To age 65 or the date the 42nd monthly benefit is payable, if later.	36	30	24	21	18	15	12

When Coverage Takes Effect - Your coverage takes effect on the later of the policy's effective date, the date you become eligible, the date we receive your completed enrollment form if required, or the date you authorize any necessary payroll deductions if applicable. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit proof of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Benefit Reductions, Conditions, Limitations and Exclusions:

Effects of Other Income Benefits - This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your outline of coverage, policy certificate, or your employer's summary plan description.

Earnings While Disabled - During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability Covered Earnings. After that, benefits will be reduced by 50% of earnings from employment.

Limited Benefit Period - Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders (including psychosomatic illnesses), Alcoholism, drug addiction or abuse. Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime outpatient limit is exhausted.

Pre-existing Condition Limitation - Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

Termination of Disability Benefits - Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date you refuse to participate in rehabilitation services.

Exclusions – This plan does not pay benefits for a Disability which results, directly or indirectly, from any of the following: • Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane. • war or any act of war, whether or not declared. • active participation in a riot; • commission of a felony; • the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy. • any cosmetic surgery or surgical procedure that is not Medically Necessary.

In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.

1 Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.
2 Costs are subject to change.

Terms and conditions of coverage for Long Term Disability insurance are set forth in Group Policy No. SGD 610575. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state.

Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Digital Prospectors Corporation

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-Time Staff & Salaried Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage the first of the month following date of hire.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	$50,000	$50,000	$50,000

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.
Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.
Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 50% of your Term Life Insurance coverage amount or $25,000, whichever is less.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits will reduce to 65% at age 65 and 50% at age 70.
Limitations - The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. **Waiver of Premium** – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. SGM 609876. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SUMMARY OF BENEFITS

Prepared for: Digital Prospectors Corporation

If you pass away or are seriously injured as a result of a covered accident or injury, you or your beneficiaries will receive a set amount to help pay for unexpected expenses, or help your loved ones pay for future expenses after you're gone.

Who Is Eligible For Coverage?:

You: All active, Full-Time Staff & Salaried Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage the first of the month following date of hire.

Available Coverage:

	Benefit Amount	Maximum
Employee	$50,000	$50,000

Benefit Details:

If, within 365 days of a Covered Accident, bodily injuries result in:	We'll pay this % of the Benefit Amount:
Loss of life; Total paralysis of both upper and lower limbs; Loss of two or more hands or feet; Loss of sight in both eyes; or Loss of speech and hearing (both ears)	100%
Total paralysis of both lower limbs or both upper limbs	75%
Total paralysis of upper and lower limbs on one side of the body; Loss of one hand, one foot, sight in one eye, speech, or hearing in both ears; or Severance and Reattachment of one hand or foot	50%
Total paralysis of one upper or one lower limb; Loss of all four fingers of the same hand; or Loss of thumb and index finger of the same hand	25%
Loss of all toes of the same foot	20%

For Comas – You will receive 1% of the full benefit amount each month, for up to a maximum of 11 months , if you or an insured family member are in a coma for 30 days or more as a result of a Covered Accident. If the covered person is still in a coma after 11 months, or dies, the full benefit amount will be paid.

Additional Features:

For Wearing a Seatbelt & Protection by an Airbag – You will receive an additional 10% benefit but not more than $5,000 if the covered person dies in a covered automobile accident and law enforcement-certified to be wearing a seatbelt or approved child restraint. We will increase the benefit by an additional 5% but not more than $2,000 if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).
For Exposure & Disappearance – Benefits are payable if you or an insured family member suffer a covered loss due to unavoidable exposure to the elements as a result of a Covered Accident. If your or an insured family member's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or an insured family member were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a Covered Accident.
Conversion – If group accident coverage ends (except due to nonpayment of premium), your employment is terminated, membership in an eligible class is terminated, or insurance coverage is reduced based on attained age, you can convert to an individual non-term policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Dependents may convert their coverage as well if applicable. Premiums may change at this time, and terms of coverage will be subject to change. You can also convert to an individual policy of up to $10,000 if you have been insured for at least 3 years and the policy is terminated or amended, provided coverage is not replaced and you are not covered under a different conversion policy issued by Life Insurance Company of North America. Refer to your certificate for details.

Important Definitions and Policy Provisions:

When your coverage begins - Coverage begins on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any dependent who on the effective date is hospital or home confined; receiving chemotherapy or radiation treatment; or disabled and under the care of a physician.
When your coverage ends - Coverage ends on the earliest of the date you or your dependents , if applicable, are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.)

Benefit Reductions, Exclusions and Limitations

Benefit Reduction Schedule: If you are still employed, your benefits will reduce to 65% at age 65 and 50% at age 70. Your premiums will also reduce to match your benefits.

Exclusions - Self-inflicted injuries or suicide while sane or insane • commission or attempt to commit a felony or an assault • any act of war, declared or undeclared • any active participation in a riot, insurrection or terrorist act • bungee jumping • parachuting • skydiving • parasailing • hang-gliding • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food • voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it • a Covered Accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days) • traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates • air travel, except as a passenger on a regularly scheduled commercial airline or in an aircraft being used by the Air Mobility Command or its foreign equivalent • flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface being flown by the covered person or in which the covered person is a member of the crew.

Limitations – For multiple covered losses, benefits are paid for the single largest benefit available. For loss of life, the benefit amount shown will be reduced by the amount of any dismemberment benefits that were previously paid or payable.

THIS POLICY PROVIDES LIMITED ACCIDENT-ONLY COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. IT DOES NOT COVER LOSSES CAUSED BY SICKNESS. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE.

Terms and conditions of coverage for Accidental Death and Dismemberment insurance are set forth in Group Policy No. SOK 607385. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible injuries, their respective payments and policy exclusions and limitations are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192

Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid
TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

SUMMARY OF BENEFITS

Prepared for: Digital Prospectors Corporation

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them. If you pass away or are seriously injured as a result of a covered accident or injury, you or your beneficiaries will receive a set amount to help pay for unexpected expenses, or help your loved ones pay for future expenses after you're gone.

Who Is Eligible For Coverage?:

You: All active, Full-Time Staff & Salaried Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage the first of the month following date of hire.
Your Spouse*: Up to age 70, as long as you apply for and are approved for coverage yourself.
Your Child(ren): Birth to 26, as long as you apply for and are approved for coverage yourself.

*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

Available Coverage: You, your spouse, and children will receive equal amounts of Term Life and Accidental Death and Dismemberment insurance.

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of $10,000	Lesser of 5 times salary or $300,000	$150,000
Spouse	Units of $5,000	$150,000	$25,000
Children	Units of $1,000	$10,000; under 6 Months old $500	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

AD&D Benefit Details:

If, within 365 days of a Covered Accident, bodily injuries result in:	We'll pay this % of the Benefit Amount:
Loss of life; Total paralysis of both upper and lower limbs; Loss of two or more hands or feet; Loss of sight in both eyes; or Loss of speech and hearing (both ears)	100%
Total paralysis of both lower limbs or both upper limbs	75%
Total paralysis of upper and lower limbs on one side of the body; Loss of one hand, one foot, sight in one eye, speech, or hearing in both ears; or Severance and Reattachment of one hand or foot	50%
Total paralysis of one upper or one lower limb; Loss of all four fingers of the same hand; or Loss of thumb and index finger of the same hand	25%
Loss of all toes of the same foot	20%

For Comas – You will receive 1% of the full benefit amount each month, for up to a maximum of 11 months, if you or an insured family member are in a coma for 30 days or more as a result of a Covered Accident. If the covered person is still in a coma after 11 months, or dies, the full benefit amount will be paid.

Additional AD&D Features:

For Wearing a Seatbelt & Protection by an Airbag – You will receive an additional 10% benefit but not more than $25,000 if the covered person dies in a covered automobile accident and law enforcement-certified to be wearing a seatbelt or approved child restraint. We will increase the benefit by an additional 5% but not more than $10,000 if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).
For Exposure & Disappearance – Benefits are payable if you or an insured family member suffer a covered loss due to unavoidable exposure to the elements as a result of a Covered Accident. If your or an insured family member's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or an insured family member were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a Covered Accident.

Additional AD&D Features — continued

Conversion – If group accident coverage ends (except due to nonpayment of premium), your employment is terminated, membership in an eligible class is terminated, or insurance coverage is reduced based on attained age, you can convert to an individual non-term policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Dependents may convert their coverage as well if applicable. Premiums may change at this time, and terms of coverage will be subject to change. You can also convert to an individual policy of up to $10,000 if you have been insured for at least 3 years and the policy is terminated or amended, provided coverage is not replaced and you are not covered under a different conversion policy issued by Life Insurance Company of North America. Refer to your certificate for details.

Additional Term Life Features:

Continuation of Disability – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.

Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 50% of your Term Life Insurance coverage amount or $250,000, whichever is less.
Spouse: 50% of your Term Life Insurance coverage amount or $75,000, whichever is less.

Portability – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Employee's Bi-Weekly Cost of Coverage:

Age	Employee Cost Per $10,000 Unit	Spouse Cost Per $5,000 Unit	Age	Employee Cost Per $10,000 Unit	Spouse Cost Per $5,000 Unit
0-19	$0.392	$0.196	60-64	$3.590	$1.795
20-24	$0.392	$0.196	65-69	$6.429	$3.214
25-29	$0.392	$0.196	70-74	$10.269	
30-34	$0.475	$0.238	75-79	$10.269	
35-39	$0.530	$0.265	80-84	$10.269	
40-44	$0.706	$0.353	85-89	$10.269	
45-49	$1.061	$0.531	90-94	$10.269	
50-54	$1.620	$0.810	95-99	$10.269	
55-59	$2.469	$1.234			

Child Cost Per $1,000 Unit = $0.120

Actual per pay period premiums may differ slightly due to rounding. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Bi-Weekly Cost:

Step 1: Use the chart above to find your **Bi-Weekly** rate based on your age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.
Step 3: The result is the **Bi-Weekly** cost.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Term Life Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits and your spouse's benefits will reduce to 50% at age 75.
Exclusions – Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.
Limitations – The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. **Waiver of Premium** – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

AD&D Benefit Reductions, Exclusions and Limitations

Benefit Reduction Schedule: If you are still employed, your benefits will reduce to 50% at age 75. Your premiums will also reduce to match your benefits.
Exclusions - Self-inflicted injuries or suicide while sane or insane • commission or attempt to commit a felony or an assault • any act of war, declared or undeclared • any active participation in a riot, insurrection or terrorist act • bungee jumping • parachuting • skydiving • parasailing • hang-gliding • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food• voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it • a Covered Accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days) • traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates • air travel, except as a passenger on a regularly scheduled commercial airline or in an aircraft being used by the Air Mobility Command or its foreign equivalent • flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface being flown by the covered person or in which the covered person is a member of the crew.
Limitations – For multiple covered losses, benefits are paid for the single largest benefit available. For loss of life, the benefit amount shown will be reduced by the amount of any dismemberment benefits that were previously paid or payable.

