

Summary Plan Description

For the

Misericordia University Health and Welfare Benefit Wrap Plan

Effective as of July 1, 2017

This document together with the Certificates of Coverage or the Component Benefit Plans and other documents identified in this document constitutes the Summary Plan Description.

Misericordia University Health and Welfare Benefit Wrap Plan
SUMMARY PLAN DESCRIPTION
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Introduction

Misericordia University (the “Employer”) has established the Misericordia University Health and Welfare Benefit Wrap Plan (the “Plan”). The Plan’s purpose is to combine in one plan document provisions of the health and welfare benefit plans (the “Component Benefit Plans”) sponsored by Misericordia University and its affiliated employers (if any), and to provide uniform administration of these health and welfare benefits. The Component Benefit Plans are listed in **Appendix A** to this Summary Plan Description (“SPD”). This SPD reflects and summarizes the terms of the Plan in effect on July 1, 2017. Presently, there are no controlled group entities or affiliated employers of the Employer that have employees participating in the Plan. Participating controlled group entities or affiliated employers may be added or changed from time to time.

The insurance contracts (including Certificates of Coverage), summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are not affected by the adoption of the Plan, and the terms of the Component Benefit Plans will continue to control for purposes of determining your benefits. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts (if any) or similar arrangements.) The terms of each Component Benefit Plan are incorporated into this SPD by reference and will continue to act as the primary source of information for each Component Benefit Plan. However, if a conflict of language exists between the Component Benefit Plan and the Plan or SPD, the Component Benefit Plan will control as long as the Component Benefit Plan is not inconsistent with Federal law and regulations. The exception is, regardless of a Component Benefit Plan’s identification of a Plan Year or Plan Number, the Plan Year or Plan Number of this SPD will control.

Note: Every effort has been made to accurately describe the Plan in this SPD. However, if there should be a discrepancy between the SPD and the Plan document -- or if the Plan is required to operate in a different manner to comply with Federal laws and regulations -- the Plan document or the appropriate Federal laws and regulations will control.

If you have not received a Certificate of Coverage (which also may be known as a certificate of insurance or evidence of coverage) or other document that summarizes in detail a Component Benefit Plan, you may request the Certificate of Coverage or other document which will be made available by the Plan Administrator (identified under the heading "Plan Administrator") to you or your beneficiaries without cost.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address or email and the addresses of any family members who are covered by the Plan.

General Information Pertaining to the Plan

[Plan Name, Sponsor and Employer EIN](#)

The name of the Plan is Misericordia University Health and Welfare Benefit Wrap Plan. Misericordia University is the Plan Sponsor. The Employer’s address is 301 Lake Street, Dallas, PA, 18612. The Employer’s telephone number is 570-674-6400. The Employer’s Federal employer identification number (EIN) is 24-0795406.

[Plan Year](#)

For recordkeeping purposes, the Plan Year for the Plan is the 12 month period beginning on July 1 and ending June 30.

[Plan Number](#)

The number of this Plan is 507.

Type of Welfare Benefit Plan(s)

The Plan may provide various welfare benefits under the Component Benefit Plan(s) listed in **Appendix A** to this SPD.

Funding

Benefits under the Plan are funded by one or more of the following methods selected by Misericordia University for a Component Benefit Plan: insured benefits, self-funded benefits (these are benefits funded by general assets of the Employer or through a trust), or a combination of insured benefits, self-funded benefits and trust benefits. For details on the funding status of Component Benefit Plans, see **Appendix A**. Funding for the Plan will consist of the funding for all Component Benefit Plans and may include funding through a cafeteria plan which, if available, is identified as a funding source in **Appendix A**.

Misericordia University has the right to pay benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as Misericordia University determines advisable in its sole discretion. In addition, Misericordia University has the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any benefit or portion of the benefit is funded by the purchase of insurance, the benefit or portion of the benefit will be payable solely by the insurance company.

Plan Administrator

The Plan Administrator is Misericordia University, 301 Lake Street, Dallas, PA, 18612, telephone number 570-674-6400, which, for insured benefits offered through the Plan, administers the Component Benefit Plans with the insurance companies providing benefits under the Component Benefit Plans as named fiduciaries. The insurance companies shown in **Appendix A** are responsible for considering,

accepting or denying, and paying claims for the insured benefits. The indicated insurance company is responsible for considering any appeals to the insured benefits made following a Component Benefit Plan's claim procedures and, if applicable, the claim procedures indicated in this SPD. Any third-party administrator ("TPA") responsible for administering a Component Benefit Plan not funded through insurance may be listed in **Appendix A**. Therefore, the Plan Sponsor is the administrator of the Component Benefit Plan, unless otherwise specified in **Appendix A**, which identifies the administrator as the "Sponsor" or the "Insurer" or the "Contract Administrator." In addition, if a party has accepted named fiduciary status in considering, accepting or denying, and paying claims (including any appeals relating to such claims), that party (also referred to as a "Claim Fiduciary") is identified in **Appendix A**.

Agent for Service of Legal Process

The agent for service of legal process is Misericordia University, 301 Lake Street, Dallas, PA, 18612. Service may also be made on the Plan Administrator.

Named Fiduciary

The Plan Administrator is the primary named fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans to the extent not delegated to another named fiduciary. For insured Component Benefit Plans, the insurance company is also a named fiduciary under the Plan as to the determination of the amount of, and entitlement to, insured benefits with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the insurance policy. In addition, where any other party has accepted status as a named fiduciary, with respect to the determination of the amount of, and entitlement to, benefits under any uninsured Component Benefit Plan, such named fiduciary (also referred to as the Claim Fiduciary) with respect to the applicable

Component Benefit Plan is identified in **Appendix A**.

Insurance Company Refund

As to any insurance company refund/rebate received by Misericordia University that is subject to the Medical Loss Ratio (“MLR”) provisions of the Patient Protection and Affordable Care Act of 2010 (the “Affordable Care Act” or “ACA”), the Plan Administrator will determine what portion (if any) of such rebate must be treated as “plan assets” under ERISA. If any portion of the rebate must be treated as “plan assets,” the Plan Administrator will determine, in its sole discretion, the manner in which such amounts will be used by the Plan or applied to the benefit of the Participants (the Participants need not be the same as those who made contributions under the policy that issued the rebate). Any portion of the rebate that is not treated as a ‘plan asset’ will be allocated to any employer or, if applicable, among one or more employer(s) as the Plan Sponsor in its sole discretion determines appropriate. If the rebate is applied toward a benefit enhancement or as an offset to participants’ share of future premiums, verification of the additional benefit or how the premium offset will be applied (e.g., will there be a one-time premium holiday, or will the participants’ share of premiums be reduced over a period of months).