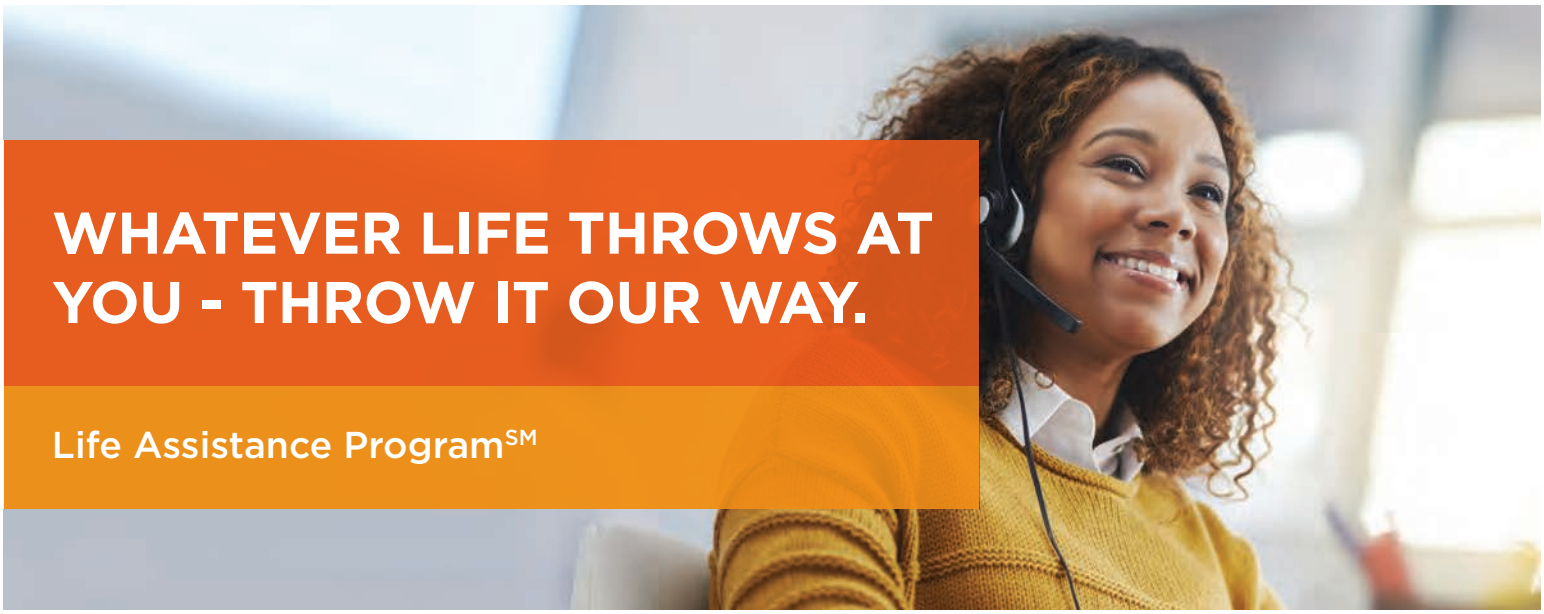
Guaranteed Issue for Term Life Insurance Coverage:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. SGM 609876. Terms and conditions of coverage for Accidental Death and Dismemberment insurance are set forth in Group Policy No. SOK 607385. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.



WHATEVER LIFE THROWS AT YOU - THROW IT OUR WAY.

Life Assistance Program℠

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, your Life Assistance & Work/Life Support Program is there for you. It can help you and your family find solutions and restore your peace of mind.

Call us anytime, any day.

We're just a phone call away whenever you need us. At no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist.

You have three face-to-face sessions with a behavioral counselor available to you - and your household members. Call us to request a referral.

Monthly Webinars

Educational seminars on a variety of relevant topics such as managing your life, work, money and health, are available in a quarterly calendar of monthly webcasts distributed to your employer.

Achieve work/life balance.

For help handling life's challenges go on line for articles and resources including on family, care giving, pet care, aging, grief, balancing, working smarter, and more.

Legal consultation and referrals*
Receive a free 30-minute consultation with a network attorney. And up to a 25% discount on select fees.

Financial consultations.
Receive a free 30-minute consultation and 25% discount on tax planning and preparation.

Life Assistance Program – 24/7 support

Phone: **800.538.3543**
website: **www.cignalap.com**

Together, all the way.®

Cigna®

Offered by: Life Insurance Company of North America or Connecticut General Life Insurance Company.

*Legal consultations and discounts are excluded for employment-related issues.

These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description, and are subject to change. Program availability may vary by plan type and location, and are not available where prohibited by law. These programs are not available under policies insured by Cigna Life Insurance Company of New York (New York, NY).

SOLUTIONS FOR ALL TYPES OF PERSONAL FINANCIAL CHALLENGES

My Secure Advantage

Cigna knows that financial issues are one of the leading causes of stress in America.* That's why we offer a full-service financial wellness program. My Secure Advantage™ can help support the financial health of your household, at no additional cost to you.

MY SECURE ADVANTAGE PROGRAM INCLUDES:

My Secure Advantage (MSA) Money Coaching

- You can take advantage of a free 30-minute consultation with a certified financial expert before you decide to participate in Money Coaching.
- Individuals and couples can work with a designated Money Coach for 30 days, paid for by Cigna.
- Your Money Coach can help you handle a wide range of financial challenge, including but not limited to: Basic money management, getting out of debt, saving for college or retirement, purchasing a home, marriage or divorce, loss of income, death in the family, and more.
- Through an easy-to-use online portal, you can communicate with your Coach, view educational webinars and access a library of financial tools, forms and tips.
- After the first 30-day coaching period, you may continue working with your Money Coach for $39.95 per month.
- Even if you don't participate in Money Coaching you can get a 25% discount on tax planning and preparation.

Identity theft protection and will preparation services include:

- Education on how to avoid identity theft, consultation with a Fraud Resolution Specialist, and a fraud resolution kit that provides the right documents to use and steps to follow
- Online resources to create and execute state-specific wills, powers of attorney and a variety of other important legal documents
- Free 30-minute legal consultation with a licensed practicing attorney to obtain advice or review legal documents, and a 25% discount off standard fixed or hourly attorney's fees

Call 888.724.2262, Monday - Friday from 9:00 am to 11:00 pm EST (6:00 am to 8:00 pm PST) to speak with an MSA representative.

All you'll need to give is your name, city, state, zip code and the name of your employer or plan sponsor. You can also visit cigna.mysecureadvantage.com for more information, or to register and access online tools and educational resources and create legal documents.

Together, all the way.®

Cigna®

Offered by: Life Insurance Company of North America or Connecticut General Life Insurance Company.

* Stress in America™: Coping with Change American Psychological Association, January, 2017.

My Secure Advantage is a trademark of CLC Incorporated (CLC). The My Secure Advantage Financial Wellness Program is independently administered by CLC. Cigna does not provide financial services and makes no representations or warranties as to the quality of the information on the CLC website or the services of CLC.

These programs are NOT insurance and do not provide reimbursement for financial losses. Presented here are only the highlights of these programs. Full terms, conditions and exclusions are contained in the applicable offering descriptions. Program availability may vary by plan type and location and is subject to change. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services. These programs are not available under policies insured by Cigna Life Insurance Company of New York.

Cigna Group Insurance®

ADDITIONAL PROTECTION WHEN YOU TRAVEL

Emergencies can happen while traveling, but help is only a phone call away with Cigna Secure Travel.

Cigna Secure Travel® offers pre-trip planning, assistance while traveling and emergency medical transportation benefits for covered persons traveling 100 miles or more from home (see your plan for details). Service is a phone call away, 24/7/365 – in an emergency you can even call collect.

PRE-TRIP PLANNING

- Immunization requirements
- Visa and passport requirements
- Embassy/consular referrals
- Foreign exchange rates
- Travel advisories and weather conditions
- Cultural information

TRAVELING ASSISTANCE

- 24-hour multilingual assistance and referral to interpretation and translation services
- Referrals to physicians, dentists, medical facilities and legal assistance providers
- Arrangements for payment of medical expenses up to $10,000 if required prior to treatment**
- Assistance with lost or stolen items, including luggage and prescription replacement services**
- Emergency cash advances, up to $1,500**
- Advancement of bail**

EMERGENCY ASSISTANCE*

- Emergency evacuation and repatriation, when medically necessary; arrange and cover the cost of transportation to the nearest adequate medical facility***
- Travel arrangements for the return of a travel companion or children under age 18 who are left unattended due to the covered person's medical emergency
- Cover round-trip transportation as well as accommodations, up to $150 per day for up to seven days, for a family member or friend to visit a covered person who is hospitalized more than 100 miles away from home for more than seven days
- Arrange and cover the costs associated with returning a deceased covered person's remains to his or her place of residence for burial
- Emergency message relay, toll-free
- Assistance with making emergency travel arrangements**

Cigna Secure Travel

From the United States and Canada, call 888.226.4567
From other locations, call collect 202.331.7635
Fax: 202.331.1528 Email: Cigna@gga-usa.com

Emergency services must be coordinated through Cigna Secure Travel®. Services coordinated outside of this program may not be eligible for payment.

Policyholder name: _____

Policy # _____ Group# 57

To learn more call 888.226.4567

* Emergency Assistance services may be insured under a group or blanket insurance policy issued by Life Insurance Company of North America or Cigna Life Insurance Company of New York. All other Cigna Secure Travel services are NOT insurance and do not provide reimbursement of expenses or financial losses. Expenses for medical care are not covered.

** Covered person is responsible for any advances, payments, travel-related or replacement costs and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available limit to cover the amount of the advance.

*** Initial transport by ambulance following a covered medical emergency is excluded.

Together, all the way.®

Cigna Secure Travel is provided under a contract with Generali Global Assistance (GGA). GGA and Cigna do not guarantee the quality of any medical services provider or medical facility. The final selection of a local medical provider or facility is the covered person's right and responsibility. The medical professionals or attorneys suggested or designated by GGA are solely responsible for their services. They are not employees or agents of GGA or Cigna. In any case where benefits are provided through insurance, the terms of the insurance policy shall govern. All other services are provided by GGA and are subject to the terms of the service agreement with GGA. Presented here are highlights of the Cigna Secure Travel program. See the plan documents for details.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America and Cigna Life Insurance Company of New York (New York, NY). Policy Forms: GA-00-1000 et al.; BA-01-1000 et al. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Cigna Group Insurance®

CIGNA GROUP INSURANCE HEALTH ADVOCACY SERVICES

Health care and insurance can be complicated. We're here to help.

Navigating the complex health care landscape can sometimes seem overwhelming. Cigna offers health advocacy services to help employees and their families resolve their health care and health insurance challenges. These services benefit employers by helping them reduce absenteeism and increase both employee productivity and employee satisfaction.

Support from dedicated professionals

Personal health advocates, who are experienced in health benefits and services, provide individualized assistance with a range of health care and insurance-related needs. Services include:

- **Information and Guidance** – answer questions, provide information on treatments, medications, as well as helping find health care providers.
- **Administrative Support** – explaining benefits, estimating procedure costs, and working to resolve benefit and claim issues.
- **Senior Care and Special Needs Services** – locating appropriate senior care – in a facility like a nursing home or group home, or in-home assistance - such as home health aides, rehabilitation services, or physicians who make house calls.
- **Complementary & Alternative Medicine** – identifying wellness services and alternative medicine.

Services for the whole family

Employees, spouses, dependent children, parents and parents-in-law are all eligible.

Support for non-covered medical expenses

Personal health coaches also work with employees who have non-covered medical bills over $400. They help investigate charges, negotiate discounts, establish payment plans, and educate employees about how to maximize their benefits and their savings.

How it works

Employee or family member calls a toll-free number dedicated to Cigna customers.

Caller speaks to a dedicated personal health advocate and receives live, individualized assistance.

Personal health advocate continues to support the individual until the issue is resolved.

Convenient Access

Personal health advocates are available Monday through Friday between 8 a.m. and 12 a.m. ET at 866.799.2725.

A commitment to adding value

At Cigna, we're committed to adding real value to our product offerings. Health advocacy services help employees save time and effort, which helps boost productivity and job satisfaction. And we see that as a win-win for employees and employers alike.

Together, all the way.®

Cigna®

Guardian

DIGITAL PROSPECTORS CORPORATION

Group Number: 00566426

Accident Benefit Summary

Accident insurance through Guardian provides you:

- A cash benefit for covered injuries, treatments and services, in addition to whatever your medical plan may cover
- Payments go directly to you, not the doctor
- Easy enrollment with no medical questions

About Your Benefits:

	ACCIDENT
COVERAGE - DETAILS	
Your Bi-weekly premium	$4.29
You and Spouse	$7.25
You and Child(ren)	$7.79
You, Spouse and Child(ren)	$10.75
Accident Coverage Type	Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $10,000 Spouse $5,000 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
RAINY DAY FUND	Benefit Amount: $300 Rollover Maximum: $150 Fund Maximum: $600
FEATURES	
Air Ambulance	$750
Ambulance	$150
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: $0/$2,000 18 sq inches To 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burns - Skin Graft	50% of burn benefit

FEATURES (Cont.)	
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits
Chiropractic Visits	$25/visit, up to 6 visits
Coma	$7,500
Concussion Baseline Study	$25
Concussions	$100
Diagnostic Exam (Major)	$100
Dislocations	Schedule up to $3,000
Doctor Follow-Up Visits	$25, up to 6 treatments
Emergency Dental Work	$200/Crown, $50/Extraction
Emergency Room Treatment	$150
Epidural Anesthesia Pain Management	$100, 2 times per accident
Eye Injury	$200
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	$20/day, up to 30 days
Fractures	Schedule up to $4,000
Gun Shot Wound	$500
Hospital Admission	$750
Hospital Confinement	$150/day - up to 1 year
Hospital ICU Admission	$1,500
Hospital ICU Confinement	$300/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	$75
Joint Replacement (Hip/Knee/Shoulder)	$1,500/$750/$750
Knee Cartilage	$250
Laceration	Schedule up to $300
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	$100/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to $400
Outpatient Therapies	$25/day, up to 10 days
Post-Traumatic Stress Disorder	$300
Prosthetic Device/Artificial Limb	1: $250 2 or more: $500
Rehabilitation Unit Confinement	$50/day, up to 15 days
Ruptured Disc With Surgical Repair	$250
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to $1,000 Hernia: $200
Surgery (Exploratory or Arthroscopic)	$300
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$0.50 per mile, limited to $400/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	$3,000
X - Ray	$30

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.

UNDERSTANDING YOUR BENEFITS (Cont.):

- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.
- **Rainy Day Fund** – Can pay benefits when a claimant has exhausted a frequency limitation that applies to a particular benefit. Rainy Day Fund will apply to the following benefits Air Ambulance, Ambulance, Blood/Plasma/Platelets, Chiropractic visits, Diagnostic Exam (Major), Doctor Follow-Up visits, Emergency Dental Work, Epidural Anesthesia Pain Management, Eye Injury, Family Care, Fractures, Gun Shot Wound, Hospital Confinement, Hospital ICU Confinement, Joint Replacement, Knee Cartilage, Lodging, Outpatient Therapies, Rehabilitation Unit Confinement, Ruptured Disc with Surgical Repair, Surgery (Cranial, Open Abdominal, Thoracic, Hernia), Surgery (Exploratory and Arthroscopic), Transportation and X-Ray, if they are included on your plan.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

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: 00566426

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; the covered person being legally intoxicated; declared or undeclared war, act of war, or armed aggression; service in the armed forces, National Guard, or military reserves of any state or country; taking part in a riot or civil disorder; commission of, or attempt to commit a felony; treatment rendered or hospital confinement outside the United States or Canada; intentionally self-inflicted Injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-1-ACC-18

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Guardian

DIGITAL PROSPECTORS CORPORATION

Critical Illness Benefit Summary

Group Number: 00566426

A Critical Illness insurance plan through Guardian provides:

- A cash benefit for a range of covered serious illnesses such as Cancer, Stroke and Heart Attack, in addition to whatever your medical insurance may cover
- Payments are made directly to you and can be used for any purpose

About Your Benefits:

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $25,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	
Childhood Conditions	**1st OCCURRENCE ONLY**	
Cerebral Palsy	100%	
Cleft Lip/Palate	100%	
Club Foot	100%	
Cystic Fibrosis	100%	
Down's Syndrome	100%	
Muscular Dystrophy	100%	

CRITICAL ILLNESS	
Spina Bifida	100%
Type 1 Diabetes	100%
Spouse Benefit	May choose a lump sum benefit of $2,500 to $12,500 in $2,500 increments up to 50% of the employee's lump sum benefit.
Child Benefit- children age Birth to 21 years (26 if full time student)	25% of employee's lump sum benefit
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue/ **Conditional Issue:** The 'Guarantee/Conditional' 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.	We Guarantee Issue up to: Less than age 70 $20,000 For a spouse: Less than age 70 $10,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	6 months prior, 6 months after

WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Your premium will not increase as you age.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

	Bi-weekly Premiums Displayed *Election Cost Per Age Bracket*					
Issue Age	*< 30*	*30-39*	*40-49*	*50-59*	*60-69*	*70+†*
Employee						
$5,000	$1.82	$2.56	$4.92	$9.21	$14.31	$27.53
$10,000	$3.65	$5.12	$9.83	$18.42	$28.62	$55.06
$15,000	$5.47	$7.69	$14.75	$27.62	$42.92	$82.59
$20,000	$7.29	$10.25	$19.66	$36.83	$57.23	$110.12
$25,000	$9.12	$12.81	$24.58	$46.04	$71.54	$137.65
Benefit Amount Up To 50% of Employee Amount to a Maximum of $12,500						
Spouse						
$2,500	$0.91	$1.28	$2.46	$4.61	$7.15	$13.77
$5,000	$1.82	$2.56	$4.92	$9.21	$14.31	$27.53
$7,500	$2.74	$3.84	$7.38	$13.81	$21.46	$41.30
$10,000	$3.65	$5.12	$9.83	$18.42	$28.62	$55.06
$12,500	$4.56	$6.41	$12.29	$23.02	$35.77	$68.83

†Benefit reductions may apply. See plan details.

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: 00566426.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims 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.

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 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. 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. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on 1) late enrollees and 2) enrollees over age 69 (not applicable in FL). This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

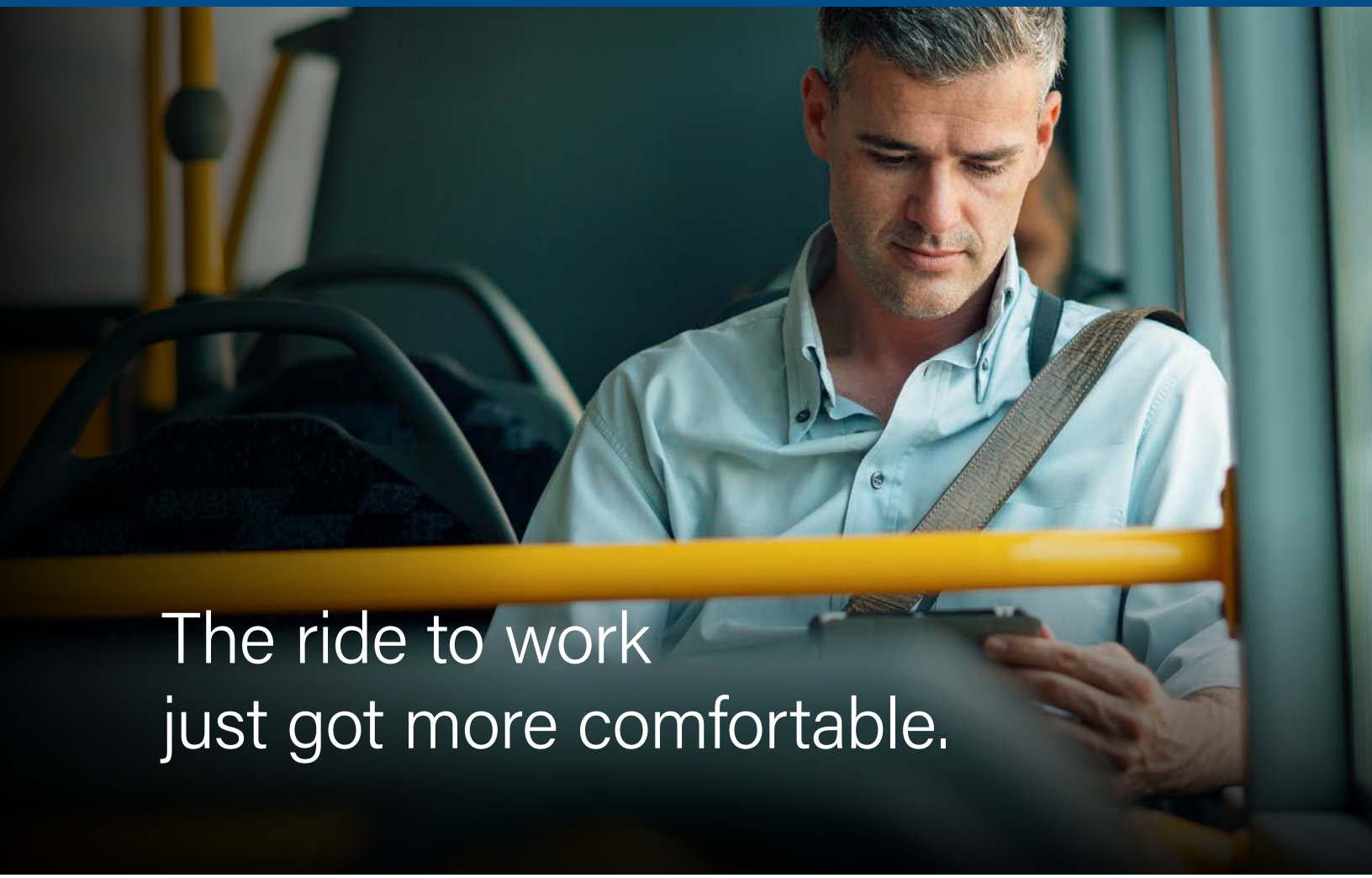
If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Commuter Transit and Parking Program

WageWorks



The ride to work just got more comfortable.

A *WageWorks*® **Commuter** program is a pre-tax benefit that can save you up to a third of what you pay for parking and public transit—that includes train, subway, bus, ferry and eligible vanpool—as part of your daily commute to work.

You need it if you want to save money.

- Save an average of 30% on public transit and parking[1]
- Sign up any time to start saving—there's no "use it or lose it" as long as you remain employed by your current employer

Commuter Transit and Parking Program

And when we say "save," we mean up to hundreds of dollars a year.

All you have to do to get going is decide how much to contribute (up to the allowed monthly limit). From there:

- Funds are moved from your paycheck and added to your account before taxes are deducted
- As soon as funds are available in your account, you can start using them for qualified commuting expenses
- You can pause or cancel contributions to your account at any time

It's easier than fighting traffic.

No matter where you go, it's easier to pay.

Public Transit Options:

- Have monthly transit passes or tickets mailed to your home
- Load funds onto your smart card

Parking Options:

- Send payments directly to your parking provider
- Get reimbursed for eligible commuting expenses you pay out of pocket

Start saving now. Like right now.

You don't need to wait for Open Enrollment. Just contact your benefits manager to get going.