Plan Document

The Plan and those documents incorporated by reference in the Plan compose a written employee benefit welfare plan as defined by ERISA.

Coverage for Spouses, Dependents

One or more Component Benefit Plans covered under the Plan may identify spouses, dependents/children and others as eligible non-employee participants on **Appendix A**. The provisions relating to that coverage should be detailed in the Certificates of Coverage or other Component Benefit Plan documents. Note that you have an obligation to notify the Employer promptly of any loss of dependent status.

No Guarantee of Non-Taxability

The Plan provides benefits often intended to be non-taxable. The Plan Administrator or any fiduciary or party associated with the Plan will not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

No Guarantee of Employment

The offering of the Component Benefit Plans under the Plan is not a commitment or guarantee of employment by any Employer and does not affect any Employer’s rights to discharge any employee.

Nondiscrimination

Contributions and benefits under the Plan will not discriminate in favor of "highly compensated employees" or "key employees" as such terms are defined under the Code. The Employer may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

Anti-Assignment

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the participant and shall not constitute an assignment of benefits under the Plan.

Eligibility, Participation and Benefits

Eligibility and Participation

Eligibility for participation and benefits under the Plan is determined under the written terms of the Plan and each Component Benefit Plan. See a summary of more information regarding eligibility and participation in **Appendix A**.

If you previously participated in the Plan and are rehired, you will be eligible to become a Participant on the same terms as if you were a newly hired employee. However, in most instances, group health plans offered by an “applicable large employer” (generally, an employer that employs an average of at least 50 full-time employees (including full-time equivalent employees)) are subject to the Affordable Care Act and have special rehire rules. These rules are as follows: if your Employer is subject to the ACA and you return to work after a period during which you were not credited with any hours of service, you may be treated as having terminated employment and been rehired as a new Employee only if the following conditions apply: (i) you had no hours of service for a period of at least 13 consecutive weeks (26 for educational organization employers); or (ii) you had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of your period of employment. These provisions are intended to comply with the ACA and are not intended to expand the rights or benefits of employees for any other purpose and should be so construed.

If your Employer believes it is an “applicable large employer” under the ACA, it may elect to take advantage of the look-back provisions of the ACA. See **Appendix B** for details.

Insurance carriers sometimes impose an “actively at work” requirement for certain types of insurance (for example, life and disability). Therefore, your participation in those benefits may be delayed or otherwise affected. This requirement would be reflected in your Certificate of Coverage. This may also be the case in which you are rehired as an employee.

Note that the “actively at work” requirement does not apply to a Group Health Plan (other than one offering only HIPAA-excepted coverage) unless there is an exception for individuals who are absent from work due to a

health factor (e.g., individual is out on sick leave on the day the coverage would otherwise become effective).

As to any Component Benefit Plan that is a group health plan (other than one offering only HIPAA-excepted coverage), any otherwise eligible employee must wait no longer than ninety (90) days to begin coverage under such Component Benefit Plan.

Contributions

The cost of the benefits provided through the Component Benefit Plans may be funded in part by Employer contributions and in part by your contributions. In some instances, a Component Benefit Plan may require only you or Misericordia University to contribute. If specified in **Appendix A**, the cost of benefits provided through a Component Benefit Plan may be funded pre-tax through a cafeteria plan under Section 125 of the Internal Revenue Code. The sources of Plan contributions are listed in **Appendix A**. Misericordia University will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Plan, and it may change that determination at any time. Misericordia University will make any Employer’s contributions in an amount that in the Employer’s sole discretion is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. Misericordia University will pay its contribution and your contributions to an insurance company or, for benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members. Your contributions will be used in their entirety prior to using Employer contributions to pay for the cost of that benefit. Where relevant to a Component Benefit Plan, you will receive during the open enrollment period notice of the amount for which you are responsible. If your cost for a Component Benefit Plan is adjusted during the Plan Year, you will be notified of that adjustment unless

the Component Benefit Plan provides otherwise.

The Plan Administrator will have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual, organization or anyone else benefiting from the improper payment.

Benefits Available

The benefits available under the Plan consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions for each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan documents. The availability of benefits is subject to your payment of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan.

Any health care flexible spending account under a cafeteria plan will be subject to this Plan and the requirements of ERISA. Nonetheless, a premium or premium equivalent (i.e., the cost of coverage) reduction portion of a cafeteria plan (and any dependent care assistance plan offered under the cafeteria plan) will not be subject to the requirements of ERISA, even though the cafeteria plan (and any dependent care assistance plan) may be considered part of the Plan.

Where a health benefit involves the use of "network providers" (also sometimes referred to as "PPO", "EPO" or "preferred providers"), you will receive listings of such providers without charge. The listings may be provided in one or more separate documents or by electronic document access via the Internet.

Where a network is involved, a benefit document will include provisions governing the use of such providers, primary care providers or providers of specialty services, the composition of the network and whether and under what

circumstances coverage is provided for emergency and out-of-network services.

Loss of Benefits

Your benefits (and the benefits of your eligible dependents) generally will cease when your participation in the Plan terminates. Benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents of the Component Benefit Plans provide additional information. The subrogation provisions of the Plan are discussed in more detail in the section "Employer's Right of Reimbursement."

Benefit Elections

Electing Your Benefits for the Plan Year Under a Component Benefit Plan

Some of the Component Benefit Plans may require you to make an annual election to enroll for coverage for the next plan year prior to the beginning of that year. The plan year for each Component Benefit Plan should be set forth in that plan and may be different than the Plan Year for this Plan. Thus, the discussion below regarding plan year refers to the relevant Component Benefit Plan's plan year.

If you first become eligible to participate in a Component Benefit Plan during a plan year in progress, your initial elections pertain to the remaining part of that plan year. Then, before each new plan year begins, you will have an opportunity to change or cancel your elections during the annual open enrollment period. The annual open enrollment period is described below.

Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under a Component Benefit Plan. You may also

elect not to participate in a Component Benefit Plan for which annual elections are then being made.