See how your savings add up with the WageWorks calculator:
wageworks.com/mycommute

1 Assumes a combined tax rate of 30%, including FICA, state and federal income taxes. Actual amounts may vary.

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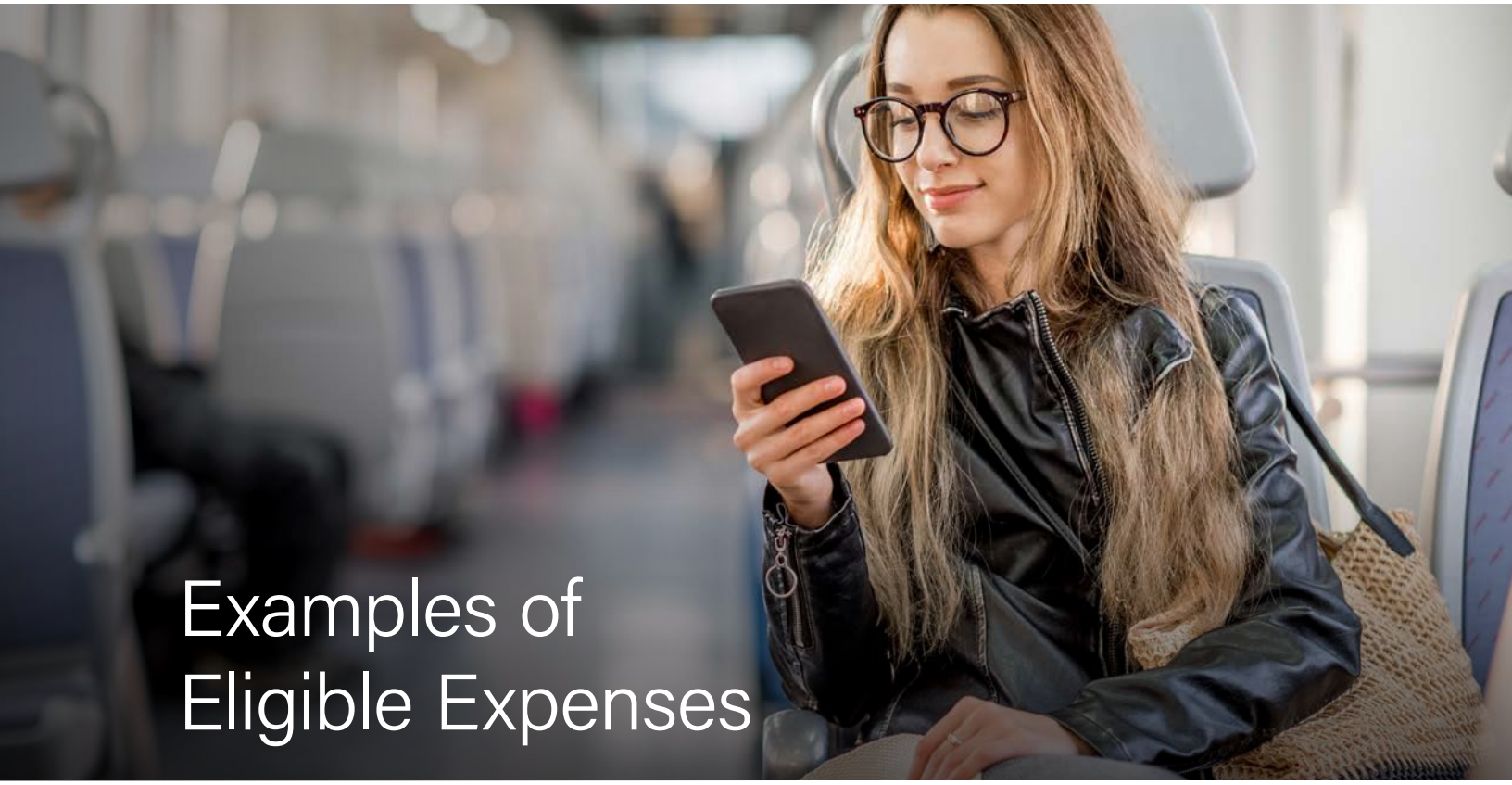
WageWorks
everyone benefits®

WageWorks



Examples of Eligible Expenses

You can use your *WageWorks*® benefits to pay for a variety of products and services with pre-tax dollars. It's like a 30% off sale on your eligible expenses.[1] Below are examples of some of the IRS-qualified eligible expenses (which can change). For an up-to-date list, log in to your *WageWorks* account or visit: wageworks.com/employees/support-center/commuter-eligible-expenses-table.

Eligible Commuter Expenses

- Bus
- Ferry
- Parking at or near work
- Parking at or near public transportation to get to work
- Streetcar
- Subway
- Train
- Vanpool

Learn more at:
wageworks.com/employees/support-center/commuter-eligible-expenses-table

1Assumes a combined tax rate of 30%, including FICA, state and federal income taxes. Actual amounts may vary.

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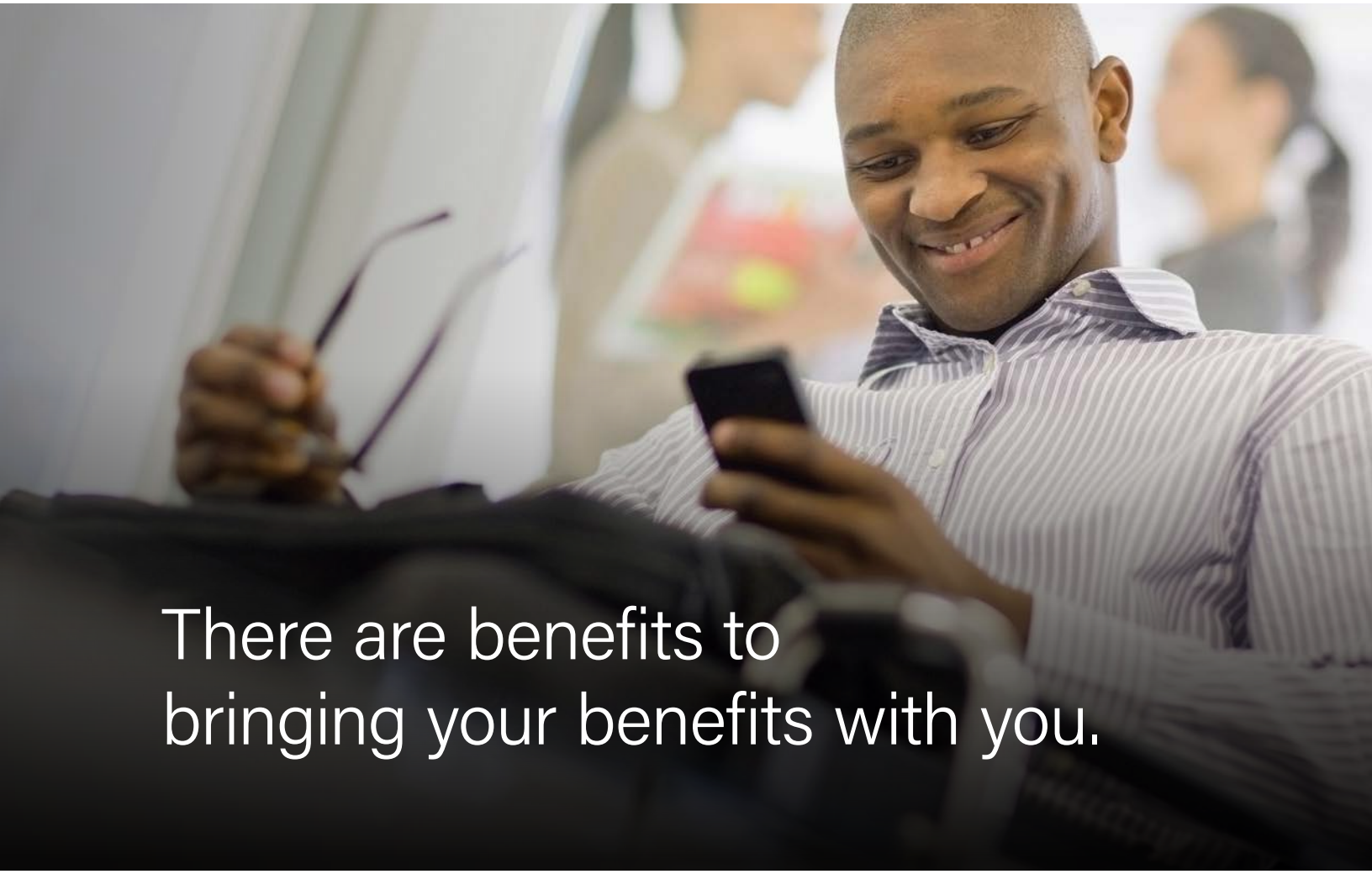


There are benefits to bringing your benefits with you.

The *EZ Receipts*® mobile app by *WageWorks* lets you check your balances, submit claims, snap photos of receipts and manage your account[1] from anywhere. It puts the WageWorks web portal in the palm of your hand.

Make it easy on yourself.

- Snap and submit photos of your receipts, making it easy to verify transactions later
- File claims, view transactions and check account balances on the go
- Simplify processes—let daycare providers, for example, sign eligible expenses directly within the app
- Sign up for email and text alerts to stay on top of everything

EZ Receipts

No forms to fill out.
Nothing to mail in.
And even less to worry about.

All you have to do is download the free *EZ Receipts* app to your iPhone or Android smartphone. Then log in to your WageWorks account and go.

- View transactions and account balances
- File claims for quick reimbursements
- View and edit your account profile

Download on the App Store

GET IT ON Google Play

Learn more at:
wageworks.com/myezreceipts

1 Commuter Transit Accounts are not available on EZ Receipt app.

3203 (201806)

WageWorks
everyone benefits®

BASE® 125 Cafeteria Plan - Save Money On Your Health Care & Increase Your Take Home Pay

Your employer is sponsoring a BASE® 125 Cafeteria Plan. Not only will the BASE® 125 Cafeteria Plan save on your dependent care expenses, but it also increases your spendable income.

If you pay dependent care expenses then you may be eligible to pay those expenses on a pre-tax basis.

You can save in the following ways:

Dependent Care Assistance Plan

The Dependent Care Assistance Plan (DCAP), is an account established by an employer to allow employees to set aside money from each paycheck on a pre-tax basis to pay for qualifying dependent and elder care expenses. Expenses paid for pre-school programs and before- and after-school programs are eligible for reimbursement.

In order to qualify for DCAP, you must meet the following:

- You must remain actively employed by your current employer. If you are married, your spouse must also work, go to school full-time, or be incapable of self-care for you to be eligible.
- Your childcare provider must claim your payments as income on their tax return.
- Children must be under 13 years of age and considered a dependent for tax return purposes. If your child turns 13 during the plan year, expenses for that child are no longer eligible for reimbursement under the plan.
- In order to qualify for DCAP, a spouse or dependent over 13 years of age must be incapable of self-care and
  regularly spend at least eight hours per day in your home (i.e. an invalid parent)
- Your provider may not be a minor child or dependent for income tax purposes (i.e. an older child)
- Service must be for the physical care of the child, not for education, meals, etc.
- Overnight camps are not eligible for reimbursement.
- This is a pay-as-you-go account or an "accrual" account, so your employer will not advance any money.

Visit www.baseonline.com for an interactive calculator to estimate your savings.

Note: Depending on your employer agreement, there may be an additional grace period to utilize funds remaining in your account.

800.309.8012 | www.BASEonline.com

Welcome to Mobile myRSC®!

Easy-Access to BASE® Plan Management
BASE® 125 Cafeteria Plan
BASE® Health Reimbursement Arrangement
BASE® Choice Incentive Plan
Questions? 1-800-309-8012

Benefits at Your Fingertips

You can now access your employee benefits account information on your smartphone with the Mobile myRSC® app for iPhone and Android.

What You Can Do with Mobile myRSC

View Accounts — Including detailed account and balance information

Card Activity — Account information

Manage Subscriptions — Set up email notifications to keep you up-to-date on all account and health debit card activity

SnapClaim™ — Our Mobile App for iPhone® and Android® with integrated SnapClaim™ technology allows claims filing using your smartphone! Just open a claim using the mobile app, fill in some details onscreen, take a photo of your receipt with your smartphone camera, and upload. Claims filing couldn't be easier!

Locating and Loading the Mobile myRSC App

Simply search for "myRSC" on the App Store℠ for Apple products or on the Google Play™ Store for Android products, and then load as you would any other app.

Logging In

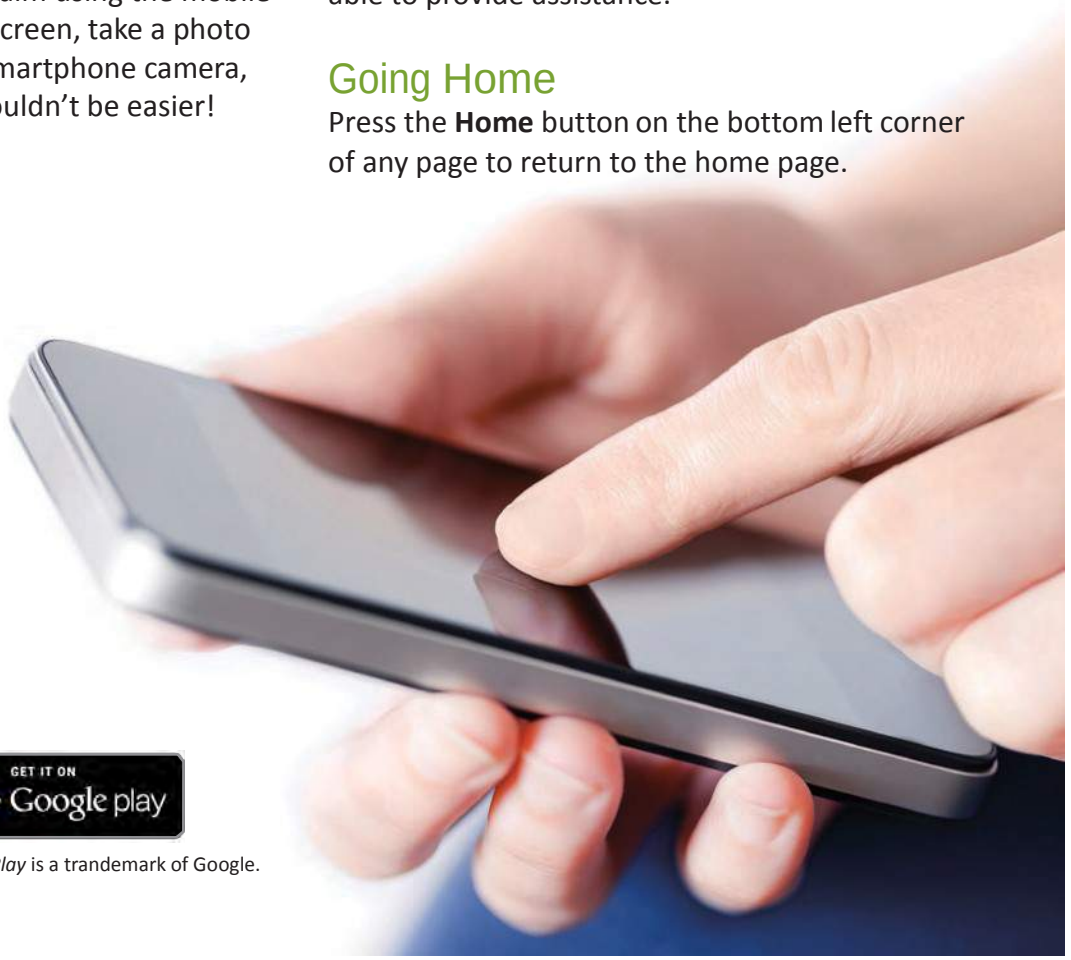
Access the mobile services using the same username and password you use to log in to the full myRSC® website. After logging in, you will be on the home page which will list your options.

Getting Help

Click the **Help** button at the bottom right of all Mobile myRSC® pages to access contact information for your administrator, who will be able to provide assistance.

Going Home

Press the **Home** button on the bottom left corner of any page to return to the home page.



Download on the App Store

GET IT ON Google play

App Store is a service mark of Apple Inc. *Google Play* is a trademark of Google.

Mobile Quick Start Guide

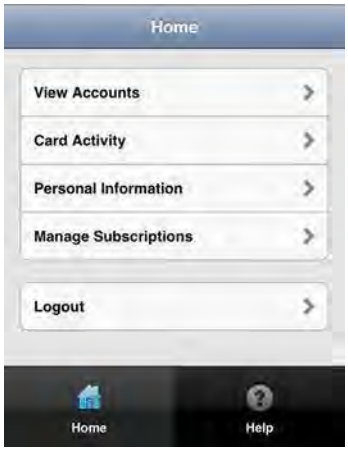
Logging In

Open the Mobile myRSC® app or point your browser to: **https://mobile.myrsc.com**.

The first page that loads is the login screen. Use the same username and password that you use to log in to the full myRSC®website.

NOTE: *The mobile site is optimized to work on Safari on an iOS, the default Android Browser, or Chrome on Android 4.x. If you are using an older browser, you will automatically be redirected to the classic myRSC® site.*

The Home Page



Once you log in, you are on the Home page. This page lists all available options you have on the mobile site:

- **View Accounts:** view the balance and details of your Health Reimbursement Account (HRA), Health Savings Account (HSA), or Flex Spending Accounts (FSA). You may have one or more of these accounts available to you, depending on your company's benefit package
- **Card Activity:** view card transactions and details
- **Personal Information:** view or edit your personal information
- **Manage Subscriptions:** change the emails and notifications sent by myRSC®
- **Logout:** logs you out of your account
- **Home and Help: Home** brings you back to this screen and **Help** provides contact information regarding your benefits
- **SnapClaim™:** Integrated SnapClaim™ technology lets you file claims on the spot using your smartphone camera.

Account Summary

When you select the **View Accounts** option, the page displays only the benefits for which you are subscribed. (Your display may look very different than the screen shot pictured here.) Select the benefit you wish to view to see unresolved transactions, benefit summary data, and details of claims and reimbursements.

Card Activity

The **Card Activity** page gives you the option to view the transaction details or account details of your debit card.

Selecting **View Transaction Detail** takes you to the **Transaction Overview** page. Select the month and year for the card activity you want to view. Only the transactions for the month and year you choose will be displayed. Clicking on a particular transaction lets you see the details of that card swipe.

Selecting **View Account Detail** lists all cardholders on your plan. You can then select the person's name and see the account details associated with that card. You also have the option of blocking a card.

CAFETERIA PLAN ELECTION FORM

(Please clearly print all information)

Employer Name: Digital Prospectors **Plan Year: 5.1.2019 – 12.31.2019**

Participant Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Phone Number: _____

E-Mail Address: _____

New Hire_____ Open Enrollment_____ Change in Status_____ (please provide explanation below)

Status Change Reason _____

DEPENDENT CARE ACCOUNT (DCAP) – Day Care Expenses

I elect to participate. YES_____ NO_____

(Not to exceed $5,000, or $2,500 if married and filing separately)

$ _____ per pay X **26** pay periods = $ _____ Annually ***(do not round)***

DIRECT DEPOSIT *(Please note: Not all employers allow Direct Deposit as a reimbursement option.)*

_____ I elect to NOT participate.

_____ Use account information on file. _____ Use account information below.

_____ Checking Account _____ Savings Account

Financial Institution: _____

Routing Number: _____ Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rate, pre-tax basis by the sum of my medical reimbursement, dependent care, and health care premium to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

Complete and return to your benefits coordinator.

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 8 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 y 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 probal 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 reach your future financial goals, and it's easy to get started. The sooner you enroll, the sooner you can ta advantage of these benefits:

- **Employer contributions**
- **Tax-advantaged saving through pre-tax contributions and the Roth 401(k) option**
- **Convenient, automatic payroll deductions**
- **A broad range of investment options**
- **Plan features that simplify planning**
- **An account you can take with you**

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

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 $19,000 (2019). Those age fifty or over can save an additional $6,000 with catch-up contributions (2019).

Find out how to maximize your contributions to take full advantage of the employer match and tax savings your plan offers.

YOUR EMPLOYER HELPS

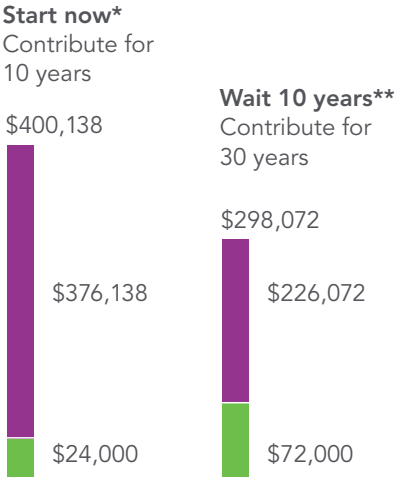
You decide how to invest this contribution. See your Plan Information for details.

AN AUTOMATED 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. You can elect this feature on your plan website.

Starting earlier can pay off

It's important to save enough for your future, and it's also important to understand the concept of compounded returns. The chart shows how starting earlier puts compounding to work for you over time.



Starting earlier
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. ADP makes no recommendation regarding the appropriateness of any amount you may consider contributing to your employer's plan.

REDUCE YOUR INCOME TAXES TODAY BY SAVING PRE-TAX

There are benefits to saving in the plan pre-tax. Saving pre-tax lowers your current 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 may be able to 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 make 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 59 1/2 may be subject to a 10% tax penalty. ADP makes no recommendation regarding the appropriateness of any amount you may consider contributing to your employer's plan.

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.

ADP makes no recommendation regarding the appropriateness of Roth versus non-Roth elective deferrals.

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	Please see the Plan Information section at the back of this guide for more details.	Tax-free, provided you meet the plan requirements as detailed in the Plan Information section located at the back of this guide.

*Tax law requirements must be met.

Choose how you want to get there.

INVESTMENT OPTIONS

You control how your savings are 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.

Asset Allocation

When you make your own asset allocation decision, it's important to spread your savings among different investments, which can help smooth the ups and downs of market cycles and reduce portfolio 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 think about your asset allocation, the Investor Profiler on page 5 can get you started.

In deciding how to allocate the investment of your account balance, keep in mind that some of the plan's investment options, known as "target date funds," contain an asset allocation strategy within the investment option itself. 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 funds automatically change their underlying asset allocation gradually over time, becoming more conservative as the target date approaches. Choosing one of these investment options could simplify your asset allocation approach.*

NEED MORE INFORMATION?
Visit www.mykplan.com to access calculators, tools and information to help with your planning.

Concepts every investor should understand:

- **Put time on your side.** Starting earlier 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.** Consider creating a diversified investment mix taking into account your age, years to retirement and risk tolerance, and sticking to 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. Keep in mind that a target date mutual fund is comprised of a mix of underlying investment options in various asset classes. Therefore, if you decide to invest in other funds in addition to a target date mutual fund, you may overweight your account in a particular asset class.

Diversification and dollar cost averaging do 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

The asset allocations provided by this Personal Investor Profile are provided for educational purposes only and should not be construed as investment advice. In applying any asset allocation model to your individual situation, you should consider your other assets, income and investments in addition to any balance you may have in a retirement plan. See your financial advisor before making any decision as to your asset allocation.

Answer the following questions with the corresponding point value to determine your investor profile score.

1. How would you best describe your investment experience and knowledge?

- I am very experienced and knowledgeable about investments. *(4 points)*
- I have some experience and knowledge about investments. *(2 points)*
- I have very little or no investment experience and knowledge. *(0 points)*

2. The main objective for my account is to:

- Avoid losses. *(0 points)*
- Keep pace with inflation. *(2 points)*
- Keep pace with the stock market. *(4 points)*

3. If my account lost 30% of its value over a short period of time, I would be:

- Extremely uncomfortable – I cannot accept large short-term losses. *(0 points)*
- Slightly uncomfortable – I may be ok with a short-term loss as long as I have time to regain those losses. *(2 points)*
- Comfortable – Because I have time to regain those losses. *(4 points)*

4. I am willing to accept a greater risk of losing money in my account for the potential of higher long-term returns:

- Strongly Agree *(4 points)*
- Agree *(3 points)*
- Neutral *(2 points)*
- Disagree *(1 points)*
- Strongly Disagree *(0 points)*

5. My account has $100,000 in it. I would move my money to a lower risk investment if it lost _____ in one year. *(Fill in the blank.)*

- $5,000 (5%) *(0 points)*
- $10,000 (10%) *(1 points)*
- $15,000 (15%) *(2 points)*
- $20,000 (20%) *(3 points)*
- I would not move my money at all. *(4 points)*

6. When attempting to achieve my investment goals:

- I do not want my account to lose any value, even if it will take longer to achieve my investment goals. *(0 points)*
- I will accept small fluctuations in my account's value. *(1 points)*
- I will accept moderate fluctuations in my account's value. *(2 points)*
- I will accept large fluctuations in my account's value. *(3 points)*
- I will accept extreme fluctuations in my account's value. *(4 points)*

Total the points for your score.

Your Score

Find your total score in the chart below, along with your retirement timeline, to see what type of investment profile may be best for you. This chart should only serve as a guide to help you determine your own investing comfort zone.

Years To My Retirement	My Investor Score				
	0-2 points	**3-8 points**	**9-16 points**	**17-21 points**	**22-24 points**
0-3 years	Conservative	Conservative	Conservative	Conservative	Conservative
3-5 years	Conservative	Moderate Conservative	Moderate Conservative	Moderate Conservative	Moderate Conservative
5-7 years	Conservative	Moderate Conservative	Moderate	Moderate	Moderate
7-12 years	Conservative	Moderate Conservative	Moderate	Moderate Aggressive	Moderate Aggressive
12+ years	Conservative	Moderate Conservative	Moderate	Moderate Aggressive	Aggressive

The results of this quiz are intended to help you identify what type of investor you may be. This quiz is not intended to recommend a particular asset allocation or to provide individual advice.