Benefits are elected by completing and submitting an election form in a format approved by the Plan Administrator (whether in paper or electronic format) before the end of the annual open enrollment period. When you make your elections, you also authorize the necessary payroll deductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a plan year, you will be given an opportunity to elect and enroll in the benefits for which you are newly eligible.

Annual Election Period

Before the beginning of each plan year, Misericordia University often may hold an annual open enrollment period. In that case, Misericordia University will notify you when the dates for the annual open enrollment period will occur each year. During this time, you may make new elections for the upcoming plan year. Your elections from the prior year may roll forward to the current year. You should consult with material provided to you during the annual open enrollment period to determine whether an election is required.

Changing Your Elections during a Plan Year

Where a Component Benefit Plan is funded through a cafeteria plan, once you have made your elections for a plan year, it pertains to the entire plan year as it applies to that Component Benefit Plan and cannot be changed or cancelled during that time except in certain limited situations that are described in the cafeteria plan. Other election restrictions may apply to Component Benefit Plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Component Benefit Plan.

If you, your spouse, or your dependent child experience a “change in status,” and that change in status makes you, your spouse, or your dependent child eligible or ineligible for any of the pre-tax benefits, or for any of the benefit options sponsored by your spouse’s or your eligible dependent child’s employer, you may change the amount of your election in a way that is consistent with that “change in status,” provided you notify the Plan Administrator of such change within 30 days of such change. The determination of whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such an event shall be made in the sole discretion of the Plan Administrator.

A “change in status” includes a change in the following:

- (a) marriage;
- (b) other changes in your legal marital status (for example, your divorce, annulment, or legal separation, or the death of your spouse);
- (c) birth or adoption of a child, including placement for adoption;
- (d) other changes in the number of your dependents (for example, legal guardianship for a child);
- (e) you, your spouse’s or your dependent child’s employment status (for example, terminating or beginning a job; changing the number of hours worked, such as switching from full-time to part-time, or vice versa);
- (f) you, your spouse or your dependent child begins or returns from certain types of unpaid leave of absence (FMLA or USERRA) or change in worksite;
- (g) your dependent satisfies or ceases to satisfy eligibility requirements (for example, attainment of the limiting age,

loss of student status, or similar circumstances);

- (h) your (or your spouse's or dependent's) residence that results in gaining or losing eligibility for a health care option (such as moving out of an HMO service area); and
- (i) any other event specified under the Employer's cafeteria plan that is consistent with IRS regulations and pronouncements, such as the specific situations related to the availability of coverage through a Health Insurance Exchange (or Marketplace) as provided in IRS Notice 2014-55, which allows prospective revocation of the employee's election under certain circumstances.

Claims Procedures

Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a TPA must be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third party administrative services agreement. These procedures will be followed unless inconsistent with the requirements of ERISA as specified in more detail below. The name (and in the case of group health plan claims, the address) of the individual insurance company providing benefits and reviewing claims relating to its insurance policy is set forth in **Appendix A**. Further, the name and address of the TPA (if any) that reviews claims made under a Component Benefit Plan may be set forth in **Appendix A**. All other general claims or requests should be directed to the Plan Administrator.

Personal Representative

You may exercise your rights directly or through an authorized personal representative. You may only have one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination.

Your personal representative will be required to produce evidence of his or her authority to act on your behalf. The Plan may require you to execute a form relating to the representative's authority before that person will be given access to your protected health information ("PHI") or allowed to take any action for you. (A mere assignment or attempted assignment of your benefits does not constitute a designation of an authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Plan.) This authority may be proved by one of the following:

- (a) A power of attorney for health care purposes, notarized by a notary public;
- (b) A court order of appointment of the person as the conservator or guardian of the individual; or
- (c) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

General Claims Procedure

If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical

child support order, you may file suit in Federal court.

The Plan's claims procedures are described below. (These claims procedures do not apply to any cafeteria plan which is a premium-only plan ("POP") or to any dependent care assistance plan offered.)

The following procedures will be followed for denied claims under a Component Benefit Plan that is not a group health plan or disability plan. For group health claims and disability claims, see headings "Special Rules for Group Health Plan Claims" and "Special Rules for Disability Claims."

(a) If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. Under special circumstances, the Claim Fiduciary may take up to an additional 90 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The written notification of a denied claim for benefits will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied.

(b) Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator or its delegate such as the insurance company or TPA, which includes the reasons why you feel the claim is valid and the reasons why you think the claim

should not be denied. Before submitting an appeal request, you may request to examine and receive copies of all documents, records, and other information relevant to the claim. If you fail to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Documents, records, written comments, and other information in support of your appeal should accompany any appeal request. The Plan Administrator or its delegate will consider such information in reviewing the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator or its delegate due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The Plan Administrator's response will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement about your right to bring a civil action under ERISA Section 502(a).

(c) The Plan Administrator or delegate has the exclusive and discretionary right to interpret the appropriate plan provisions. The Plan Administrator or its delegate has the sole discretion to interpret the appropriate Plan provisions, and such decisions are conclusive and binding.

(d) To the extent not inconsistent with the provisions of the applicable Component

Benefit Plan, with respect to any civil action brought under the Plan, a claimant will be barred from bringing such civil action after one year from the date of exhausting the Plan's claims procedures relating to the denial of the claim. In the case of a group health plan claim discussed below, this includes not only exhausting the Plan's internal claims procedure but also exhausting the Plan's external claims procedure, where applicable.

Special Rules for Group Health Plan Claims

For purposes of ERISA, there are three categories of claims under a Component Benefit Plan that is a group health plan (e.g., medical, dental, vision, health care flexible spending account and EAP benefits), and each one has a specific timetable for approval, request for additional information, or denial of the claim. The three categories of claims are:

Urgent Care Claims - a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition or an insurance company or TPA (applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine) may determine if a claim is an Urgent Care Claim.

Pre-Service Claims - a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

Post-Service Claims - a request for payment for covered services you have already received.

Concurrent Care Claims – a request to extend an ongoing course of treatment beyond the period of time or number of treatments that has previously been approved under the Plan.

(a) Time for Decision on a Claim. The time deadline for making decisions on claims

under the Plan depends on the category of the claim. (See Time Limit Chart below for maximum time limits.) You will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, you will be notified orally and written notice will be provided to you within three days.

Note that fully-insured plan claims (if any) may be subject to an even more accelerated response time by the insurance company handling the claim. See Certificates of Coverage for details.

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information from you will be sent within the timeframes shown in the chart below and will specify what information is needed. You must provide the specified information to the Claim Fiduciary within 45 days after receiving the notice. The determination period will be suspended on the date the Claim Fiduciary sends a notice of missing information and the determination period will resume on the date you respond to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Fiduciary may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The notice of extension that you receive will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

(b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice if your claim is denied. The notice will contain the following information:

- (1) the specific reason or reasons for the adverse determination;
- (2) reference to the specific Plan provisions on which the determination was made;
- (3) a description of any additional material or information necessary to perfect your claim and an explanation of why this material or information is necessary;
- (4) a description of the Plan's review procedures and the time limits that apply to these procedures, including a statement of your right to bring a civil action under ERISA Section 502 if your claim is denied on review;
- (5) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;
- (6) if an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request; and
- (7) if the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination. The Plan

fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

(c) How to Appeal a Denied Group Health Plan Claim. If your claim is denied, you (or your attorney or other person authorized by you in writing to act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal such denial. If you fail to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review must contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Plan to review your appeal request and to notify you of its decision depends on the type of claim as follows:

Urgent Care Claim – 72 hours; you will be notified orally and written notice will be provided within three days.

Pre-Service Claim – 30 days if the Component Benefit Plan provides for only one mandatory appeal; 15 days for each appeal if the Component Benefit

Plan provides for two mandatory appeals.

Post-Service Claim – 60 days if the Component Benefit Plan provides for only one mandatory appeal; 30 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether that information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claim Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claim Fiduciary in deciding the initial claim. The Plan fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review. The notice will contain the following information:

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

(2) specific references to the pertinent plan provisions on which the denial is based;

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

(4) a statement about your right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination;

(5) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request; and

(6) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claim Fiduciary will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to your medical circumstances.

Also, upon request, the Claim Fiduciary will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Time Limit (Group Health Plan Claims)	Urgent Care*	Pre-Service*	Post-Service*
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days

* The Claim Fiduciary will decide the appeal of "Concurrent Care Claims" within the time frame set forth above depending on whether that claim is also an Urgent Care Claim and the request to extend care is not made at least 24 hours prior to the scheduled expiration of treatment, a Pre-Service Claim, or a Post-Service Claim and before the expiration of any previously approved course of treatment For an Urgent Care Claim that is a Concurrent Care Claim, if the request to extend care is made at least 24 hours prior to the scheduled expiration of the treatment, the initial claim determination will be made no later than 24 hours after such claim is filed with the Claim Fiduciary..

Special Internal Appeals Review Procedures Under the Affordable Care Act

Under the ACA, the following internal claims provisions apply to any "non-grandfathered," non-HIPAA-excepted coverage of the Plan based upon, generally whether the Plan is (1) fully-insured or (2) self-funded for any "Adverse Benefit Determination" (i.e., any medical claim or any claim involving a rescission of coverage).

- (a) A rescission is allowed only upon a finding of fraud or intentional misrepresentation of a material fact;
- (b) You must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. It must also provide you with any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to the new evidence or rationale;
- (c) Decisions regarding hiring, compensation, termination, promotion,

or other similar matters with respect to an individual by a claims adjudicator or medical expert may not be based on the likelihood that that person will support the denial of benefits due to that influence (this prohibition is to avoid conflicts of interest);

(d) Notices to claimants by the Plan or Claim Fiduciary must also include additional content as follows:

- (1) Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon your request, the diagnosis code and treatment code and their corresponding meanings will be provided as soon as practicable.
- (2) Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a

description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

(3) A description of available internal appeals and external review processes, including information about how to initiate an appeal.

(4) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

(5) Notices of any Adverse Benefit Determination must be in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to any claimant in the health plan who resides in a county in which ten percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in that other relevant non-English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Plan or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide assistance with filing claims and appeals.

(e) Generally, the Plan's or Claim Fiduciary's failure to adhere to the requirements of the ACA will allow you to deem the internal claims and appeals process "not in compliance" under the ACA, therefore declaring your claim procedure "exhausted." At this point, you may proceed to pursue any external review process or remedies available under ERISA or under State law, if applicable.

You may appeal this determination by requesting external review described in more detail, below.

Special State External Appeals Review Process Under the Affordable Care Act

You should be aware that the Department of Labor ("DOL") has given States a number of options to implement protections included in the external review process for any Adverse Benefit Determination that involves medical judgment (including, but not limited to, a determination regarding medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at this time), relating to *insured health benefits* (and certain self-funded arrangements which have been allowed by State law to be subject to the State's review rules). Please refer to the external appeals table identified here: https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

(a) A State may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections;

(b) A State may operate an external review process under "similar standards to those outlined in the July 2010"

interim final rule (These "similar standards" apply until January 1, 2018); or

(c) Where the State meets the "strict standards" or the "similar standards," your health plan is subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to you by the insurance company or the Plan.

Special Federal External Appeals Review Process Under the Affordable Care Act

Generally, Plans that are either *self-funded* (are not provided through insured health benefits) or *have not elected or are not eligible to qualify for the State review external appeals process* for any Adverse Benefit Determination are subject to Federal review process described below.

(a) You will have four months after the day you receive notice or are deemed notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination.

(b) The Plan or Claim Fiduciary has five business days from the date a claim is made to complete a preliminary review to determine if the claim is eligible for external review (determining whether you were covered (eligible) at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully.

(c) Within one business day after the preliminary review, the Plan or Claim Fiduciary will notify you in writing of its decision. If the claim is complete but not eligible for external review, you will

be provided with the reason for its ineligibility and as well as contact information for the Employee Benefits Security Administration. If the claim is incomplete, you will be provided with an explanation of what is necessary to complete the claim and the Plan Administrator or Claim Fiduciary must give you a reasonable time to complete the claim (i.e., the remainder of the four month appeal period or, if later, 48 hours after the notice of incompleteness).

(d) If you appeal an appealable final internal adverse benefits determination (or challenge whether or not it is appealable), your claim must be referred to an Independent Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally-recognized accrediting organization to conduct external reviews. The referral will occur through an unbiased selection process involving several IROs.

(e) Once assigned to the IRO, the IRO must make a determination on a non-Urgent Care Claim within forty-five (45) days after the IRO receives the assignment.

(f) If the IRO reverses the decision of the Plan or Claims Administrator, your payments or coverage must begin immediately, even if the Plan or Claims Administrator expects to appeal it to a court of law.