Profiles

Conservative Profile

This profile may be right for you if you want to avoid a potential loss of account value, or if you are nearing retirement. You should be willing to go without the potential for higher long-term returns in exchange for a more stable and predictable return.

Moderate Conservative Profile

This profile may be right for you if your primary goal is to avoid short-term losses. However, you also want higher long-term returns to offset the effects of inflation. Your account will likely have relative stability, but in order to keep up with inflation, some fluctuations in your account value should be expected.

Moderate Profile

This profile may be right for you if you are interested in balancing your level of risk and return. You want to have returns in excess of inflation and an increase in your account value over the long term, and, you should be willing to accept short-term losses and fluctuations in your account value.

Moderate Aggressive Profile

This profile may be right for you if you have more time until retirement and can tolerate higher-than-average fluctuations in your account value. This type of allocation provides the potential for higher-than-average returns over the long term. You should be willing to accept short-term losses and less stable returns.

Aggressive Profile

This profile may be right for you if you are willing and able to stay the course through short-term gains and losses because you want the potential for higher returns over the long term. You should have a long time until retirement and a high tolerance for risk. You should be willing to accept frequent short-term losses and extreme fluctuations in account value.

Investor Profiles

Match your investor profile to one of the sample asset allocation models.*

Conservative	Moderate Conservative	Moderate	Moderate Aggressive	Aggressive
				
20% Equity	40% Equity	60% Equity	75% Equity	90% Equity
65% Fixed Income	50% Fixed Income	35% Fixed Income	25% Fixed Income	10% Fixed Income
15% Cash or Cash Equivalents	10% Cash or Cash Equivalents	5% Cash or Cash Equivalents	0% Cash or Cash Equivalents	0% Cash or Cash Equivalents

* These risk-based asset allocation models were created using the following three asset classes: Domestic Equity; Intermediate-Term Domestic Bond; and Cash Equivalent.

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.
- Determine your contribution level to the plan and whether you want to contribute at least enough to receive the maximum matching contribution under the plan (if your employer makes a matching contribution).
- While establishing your account, you can also review account features that may be helpful with planning like Save Smart® and automatic Account Rebalancing. You can get information and elect them on www.mykplan.com.

Once you establish a retirement account, you can track your progress using the account resources available to help you.

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 c
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 Pass
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 balanc
  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 w
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 y
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.

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

You may elect Account Rebalancing 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 exp
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%.

SQ	American Funds 2010 Target Date Retirement Fund - Class R6*
ZL	American Funds 2015 Target Date Retirement Fund - Class R6*
5G	American Funds 2020 Target Date Retirement Fund - Class R6*
EY	American Funds 2025 Target Date Retirement Fund - Class R6*
07	American Funds 2030 Target Date Retirement Fund - Class R6*
J6	American Funds 2035 Target Date Retirement Fund - Class R6*
3O	American Funds 2040 Target Date Retirement Fund - Class R6*
JQ	American Funds 2045 Target Date Retirement Fund - Class R6*
L7	American Funds 2050 Target Date Retirement Fund - Class R6*
CZ	American Funds 2055 Target Date Retirement Fund - Class R6*
1M	American Funds 2060 Target Date Retirement Fund - Class R6*
SI	American Funds Capital Income Builder Fund - Class R-6*
9N	BlackRock Global Allocation Fund - Class K*
JP	Janus Henderson Balanced Fund - Class A*
RN	BlackRock T-Fund - Institutional Class
6M	American Funds Intermediate Bond Fund of America - Class R6
R9	American Funds Short Term Bond Fund of America - Class R4
NC	iShares U.S. Aggregate Bond Index Fund - Class K
VT	Janus Henderson Flexible Bond Fund - Class T
ZM	PIMCO Investment Grade Credit Bond Fund - Institutional Class
AM	PIMCO Income Fund - Institutional Class
7D	Templeton Global Bond Fund - Class R6
G6	Templeton Global Total Return Fund - Class R6
Q4	American Mutual Fund - Class R-6
VL	TIAA-CREF Large Cap Value Index Fund - Institutional Class
VD	Franklin Rising Dividends Fund - Advisor Class
YS	Franklin Rising Dividends Fund - Class R6
09	iShares S&P 500 Index Fund - Class K
BF	American Funds The Growth Fund of America - Class R6
EK	Janus Henderson Forty Fund - Class N
AF	TIAA-CREF Large Cap Growth Index Fund - Institutional Class
MP	iShares Russell Mid-Cap Index Fund - Class K
4M	JPMorgan Mid Cap Value Fund - Class R6
VK	Franklin Small Cap Value Fund - Class R6
17	iShares Russell 2000 Small-Cap Index Fund - Class K
YC	Janus Henderson Triton Fund - Class I
JE	Janus Henderson Triton Fund - Class S
8H	Janus Henderson Global Equity Income Fund - Class I
1X	iShares MSCI EAFE International Index Fund - Class K
H6	American Funds EuroPacific Growth Fund - Class R6
VX	American Funds Capital World Growth and Income Fund - Class R6
TJ	American Funds New World Fund - Class R-6
R7	American Funds New World Fund - Class A
9T	Voya Real Estate Fund - Class R6

Investment options with an asterisk are Target Date Funds, whose underlying mutual funds are subject to stock mar
risk and that 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 wh
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.

Social Security #: ___ – ___ – ____

Employee Name: _____
Last, First, Middle

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally separated or abandoned (Must provide court order to Plan Administrator)

Return this form to the Plan Administrator. DO NOT SEND TO ADP.

I BENEFICIARY INSTRUCTIONS

The Beneficiary Designation Form is used to designate the recipient of your account balance upon your death. This form must be completed by all employees when completing the Enrollment Form or Rollover Form (if not previously enrolled).

Section II. A primary beneficiary must and a secondary beneficiary may be designated. If you are married, your spouse must be the sole primary beneficiary, unless your spouse approves otherwise and signs the waiver below. If the primary beneficiary(ies) predeceases you, the secondary beneficiary(ies) will receive the account balance. You must attach an additional beneficiary form(s), if you elect to designate more than two primary and/or more than two secondary beneficiaries. Please ensure all primary beneficiaries' benefit percentages total 100%. Also, ensure all secondary beneficiaries' benefit percentages total 100%. Please note that a Joint Primary Beneficiary can be the same person named as the secondary beneficiary. Sign and date the form upon completion.

Section III. If you are legally married and have chosen a primary beneficiary other than your spouse, Section III must be completed and notarized.

II BENEFICIARY DESIGNATION

Primary Beneficiary

SSN#: ___ – ___ – ____

Name: _____
Last, First, Middle

Address: _____
Street Apt. # / PO Box #

_____
City, State, Zip

Relationship: _____

Birth Date: _____ ___ %
Month Day Year

SSN#: ___ – ___ – ____

Name: _____
Last, First, Middle

Address: _____
Street Apt. # / PO Box #

_____
City, State, Zip

Relationship: _____

Birth Date: _____ ___ %
Month Day Year

Secondary Beneficiary

SSN#: ___ – ___ – ____

Name: _____
Last, First, Middle

Address: _____
Street Apt. # / PO Box #

_____
City, State, Zip

Relationship: _____

Birth Date: _____ ___ %
Month Day Year

SSN#: ___ – ___ – ____

Name: _____
Last, First, Middle

Address: _____
Street Apt. # / PO Box #

_____
City, State, Zip

Relationship: _____

Birth Date: _____ ___ %
Month Day Year

If none of my designated beneficiaries are living at the time of my death, or I have not designated a beneficiary, then any distribution of my plan accounts shall be payable to a default beneficiary or beneficiaries in accordance with the terms of the plan. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If no primary beneficiary survives me, the contingent beneficiary(ies) shall acquire the designated share of my plan balance.

_____ _____
Signature of Employee/Participant Date

III SPOUSAL CONSENT (Do not complete if your spouse is the sole beneficiary.)

I hereby consent to the above designation by my spouse of a beneficiary other than me under the Plan and I understand that my spouse's election is not valid unless I consent to it, and that my consent is irrevocable unless my spouse revokes the election. I have read the instructions above and understand that by consenting to the above designation, either (i) no benefit from the Plan will be payable to me upon my spouse's death or (ii) only a partial benefit from the Plan will be payable to me upon my spouse's death if a Joint Primary Beneficiary Designation was elected above.

_____ _____
Signature of Spouse Date

Acknowledgment of Witness:

I hereby acknowledge that _____, to me known personally, appeared before me on the _____ day of _____(mo), _____(yr) and subscribed his/her name above and acknowledged to me that he/she did so as his free and voluntary act and deed for the uses and purposes set forth in this beneficiary designation form.

Notary Public for the State/Commonwealth of: _____ Affix Seal Here

My commission expires:_____ County of: _____

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

Employee Name:
Last, First, Middle

Address:
Street Apt. # / PO Box #

City State Zip Code

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

I ROLLOVER INSTRUCTIONS

This form is used to invest prior plan money into your current retirement plan. Generally, you can roll over assets from these types of plans: Qualifie (Including 401(k) Plans), SIMPLE IRAs in existence for at least 2 years, Conduit and Traditional IRAs (taxable non- Roth distributions only), 457(b) plan 403(b) tax sheltered annuity contracts.

Please note: if available, your existing Investment Allocations will be used. Otherwise monies will be invested in the Plan's Default Fund.

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

Section II.B. A preprinted certified or bank check must accompany this form for the stated dollar amount. Personal checks will be returned. **Please include the last four digits of your Social Security Number and Plan Number on the check made payable to Reliance Trust C**

Section II.C. Gather Required Rollover Documentation

All rollovers must be from an eligible retirement plan source. Attach **one** of the following in support of this:

- Quarterly Participant Statement from prior employer plan
- Most recent account statement from Individual Retirement Account (IRA)
- IRS Determination or Opinion Letter from prior plan
- Letter from Prior Trustee or IRA Custodian stating the Plan or account is qualified

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 one of the following eligible rollover sources: (Select one type of plan or account.)

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

If Qualified Plan, is this rollover from a related employer? (Most rollovers are from plans maintained by *unrelated employer.*)

☐ 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 $ ____.__
TOTAL ROLLOVER AMOUNT

☐ Roth 401(k) $ ____.__ = $ ____.__ + $ ____.__
TOTAL ROTH AMOUNT Contributions Earnings

Year Roth 401(k) contributions began: (if not provided, ADP will use the year this rollover contribution is received) 20__

NOTE: Rollovers of Roth 401(k) monies may only be made via direct rollover and may not be rolled over from an IRA. Please refer to the distri statement provided by your prior 401(k) provider for this information.

III PARTICIPANT ACKNOWLEDGMENT, ROLLOVER INVESTMENT DIRECTION AND SIGNATURE

I have read and understand the Summary Plan Description, agree to the Plan provisions, received the Fee Disclosure Statement and reviewed and ur the fund prospectuses/descriptions, including the funds' objectives, risks, expenses and charges. By signing this form, I certify that:

- I am rolling over these funds within 60 days of the date I received them from an eligible employer plan or IRA (not applicable to direct rollov
- The rollover is from the source indicated and has not been combined with any money that would disqualify it.
- No portion of this rollover contribution represents amounts received as a hardship distribution, required minimum distribution or periodic payment from another employer plan.
- I have attached the required documentation.

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

Many investment companies have excessive trading and/or redemption fee policies for certain investments to eliminate or reduce the negative effects of short trading and market timing. When possible, ADP Retirement Services implements the investment company's market timing policy (as disclosed in the prospectus However, in some circumstances ADP may impose a different policy than listed in the prospectus at the request or with the agreement of a fund company. Y investment options may be subject to these policies. See your plan website for your plan's fund policies and additional information.