(g) You must also have a right to expedited review for an Urgent Care Claim upon request. Once assigned to the IRO, the IRO must make a determination as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after its receipt of the request. If the IRO's

notice of its determination is not provided in writing within 48 hours after the date of providing that notice it must provide written confirmation to you and the Plan.

(h) The contracts with the IROs must include the requirements contained in the DOL Technical Releases, and the IROs must agree, among other things, to the following: de novo review of all information and documents timely received (including the Plan document, claims records, health care professional recommendations, and clinical review criteria used, if any), retaining its records for six years and making them available to the applicable claimant (or to State and Federal government agencies, to the extent not in violation of any privacy laws) for examination upon request, and inclusion of certain information in notices to claimants.

The Plan intends and is taking steps in good faith to comply with the claims and appeals rules under the ACA and the provisions herein should be interpreted accordingly.

Special Rules for Disability Claims

A disability claim requires the Plan to determine if you are disabled for purposes of eligibility for disability benefits under a Component Benefit Plan. The Plan will notify you of its determination within 45 days after its receipt of your claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. If the Claim Fiduciary extends its period for reviewing a claim due to special circumstances, the notice of extension you receive will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. If more

information is requested during either extension period, you will have at least 45 days to supply it. The Plan will notify you of its initial claim determination in accordance with the procedures described in paragraph (b) under the heading "Special Rules for Group Health Plan Claims". You may appeal the Plan's determination within 180 days following receipt of an adverse determination in accordance with the procedures described in paragraph (c) under the heading "Special Rules for Group Health Plan Claims". The Plan will notify you of its determination on review within 45 days and in accordance with the procedures in paragraph (b) under the heading "General Claims Procedure." Otherwise, the general claims procedures apply, including the provisions relating to any Plan fiduciary's rights and responsibilities and the claims limitation period. Under special circumstances, the Claim Fiduciary may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. You have at least 45 days to provide the specified information.

Coverage While on Leave of Absence

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any

individual, and such language should be interpreted accordingly.

Family and Medical Leave Act Coverage

The Family and Medical Leave Act (“FMLA”) of 1993 generally applies to employers with 50 or more employees within a 75 mile radius. FMLA also requires you to have worked a certain number of hours and months in order to be eligible. If you have questions about whether or how FMLA applies to you, you should contact the Plan Administrator for more details. Where applicable it provides certain rights and options relating to your health plan coverage. Generally, this law requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. This family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee’s child after birth or placement for adoption or foster care; care for the employee’s spouse, child or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform the employee’s job.

FMLA was expanded for an eligible employee’s parents or immediate family members being called to active military duty status or in active military duty in the following ways: (1) the events for triggering family leave now include “qualifying exigencies” of covered service members. (See your Employer for details.) and (2) eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period care for covered service members with a serious injury or illness.

If you are eligible and choose to take FMLA leave, your Employer must maintain your health coverage under any “group health plan” on the same terms as if you had continued to work. Any changes to the group health plan during the time you are

on FMLA leave apply to you. Your Employer must also provide you with notice of any opportunity to change plans or benefits during your FMLA leave period.

Depending on your payment of plan premiums, you may be required to continue to pay premiums during FMLA leave. If you are 30 or more days late in making payment and your employer has given you written notice at least 15 days in advance advising that coverage will cease if payment is not received, you will be no longer covered, but upon your return to employment, the employer is required to restore your coverage. However, if you take FMLA leave and do not return to work after leave for a reason other than medical necessity, then you may be required to reimburse your employer for the payments made for your coverage during your leave.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of your leave. In addition, your Employer cannot require you to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends. Therefore, if you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an Employer's obligation to maintain health

benefits under FMLA ceases, such as if you notify the Employer of your intent not to return to work.

Military Service Leave (USERRA Coverage)

Any participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) will continue to participate and be eligible to receive benefits under any Component Benefit Plan that is a group health plan in accordance with USERRA rules and regulations.

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the “uniformed services”, which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meeting the following criteria:

- (a) you held the job prior to service;
- (b) you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
- (c) your cumulative period of service did not exceed five years;
- (d) you were not released from service under dishonorable or other punitive conditions; and
- (e) you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- (a) for less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- (b) for 31 to 180 day of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- (c) for 181 days or more of service – your must apply for reemployment no later than 90 days after completion of military service;
- (d) for service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

If you were covered under a Component Benefit Plan which is a group health plan immediately prior to taking a leave for service in the uniformed services, you may elect to continue your coverage under USERRA for certain periods required under USERRA, if you pay any required contributions toward the cost of your group health plan coverage during the leave. Any USERRA continuation coverage you elect will end earlier if one of the following events takes place:

- (a) You fail to make a premium payment (or premium equivalent) within the required time;
- (b) You fail to report to work or to apply for reemployment within the time

period required by USERRA following the completion of your service; or

(c) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or fewer, your contribution amount will be the same as for active employees, as long as you remain an active employee. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled “Other Continuation/Conversion Privileges.” If you elect USERRA coverage, you may not elect COBRA coverage during your military service. Likewise, if you elect COBRA continuation coverage during your military service, you may not elect USERRA coverage when your COBRA coverage ends.

If your coverage under the Plan terminated because of your service in the uniformed services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period required by USERRA. See the Plan Administrator for details.

Certain Federal Rights of Individuals Under Health Plans

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer’s control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any

individual, and such language should be interpreted accordingly.

Benefits for Adopted Children

If the group health plan under which you are covered provides benefits for dependent children, Misericordia University group health plan will extend benefits to dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants.

Children’s Health Insurance Program Reconciliation Act

The Children’s Health Insurance Program (“CHIP”) was created to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid yet cannot get private coverage. In the case of group health plans, amendments to CHIP designated “CHIPRA” and “MACRA” allow States to subsidize premiums for employer-provided group health coverage for eligible employees and their dependents. Each State in which an employee resides will choose whether it will implement this optional subsidy. CHIPRA and MACRA also allow for a special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage.

Generally, if you are eligible, you may be able to enroll in the employer’s group health plan within 60 days of losing coverage under the Medicaid or CHIP plan or within 60 days of becoming eligible for premium assistance under the Medicaid or CHIP plan. Find out if your State has CHIP and/or Medicaid available, and speak with your Plan Administrator for further details.