Signature of Employee/Participant

Date

Forward form with check to:

Regular Mail:
ADP NJ CRS
PO Box 13399
Newark, NJ 07101-3399

Overnight Mail:
ADP C/O FIS
Attention: Lockbox 13399
Lockbox Dept 1ST Floor
400A Commerce Blvd
Carlstadt NJ 07072

Recordkeeping Plan #: 717690

Fund Name[1]/Inception	Morningstar Category	Ticker[2]
Income		
BlackRock T-Fund - Institutional Class (N/A)	N/A	TSTXX
American Funds Intermediate Bond Fund of America - Class R6 (05/2009)	Short-Term Bond	RBOGX
American Funds Short Term Bond Fund of America - Class R4 (01/2007)	Short-Term Bond	RAMEX
iShares U.S. Aggregate Bond Index Fund - Class K (07/1993)	Intermediate-Term Bond	WFBIX
Janus Henderson Flexible Bond Fund - Class T (07/1987)	Intermediate-Term Bond	JAFIX
PIMCO Investment Grade Credit Bond Fund - Institutional Class (04/2000)	Corporate Bond	PIGIX
PIMCO Income Fund - Institutional Class (03/2007)	Multisector Bond	PIMIX
Templeton Global Bond Fund - Class R6 (05/2013)	World Bond	FBNRX
Templeton Global Total Return Fund - Class R6 (05/2013)	World Bond	FTTRX
Growth & Income		
American Funds 2010 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2000-2010	RFTTX
American Funds 2015 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2015	RFJTX
American Funds 2020 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2020	RRCTX
American Funds 2025 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2025	RFDTX
American Funds 2030 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2030	RFETX
American Funds 2035 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2035	RFFTX
American Funds 2040 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2040	RFGTX
American Funds 2045 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2045	RFHTX
American Funds 2050 Target Date Retirement Fund - Class R6 (07/2009)	Target-Date 2050	RFITX
American Funds 2055 Target Date Retirement Fund - Class R6 (02/2010)	Target-Date 2055	RFKTX
American Funds 2060 Target Date Retirement Fund - Class R6 (03/2015)	Target-Date 2060+	RFUTX
American Funds Capital Income Builder Fund - Class R-6 (05/2009)	World Allocation	RIRGX
BlackRock Global Allocation Fund - Class K (06/2016)	World Allocation	MKLOX
Janus Henderson Balanced Fund - Class A (07/2009)	Allocation--50% to 70% Equity	JDBAX
Growth		
American Mutual Fund - Class R-6 (05/2009)	Large Value	RMFGX
TIAA-CREF Large Cap Value Index Fund - Institutional Class (10/2002)	Large Value	TILVX
Franklin Rising Dividends Fund - Advisor Class (10/2005)	Large Blend	FRDAX
Franklin Rising Dividends Fund - Class R6 (05/2013)	Large Blend	FRISX
iShares S&P 500 Index Fund - Class K (07/1993)	Large Blend	WFSPX
American Funds The Growth Fund of America - Class R6 (05/2009)	Large Growth	RGAGX
Janus Henderson Forty Fund - Class N (05/2012)	Large Growth	JFRNX
TIAA-CREF Large Cap Growth Index Fund - Institutional Class (10/2002)	Large Growth	TILIX
iShares Russell Mid-Cap Index Fund - Class K (05/2015)	Mid-Cap Blend	BRMKX
JPMorgan Mid Cap Value Fund - Class R6 (09/2016)	Mid-Cap Blend	JMVYX
Aggressive Growth		
Franklin Small Cap Value Fund - Class R6 (05/2013)	Small Value	FRCSX

Fund Name[1]/Inception	Morningstar Category	Ticker[2]
Aggressive Growth (continued)		
iShares Russell 2000 Small-Cap Index Fund - Class K (03/2011)	Small Blend	BDBKX
Janus Henderson Triton Fund - Class I (07/2009)	Small Growth	JSMGX
Janus Henderson Triton Fund - Class S (07/2009)	Small Growth	JGMIX
Janus Henderson Global Equity Income Fund - Class I (03/2009)	Foreign Large Value	HFQIX
iShares MSCI EAFE International Index Fund - Class K (03/2011)	Foreign Large Blend	BTMKX
American Funds EuroPacific Growth Fund - Class R6 (05/2009)	Foreign Large Growth	RERGX
American Funds Capital World Growth and Income Fund - Class R6 (05/2009)	World Large Stock	RWIGX
American Funds New World Fund - Class R-6 (05/2009)	Diversified Emerging Mkts	RNWGX
American Funds New World Fund - Class A (06/1999)	Diversified Emerging Mkts	NEWFX
Voya Real Estate Fund - Class R6 (07/2014)	Real Estate	VREQX

BlackRock T-Fund - Institutional Class
STRATEGY: The fund's objective is to seek maximum current income consistent with liquidity and stability of principal.

American Funds Intermediate Bond Fund of America - Class R6
STRATEGY: The investment seeks current income consistent with the maturity and quality standards and preservation of capital. The fund maintains a portfolio of bonds, other debt securities and money market instruments having a dollar-weighted average effective maturity of no less than three years and no greater than five years under normal market conditions. It invests primarily in bonds and other debt securities with quality ratings of A- or better or A3 or better or unrated but determined to be of equivalent quality by the fund's investment adviser. The fund primarily invests in debt securities denominated in U.S. dollars.

American Funds Short Term Bond Fund of America - Class R4
STRATEGY: The investment seeks current income, consistent with the maturity and quality standards described in the prospectus, and preservation of capital. The fund will invest at least 80% of its assets in bonds (bonds include any debt instrument and cash equivalents). It maintains a portfolio of bonds, other debt securities and money market instruments having a dollar-weighted average effective maturity no greater than three years and consisting primarily of debt securities rated AA- or Aa3 or better. The fund primarily invests in debt securities denominated in U.S. dollars. It may invest up to 10% of its assets in debt securities in the A rating category.

iShares U.S. Aggregate Bond Index Fund - Class K
STRATEGY: The investment seeks to provide investment results that correspond to the total return performance of fixed-income securities in the aggregate, as represented by the Bloomberg Barclays U.S. Aggregate Bond 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. Under normal circumstances, at least 90% of the value of the fund's assets, plus the amount of any borrowing for investment purposes, is invested in securities comprising the Barclays U.S. Aggregate Index.

Janus Henderson Flexible Bond Fund - Class T
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.

PIMCO Investment Grade Credit Bond Fund - Institutional Cla
STRATEGY: The investment seeks maximum total return, consistent wit preservation of capital and prudent investment management. The fund normally invests at least 80% of its assets in a diversified portfolio of investment grade fixed income securities of varying maturities, which be represented by forwards or derivatives such as options, futures contracts or swap agreements. It may invest up to 30% of its total as securities denominated in foreign currencies, and may invest beyond t limit in U.S. dollar-denominated securities of foreign issuers.

PIMCO Income Fund - Institutional Class
STRATEGY: The investment seeks to maximize current income; long-te capital appreciation is a secondary objective. The fund invests at least of its total assets in a multi-sector portfolio of Fixed Income Instrume varying maturities, which may be represented by forwards or derivativ such as options, futures contracts or swap agreements. It may invest 50% of its total assets in high yield securities rated below investment by Moody's, S&P or Fitch, or if unrated, as determined by PIMCO.

Templeton Global Bond Fund - Class R6
STRATEGY: The investment seeks current income with capital apprecia and growth of income. Under normal market conditions, the fund inv least 80% of its net assets in "bonds." Bonds include debt obligations maturity, such as bonds, notes, bills and debentures. It invests predominantly in bonds issued by governments, government-related entities and government agencies located around the world. The fund invest up to 25% of its total assets in bonds that are rated below inv grade or, if unrated determined by the investment manager to be of comparable quality. It is non-diversified.

Templeton Global Total Return Fund - Class R6
STRATEGY: The investment seeks total investment return consisting of combination of interest income, capital appreciation, and currency gai Under normal market conditions, the fund invests primarily in fixed a floating rate debt securities and debt obligations (including convertible bonds) of governments, government agencies and government-related 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, and debentures. The fund is non-diversified.

American Funds 2010 Target Date Retirement Fund - Class R
STRATEGY: The investment seeks growth, income and conservation of capital. The fund normally invests a greater portion of its assets in b equity-income and balanced funds as it passes its target date. The ad will attempt to achieve the fund's investment objectives by investing in of American Funds in different combinations and weightings. The underlying American Funds represent a variety of fund categories, including growth-and-income funds, equity-income funds, balanced fun and fixed income funds. The fund categories represent differing invest objectives.

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.

American Funds 2015 Target Date Retirement Fund - Class R6
STRATEGY: The investment seeks growth, income and conservation of capital. The fund normally invests a greater portion of its assets in bond, equity-income and balanced funds as it approaches and passes its target date. The advisor attempts to achieve its investment objectives by investing in a mix of American Funds in different combinations and weightings. The underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income funds, balanced funds and fixed income funds. The fund categories represent differing investment objectives.

American Funds 2020 Target Date Retirement Fund - Class R6
STRATEGY: The investment seeks growth, income and conservation of capital. The fund normally invests a greater portion of its assets in bond, equity-income and balanced funds as it approaches and passes its target date. The advisor attempts to achieve its investment objectives by investing in a mix of American Funds in different combinations and weightings. The underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income funds, balanced funds and fixed income funds. The fund categories represent differing investment objectives.

American Funds 2025 Target Date Retirement Fund - Class R6
STRATEGY: The investment seeks growth, income and conservation of capital. The fund normally invests a greater portion of its assets in bond, equity-income and balanced funds as it approaches and passes its target date. The advisor attempts to achieve its investment objectives by investing in a mix of American Funds in different combinations and weightings. The underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income funds, balanced funds and fixed income funds. The fund categories represent differing investment objectives.

American Funds 2030 Target Date Retirement Fund - Class R6
STRATEGY: The investment seeks growth, income and conservation of capital. The fund normally invests a greater portion of its assets in bond, equity-income and balanced funds as it approaches and passes its target date. The advisor attempts to achieve its investment objectives by investing in a mix of American Funds in different combinations and weightings. The underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income funds, balanced funds and fixed income funds. The fund categories represent differing investment objectives.

American Funds 2035 Target Date Retirement Fund - Class R6
STRATEGY: The investment seeks growth, income and conservation of capital. The fund normally invests a greater portion of its assets in bond, equity-income and balanced funds as it approaches and passes its target date. The advisor attempts to achieve its investment objectives by investing in a mix of American Funds in different combinations and weightings. The underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income funds, balanced funds and fixed income funds. The fund categories represent differing investment objectives.

American Funds 2040 Target Date Retirement Fund - Class
STRATEGY: The investment seeks growth, income and conservation o capital. The fund normally invests a greater portion of its assets in equity-income and balanced funds as it approaches and passes its ta date. The advisor attempts to achieve its investment objectives by inv in a mix of American Funds in different combinations and weighting underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income fun balanced funds and fixed income funds. The fund categories represe differing investment objectives.

American Funds 2045 Target Date Retirement Fund - Class
STRATEGY: The investment seeks growth, income and conservation o capital. The fund normally invests a greater portion of its assets in equity-income and balanced funds as it approaches and passes its ta date. The advisor attempts to achieve its investment objectives by inv in a mix of American Funds in different combinations and weighting underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income fun balanced funds and fixed income funds. The fund categories represe differing investment objectives.

American Funds 2050 Target Date Retirement Fund - Class
STRATEGY: The investment seeks growth, income and conservation o capital. The fund normally invests a greater portion of its assets in equity-income and balanced funds as it approaches and passes its ta date. The advisor attempts to achieve its investment objectives by inv in a mix of American Funds in different combinations and weighting underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income fun balanced funds and fixed income funds. The fund categories represe differing investment objectives.

American Funds 2055 Target Date Retirement Fund - Class
STRATEGY: The investment seeks growth, income and conservation o capital. The fund normally invests a greater portion of its assets in equity-income and balanced funds as it approaches and passes its ta date. The advisor attempts to achieve its investment objectives by inv in a mix of American Funds in different combinations and weighting underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income fun balanced funds and fixed income funds. The fund categories represe differing investment objectives.

American Funds 2060 Target Date Retirement Fund - Class
STRATEGY: The investment seeks growth, income and conservation o capital. The fund normally invests a greater portion of its assets in equity income and balanced funds as it approaches and passes its t date. The advisor attempts to achieve its investment objectives by inv in a mix of American Funds in different combinations and weighting underlying American Funds represent a variety of fund categories, including growth funds, growth-and-income funds, equity-income fun balanced funds and fixed income funds. The fund categories represe differing investment objectives.

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 a expenses, please obtain a copy of the fund's prospectus from your Financial Advisor and/or plan sponsor.

American Funds Capital Income Builder Fund - Class R-6
STRATEGY: The investment seeks (1) to provide a level of current income that exceeds the average yield on U.S. stocks generally and (2) to provide a growing stream of income over the years. The fund normally will invest at least 90% of its assets in income-producing securities (with at least 50% of its assets in common stocks and other equity securities). It invests primarily in a broad range of income-producing securities, including common stocks and bonds. In seeking to provide the investors with a level of current income that exceeds the average yield on U.S. stocks, the fund generally looks to the average yield on stocks of companies listed on the S&P 500 Index.

BlackRock Global Allocation Fund - Class K
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 Henderson 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, non-U.S. government securities, mortgage-backed securities and other mortgage-related products, and short-term securities.

American Mutual Fund - Class R-6
STRATEGY: The investment seeks current income, growth of capital and conservation of principal. The fund invests primarily in common stocks of companies that are likely to participate in the growth of the American economy and whose dividends appear to be sustainable. It invests primarily in securities of issuers domiciled in the United States and Canada. The fund may also invest in bonds and other debt securities, including those issued by the U.S. government and by federal agencies and instrumentalities.

TIAA-CREF Large Cap Value Index Fund - Institutional Class
STRATEGY: The investment seeks a favorable long-term total return, mainly through capital appreciation, by investing primarily in a portfolio of equity securities of large domestic value companies based on a market index. Under normal circumstances, the fund invests at least 80% of its assets in securities of its benchmark index, the Russell 1000 Value Index. The Russell 1000 Value Index is a subset of the Russell 1000 Index, which represents the performance of the large-cap value segment of the U.S. equity universe. It includes those Russell 1000 Index companies with lower price-to-book ratios and lower expected growth values.

Franklin Rising Dividends Fund - Advisor Class
STRATEGY: The investment seeks long-term capital appreciation; preservation of capital, while not a goal, is also an important conside The fund invests at least 80% of its net assets in investments of com that have paid consistently rising dividends. It invests predominantly ir equity securities, primarily common stock. The fund may invest in companies of any size, across the entire market spectrum. It may inv to 25% of its total assets in foreign securities.

Franklin Rising Dividends Fund - Class R6
STRATEGY: The investment seeks long-term capital appreciation; preservation of capital, while not a goal, is also an important conside The fund invests at least 80% of its net assets in investments of com that have paid consistently rising dividends. It invests predominantly ir equity securities, primarily common stock. The fund may invest in companies of any size, across the entire market spectrum. It may inv to 25% of its total assets in foreign securities.

iShares S&P 500 Index Fund - Class K
STRATEGY: The investment seeks to provide investment results that correspond to the total return performance of publicly-traded commor 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 Portfolio of MIP, which has the same investment objective and strateg the fund. At least 90% of the value of the fund's assets is invested ir securities comprising the S&P 500 Index. The percentage of the fund' assets invested in a given stock is approximately the same as the per such stock represents in the S&P 500 Index.

American Funds The Growth Fund of America - Class R6
STRATEGY: The investment seeks growth of capital. The fund invests primarily in common stocks and seeks to invest in companies that ap to offer superior opportunities for growth of capital. It may invest up 25% of its assets in securities of issuers domiciled outside the United States. The investment adviser uses a system of multiple portfolio mar in managing the fund's assets. Under this approach, the portfolio of t fund is divided into segments managed by individual managers who d how their respective segments will be invested.

Janus Henderson Forty Fund - Class N
STRATEGY: The investment seeks long-term growth of capital. The fun pursues its investment objective by normally investing primarily in a c group of 20-40 common stocks selected for their growth potential. It invest in companies of any size, from larger, well-established compani smaller, emerging growth companies. The fund may also invest in for securities, which may include investments in emerging markets. It is non-diversified.

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.

TIAA-CREF Large Cap Growth Index Fund - Institutional Class
STRATEGY: The investment seeks a favorable long-term total return, mainly through capital appreciation, by investing primarily in a portfolio of equity securities of large domestic growth companies based on a market index. Under normal circumstances, the fund invests at least 80% of its assets in securities of its benchmark index, the Russell 1000 Growth Index. It buys most, but not necessarily all, of the stocks in its benchmark index, and the advisor will attempt to closely match the overall investment characteristics of the fund's benchmark index.

iShares Russell Mid-Cap Index Fund - Class K
STRATEGY: The investment seeks to track the investment results of the Russell Midcap Index (the "underlying index"), which measures the performance of the mid-capitalization sector of the U.S. equity market. The fund generally invests at least 90% of its assets, plus the amount of any borrowing for investment purposes, in securities of the underlying index. The underlying index is a float-adjusted, capitalization-weighted index of the 800 smallest issuers in the Russell 1000 Index.

JPMorgan Mid Cap Value Fund - Class R6
STRATEGY: The investment seeks growth from capital appreciation. Under normal circumstances, the fund invests at least 80% of its assets in equity securities of mid cap companies. "Assets" means net assets, plus the amount of borrowings for investment purposes. Mid cap companies are companies with market capitalizations equal to those within the universe of the Russell Midcap Value Index and/or between $1 billion and $20 billion at the time of purchase.

Franklin Small Cap Value Fund - Class R6
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.

iShares Russell 2000 Small-Cap Index Fund - Class K
STRATEGY: The investment seeks to match the performance of the Russell 2000 Index as closely as possible before the deduction of fund expenses. The fund is a "feeder" fund that invests all of its assets in the Series, a series of the Master LLC, which has the same investment objective and strategies as the fund. It will be substantially invested in securities in the Russell 2000, and will invest, under normal circumstances, at least 80% of its assets in securities or other financial instruments that are components of or have economic characteristics similar to the securities included in the Russell 2000.

Janus Henderson Triton Fund - Class I
STRATEGY: The investment seeks long-term growth of capital. The fun pursues its investment objective by investing at least 50% of its equity in small- and medium-sized companies. It may also invest in larger companies with strong growth potential. Small- and medium-sized companies are defined by the portfolio managers as those companies whose market capitalization falls within the range of companies in th Russell 2500 Growth Index at the time of initial purchase. The fund also invest in foreign securities, which may include investments in emerging markets.

Janus Henderson Triton Fund - Class S
STRATEGY: The investment seeks long-term growth of capital. The fun pursues its investment objective by investing at least 50% of its equity in small- and medium-sized companies. It may also invest in larger companies with strong growth potential. Small- and medium-sized companies are defined by the portfolio managers as those companies whose market capitalization falls within the range of companies in th Russell 2500 Growth Index at the time of initial purchase. The fund also invest in foreign securities, which may include investments in emerging markets.

Janus Henderson Global Equity Income Fund - Class I
STRATEGY: The investment seeks a high level of current income and, secondary objective, steady growth of capital. The fund pursues its investment objective by investing, under normal circumstances, at leas 80% of its net assets (plus any borrowings for investment purposes) portfolio of income-producing equity securities, such as common and preferred dividend-paying stocks. The adviser invests in U.S. and non- issuers and will typically invest at least 40% of its net assets in secu issuers or companies that are economically tied to different countries throughout the world, excluding the United States.

iShares MSCI EAFE International Index Fund - Class K
STRATEGY: The investment seeks to match the performance of the MS EAFE Index (Europe, Australasia, Far East) in U.S. dollars with net dividends as closely as possible before the deduction of fund expense fund will be substantially invested in securities in the MSCI EAFE Ind will invest at least 80% of its assets in securities or other financial instruments that are components of or have economic characteristics similar to the securities included in the MSCI EAFE Index.

American Funds EuroPacific Growth Fund - Class R6
STRATEGY: The investment seeks long-term growth of capital. The fun invests primarily in common stocks of issuers in Europe and the Pac Basin that the investment adviser believes have the potential for grow Growth stocks are stocks that the investment adviser believes have th potential for above-average capital appreciation. It normally will invest least 80% of its net assets in securities of issuers in Europe and the Basin. The fund may invest a portion of its assets in common stocks other securities of companies in emerging markets.

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 an expenses, please obtain a copy of the fund's prospectus from your Financial Advisor and/or plan sponsor.

American Funds Capital World Growth and Income Fund - Class R6

STRATEGY: The investment seeks long-term growth of capital while providing current income. The fund invests primarily in common stocks of well-established companies located around the world, many of which have the potential to pay dividends. It invests, on a global basis, in common stocks that are denominated in U.S. dollars or other currencies. Under normal market circumstances, the fund will invest a significant portion of its assets in securities of issuers domiciled outside the United States, including those based in developing countries.

American Funds New World Fund - Class R-6

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.

American Funds New World Fund - Class A

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.

Voya Real Estate Fund - Class R6

STRATEGY: The investment seeks total return consisting of long-term capital appreciation and current income. Under normal market conditions, the fund invests at least 80% of its net assets (plus borrowings for investment purposes) in common and preferred stocks of U.S. real estate investment trusts ("REITs") and real estate companies. The Sub-Adviser may invest in companies with any market capitalization. However, the Sub-Adviser will generally not invest in companies with a market capitalization of less than $100 million at the time of purchase.

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. The information contained herein: (1) is proprietary to Morningstar and/or its content providers; (2) may not be copied or distributed; and (3) is not warranted to be accurate, complete or timely. Neither Morningstar, ADP, nor its content providers is responsible for any damages or losses arising from any use of this information.

Expressed in percentage terms, Morningstar's calculation of total retu determined each month by taking the change in monthly net asset va reinvesting all income and capital-gains distributions during that mont and dividing by the starting NAV. Reinvestments are made using the 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 Mark funds and certain other types of funds are provided by the respective manager.

Investment Type Definitions:

The investment types are four broad investment categories; each fund 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 Lifestyl investment funds. Growth: Large and Mid Capitalization investment fu Aggressive Growth: Small Capitalization, Specialty, Foreign Stock and W Stock investment funds.

The Morningstar Category identifies funds based on their actual invest styles as measured by their underlying portfolio holdings (portfolio statistics and compositions over the past three years). If the fund is and has no portfolio, Morningstar estimates where it will fall before assigning a more permanent category. When necessary, Morningstar change a category assignment based on current information.

The Morningstar fund summaries provided above were prepared by others general research purposes and are made available by ADP, LLC (ADP) in non-fiduciary capacity. ADP makes this information available solely for the purpose of providing general reference material and not as an investment recommendation or advice.

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 an 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 50 or older, 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					
Employer Contribution % 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 Participant Website for more information.

DISTRIBUTIONS

Vested savings may be eligible for distribution upon retirement, death, disability or termination of employment.

ROLLOVERS

Rollovers are accepted into the plan, even if you have not yet met the plan's age and service requirements. See the Rollover form for instructions if you are interested.

ACCOUNT MANAGEMENT FEATURES

You may elect the following plan features online at www.mykplan.com.

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 is a tool that can help you keep your current investment mix (balance by investment fund) consistent with your current investment strategy for new contributions. Once you have made an investment allocation election for new contributions, Automatic Account Rebalancing will rebalance your account as often as you choose: quarterly, semi-annually, or annually.

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 Participant 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
- Make investment elections
- 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 Participant 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 Participant 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 Participant Website 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.

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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.℠

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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 2017, the limit is $18,000. After 2017, 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 2017, this limit is $270,000. 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 2017, 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 $54,000.

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 2017), 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 2017, the limit on catch-up contributions is $6,000. After 2017, 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) 215-7065
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) 215-7065
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 1/1/2020, 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:	Jessica Catino
Mailing Address:	100 Domain Drive, Suite 103
	Exeter, NH 03833
E-mail Address (if applicable):	jcatino@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?".