COBRA Rights

Employers who employ 20 or more employees are subject to the group health plan continuation provisions of

Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). Generally, where COBRA applies, if you or your eligible family members’ group health plan coverage ceases because of certain “qualifying events” specified in COBRA (such as termination of employment for reasons other than gross misconduct, reduction in hours, divorce, death, or a child’s ceasing to meet the definition of dependent), then you or your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You may also have coverage continuation rights under State insurance laws, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Information on State insurance law continuations is contained in the Certificate of Coverage (or its equivalent) which is incorporated by reference in **Appendix A**.

If you, your spouse, or your dependents lose coverage under the Plan because you experience a life event known as a “qualifying event,” you and/or your spouse and dependents may be eligible to elect continuation coverage under COBRA for the portions of the Plan that are a “group health plan” (e.g., medical, dental, vision, health reimbursement arrangement, telemedicine, expert medical opinion (in some cases) and health care flexible spending account (“health care FSA”) benefits).

You, your spouse, or your dependents experience a “qualifying event” under COBRA if your employment terminates (or your hours are reduced making you ineligible for participation) for reasons other than gross misconduct. Additionally, your spouse or your dependents may experience a “qualifying event” due to your divorce, legal separation, death, or entitlement to Medicare. If you (or your spouse or your dependents) experience one

of these qualifying events, and as a result lose coverage under the Plan, you (or your spouse or your dependents) may be eligible for COBRA.

To be eligible for COBRA in the event of a divorce or legal separation, or if your dependents become ineligible under the Plan, you, your spouse, and/or your dependents must notify the Plan Administrator (or third-party COBRA administrator, if any) as soon as possible after the qualifying event occurs, and no later than 60 days after the qualifying event occurs. You must provide this notice, in writing to the Plan Administrator (or third-party COBRA administrator, if any). In order to protect your rights, you should keep the Plan Administrator (or third-party COBRA administrator, if any) informed of any changes in the address of you, your spouse, and/or your dependents.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends (or after the employer stops contributing toward the other coverage) because of the qualifying event listed below. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Once the Plan Administrator (or third-party COBRA administrator, if any) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA. You may elect COBRA on behalf of your spouse who was covered under the group health plan at the time of

the qualifying event, and you or your spouse may elect COBRA on behalf of your eligible dependents that were covered under the group health plan at the time of the qualifying event.

The Plan Administrator (or third-party COBRA administrator, if any) will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after your participation ends or you receive this form, whichever is later. The Plan will offer COBRA continuation coverage only after the Plan Administrator (or third-party COBRA administrator, if any) has been notified that a qualifying event has occurred.

When the qualifying event is your death, your entitlement to Medicare benefits, your divorce or legal separation, or a dependent's losing eligibility as dependents, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is your termination of employment or reduction of hours of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries (other than you) may last for up to 36 months after the date of Medicare entitlement. In some situations (described below), COBRA may last up to 29 or 36 months. Otherwise, when the qualifying event is your termination of employment or reduction of hours, COBRA generally lasts for up to a total of 18 months. There are two ways in which the 18 month period of COBRA can be extended:

(a) *Disability Extension.* If you or any of your covered dependents is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator (or third-party COBRA administrator, if any) in a

timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18 month period of COBRA. To be eligible for this disability extension, you must notify the Plan Administrator (or third-party COBRA administrator, if any) of the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month COBRA period. However, if the ruling letter is received before COBRA eligibility begins, the letter must be provided within the first 60 days of electing COBRA. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator (or third-party COBRA administrator, if any) within 30 days after the SSA's determination.

(b) *Second Qualifying Event Extension.* If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependents can get up to 18 additional months of COBRA coverage, for a total maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator (or third-party COBRA administrator, if any) within 60 days of the occurrence of the second qualifying event. This extension may be available to your spouse and dependents receiving

COBRA if you die, become entitled to Medicare benefits, get divorced or legally separated, or if your dependent stops being eligible under the Plan as a dependent, but only if the event would have caused your spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

There are a few cases in which a COBRA participant or qualified beneficiary could lose COBRA coverage early. Such person is no longer entitled to COBRA if the participant who becomes covered under another group health plan, fails to make the required contributions on time, becomes entitled to Medicare benefits (under Part A and/or Part B or both, including if someone has also enrolled in Medicare Advantage), or the Employer ceases to provide any health plan benefits.

To continue your group health coverage, you and/or your covered dependents may be charged up to 102% of the full cost of coverage (or 150% in the case of an 11-month extension due to disability). You make this payment monthly during the 18, 29 or 36-month period of continuation coverage. The first premium payment must be received by the COBRA administrator within 45 days after the date of the COBRA election and must include your COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 30 days after the premium due date. Premium payments should be sent to the Plan Administrator's (or third-party COBRA administrator's, if any) address.

If health care FSA coverage is offered under the Plan, COBRA continuation for such coverage ends on the last day of the health care FSA plan year in which the qualifying event occurs, unless your Employer allows the carryover feature, allowing you to carry

over up to \$500 in unused health care FSA amounts to the next plan year. A COBRA qualifying beneficiary must be provided the health care FSA carryover option if it is provided to active health care FSA participants. The health care FSA carryover cannot last beyond the end of the applicable maximum COBRA coverage period (e.g., 18 months from the date of the COBRA qualifying event). However, COBRA will not be provided under the health care FSA if, as of the date of the qualifying event, you would not receive (during the remainder of the plan year) a benefit under the health care FSA that is more than the amount you would pay for COBRA for the remainder of that plan year. Any carryover permitted by your Employer must be included in determining whether the health care FSA is underspent.

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.

For more information about your rights under COBRA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov/.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act ("GINA") states that health benefit plans may not discriminate on the basis of genetic information relating to eligibility, premiums and contributions. In this regard,

GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by an employer, health plan, or “business associate” of the employer. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

You should be aware that where GINA applies genetic information is treated as protected health information (“PHI”) under another Federal law called “HIPAA.” The plan must provide that an employer cannot request or require that you reveal whether you have had genetic testing. Neither can your Employer require you to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums.

There is an exception to GINA’s general prohibition against acquiring you or your family’s genetic information where your Employer offers voluntary health or genetic services to employees or their family members. Some employers want to offer inducements for employees and their family members to answer questions about their health or to take medical examinations as part of a wellness program; however, your Employer may only offer a limited incentive for your spouse to provide information about his or her current or past health status as part of a voluntary wellness program.

[HIPAA Rules](#)

Information you provide for purposes of a health plan sponsored by the Employer may be PHI under Privacy Standards established under the Health Insurance Portability and Accountability Act (“HIPAA”). Where HIPAA applies, such plan will be operated in accordance with such law and laws that affect this law such as GINA, which makes it clear that genetic information is also PHI. If

you have questions about this law, you should contact the Plan Administrator.

Regarding HIPAA portability, some group health plans are subject to HIPAA portability rules while others are not. Group health plans that are generally not subject to HIPAA portability (and therefore are considered “HIPAA-excepted coverage”) include for example certain limited dental and vision plans, as well as long-term care, nursing home care, home health care, or community-based care, specified disease or illness, hospital indemnity or other fixed indemnity, and most FSAs.

In addition, a group health plan that is subject to HIPAA portability must comply with the following:

If a group health plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of that injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Note that pre-existing condition exclusions are now prohibited for group health plans.

[Mental Health Parity Act](#)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) generally applies to employers that employ more than 50 employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, co-insurance and

out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

To the extent that non-Grandfathered small group plans are required to provide essential health benefits, including mental health and substance abuse disorder benefits, for plan years beginning on or after July 1, 2014, such benefits must comply with the final rules issued by the DOL on November 13, 2013.

[Michelle's Law](#)

Many health plans extend health coverage to dependents of an employee where they have dependent full-time college students under a certain age. In such a case, a certification of student status may be required by the Plan Administrator for continued coverage under the health plan. Group health plans must provide extended coverage to any of the Participant's dependents who is a full-time student in a postsecondary educational institution that would otherwise lose coverage because of taking medically necessary leave due to a serious illness or injury.

If you have a dependent who is a full-time student with a serious illness or injury, that dependent may be eligible for protection under Michelle's Law. Your Employer may require you to provide written certification of the condition from the child's treating physician in order for your child to be eligible.

If your child is deemed eligible under Michelle's Law, extension of coverage is required for up to 12 months or, if earlier,

the date the coverage would otherwise end under the Component Benefit Plan.

While the Affordable Care Act provision that requires extension of coverage for dependents until the end of the month in which a dependent reaches age 26 will often make reliance upon Michelle's Law unnecessary, Michelle's Law still will have relevance in certain circumstances such as its applicability to HIPAA-excepted coverage (to which the ACA does not apply).

[Newborns' and Mothers' Health Protection Act](#)

Group health plans 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 normal 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 the above periods. In any case, such plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods.

[Qualified Medical Child Support Orders](#)

The Employer's group health plans will provide benefits as required by any qualified medical child support order ("QMCSO") in accordance with ERISA. The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

[Patient Protection and Affordable Care Act](#)

The Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") of

2010 requires the modification of group health plans in a number of ways. Some of these significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for group health plans *that are neither grandfathered nor HIPAA-excepted coverage*:

(a) If you need to receive emergency services in the emergency department of a hospital, you do not need prior authorization, and your cost-sharing obligations (including co-payments and co-insurance) will be the same whether you are treated at a hospital that is in-network or out-of-network. You are not required to receive prior approval as would be applied to care received by preferred providers; however, you may be responsible for the allowed amount under your plan and what is billed by a non-network provider, to the extent permitted by the ACA;

(b) Coverage of minimum preventive care services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special provisions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women;

(c) If your health plan requires you to select a primary care physician (“PCP”), the group health plan or health insurer may designate one for you automatically. In some circumstances, you can designate any participating PCP (who participates in the network and who is accepting new patients) as your PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered dependent child; if the group health

plan designates a PCP automatically, until you make this designation, the group health plan or health insurer will designate one for you. Where selection of a PCP is required or allowed, contact the Plan Administrator or insurer at the telephone numbers listed as contacts under **Appendix A** for information on the selection process;

(d) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or insurer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the 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 the Plan Administrator or insurer at the telephone numbers listed as contacts under **Appendix A**; and

(e) Internal appeal and external review claim procedures are revised as provided in the “Claims Procedures” section of this SPD.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for *health plans that are not HIPAA-excepted coverage*:

(a) Any lifetime or annual maximum may not be imposed on the following benefits to the extent that they are covered under the Plan: ambulatory

patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (collectively, "Essential Health Benefits"). For purposes of determining whether a benefit or service is an essential health benefit relating to permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan must choose a benchmark state;

(b) No rescissions in health plan coverage will be allowed except for fraud or an intentional misrepresentation of a material fact and will require 30 calendar days' advance notice to an individual before coverage is rescinded; and

(c) If you have elected coverage for your dependents under your health plan, your child (including step-child, legally adopted child, a child placed for adoption and a child under a QMCSO or National Support Notice) can be covered until the end of the month in which a child turns age 26 regardless of the child's tax dependent status.

The above includes certain minimum provisions of the ACA. In certain cases, a Component Benefit Plan's Certificate of Coverage may be more generous than the ACA requires. Therefore, you should review the Certificate of Coverage for details.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also

provide coverage in a manner determined in consultation with the attending physician and the patient for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Component Benefit Plan identified in **Appendix A**. Call your Plan Administrator for more information.

Wellness Program

In some circumstances, the Plan may offer wellness programs designed to promote the health and well being of all employees. Some examples of wellness programs include, but are not limited to: providing financial incentives to engage in activities that encourage health lifestyle changes, providing you with information about your current health condition by undergoing health screenings or answering questionnaires, giving you the opportunity to receive health coaching, and participating in disease management programs.

These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Employer money.

Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of

open enrollment material or other communications.

Under the Americans with Disabilities Act (“ADA”), any wellness program that includes disability-related inquiries or medical examinations for employees must be voluntary, meaning that it may not (i) require any employee to participate; (ii) deny any employee who does not participate in a wellness program access to health coverage or prohibit any employee from choosing a particular plan; and (iii) take any other adverse action or retaliate against, interfere with, coerce, intimidate, or threaten any employee who chooses not to participate in a wellness program or fails to achieve certain health outcomes. Employers must also provide a notice that clearly explains what medical information will be obtained, how it will be used, who will receive it, and the restrictions on disclosure. Finally, an employer must comply with certain incentive limits.

Under the ADA, any wellness program must also be reasonably designed to promote health or prevent disease, meaning that it cannot (i) require an overly burdensome amount of time for participation; (ii) involve unreasonably intrusive procedures; (iii) be a subterfuge for violating the ADA or other laws prohibiting employment discrimination; or (iv) require employees to incur significant costs for medical examinations.

Any wellness program related to financial incentives offered under the Plan must comply with the requirements and limitations of HIPAA, the ACA, the ADA and related guidance. For example, where a wellness program subject to HIPAA is offered under the Plan, a reward may be offered based on certain standards of achievement. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable

for you to attempt to achieve the standards for the reward under this program, call the Plan Administrator, and we will work with you to develop another way to qualify for the reward.

Employer’s Rights under the Plan

Employer’s Right to Change or End the Plan

Misericordia University reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Plan, in whole or in part at any time. Any affiliated employer reserves the right to withdraw from and terminate its participation in the Plan or Component Benefit Plan, thereby terminating, suspending, amending or modifying the Plan as to its Plan participants. Generally, unless specifically provided otherwise in an underlying document relating to the applicable Component Benefit Plan, any amounts remaining in the Plan at termination will be distributed as if they were insurance company refunds/rebates (see heading “Insurance Company Refund”).

Employer’s Right to Interpret the Plan

Misericordia University has the right to appoint the Plan Administrator of the Plan. The Plan Administrator has discretion to interpret the provisions of the Plan and any Component Benefit Plan, to make factual determinations, and to delegate such authority. The Plan Administrator’s and/or delegate’s interpretations and decisions are conclusive and binding on all Plan participants.

Employer’s Right of Reimbursement

To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Plan, the

following provisions will control as to any Component Benefit Plan.

The Plan does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). If an employee, spouse, or dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A** (a "Covered Individual") incurs expenses and receives benefits from the Plan or its carrier(s) as a result of an injury or accident caused by the action of a third party, immediately upon payment of any benefits under the Plan, the Plan will be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Plan.

As a condition to participation in or the receipt of benefits under the Plan, a Covered Individual agrees that if such person receives or is entitled to any reimbursement or any other financial recovery from any source, including such Covered Individual's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by an employer, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such injury or illness, the Plan has the right to recover the amounts the Plan has paid or will pay as a result of that injury, from any amounts a Covered Individual received from any party, and the Plan has a lien on any such recovery. Similarly, if any person, including any natural person or entity, other than a Covered Individual has possession of funds

recovered from a third party as to which any Covered Individual has or had a claim, then the Plan will be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. By participating in and accepting benefits under the Plan in connection with such an injury or illness, a Covered Individual agrees and is bound to assist the Plan in its attempt to recover from that person, assigns any recovery to the Plan and authorizes such Covered Individual's attorney, personal representative, or insurance company to reimburse the Plan. In the event that a Covered Individual is deceased, the Plan has a right to recover funds from such Covered Individual's estate pursuant to this reimbursement provision. The Plan will not pay attorney fees or costs associated with any Covered Individual's claims without prior express written authorization by the Plan, which the Plan may grant or withhold in its sole discretion. In this regard, the Plan will not be subject to any "make whole" or other subrogation rule that may otherwise apply by law that reduces its right to recover the full amount of its loss unless the Plan has expressly agreed to do so in writing. Rather, the Plan is entitled to full reimbursement:

(a) before the Covered Individual is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Individual has other costs or suffered other injuries not paid for or compensated by the Plan (notwithstanding any "Make Whole Doctrine");

(b) without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;

(c) without reduction for attorneys' fees and other costs incurred by the Covered Individual in making a recovery without the prior express written consent of the Plan (notwithstanding any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine"); and

(d) notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.

A Covered Individual, and individuals acting on a Covered Individual's behalf, including attorneys, will do nothing to prejudice the Plan's subrogation and reimbursement rights and will, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is your duty, and the duty of individuals acting on your behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when you give notice to any other party, including an attorney, of your intention to pursue or investigate a claim to recover damages on behalf of a Covered Individual. The payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:

(a) informing the Plan Administrator of the action to be taken by the Covered Individual;

(b) agreeing (in such form and to such documents as the Plan may require) to the Plan being reimbursed from any recovery from a third party and subrogated to any right of recovery the Covered Individual has against a third party;

(c) refraining from action which would prejudice the Plan's subrogation rights

(including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan); and

(d) cooperating in doing what is reasonably necessary to assist the Plan in any recovery.

If the Covered Individual should fail or refuse to comply with these subrogation and right of reimbursement provisions, the Covered Individual is not entitled to benefits under the Plan and must reimburse the Plan for any and all costs and expenses, including attorneys' fees, incurred by the Plan in enforcing its rights hereunder. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described here in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

For purposes of this section, "reimbursement" includes all direct and indirect payments to a Covered Individual for injury or illness from any source, by way of settlement, judgment, or any other means, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage, and homeowner's insurance.

Other Continuation / Conversion Privileges

You may be eligible for continuation of coverage under a COBRA-type continuation of coverage arrangement mandated in the State to which your coverage applies (for

example, California, New York, or Georgia) for certain insured benefits. The availability of this continuation coverage and the rules concerning eligibility should be set forth in the policy of the insurance company allowing the continuation of coverage. Since the time period for exercising your right to elect continuation of coverage may be limited, you must inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

Also, when you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage), you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility should be set forth in the policy of the insurance company allowing the conversion privilege. Since the time period for exercising your conversion privileges may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

ERISA Rights

You are entitled to certain rights and protections under ERISA. ERISA provides that Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including any applicable insurance contracts and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) where required to be filed by the Plan with the U.S. Department of Labor and available at

the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any applicable insurance contracts, and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (Form 5500), if any is required by ERISA to be prepared. Where the annual financial report must be prepared, the Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for yourself or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the group health plans for the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your Employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your

benefits under the Plan or exercising your rights under ERISA.

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

- Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any is required to be prepared, from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$147 a day (not to exceed \$1,472 per request) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these

costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your benefits or the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

Appendix A: Component Benefit Plans

*The information below is effective July 1, 2017,
unless otherwise indicated below.*

Component Benefit Plans Offered Under the Plan

Below is a list of each Component Benefit Plan and the eligibility and participation requirements of those plans. Also listed is the name (and in the case of group health plan claims, the address and telephone number) of the individual insurance company that provides benefits (if any) and reviews claims relating to its insurance policy. Also below may be a list of the name and address of the TPA (if any) that reviews claims made under a Component

Benefit Plan as well as the telephone number to call for questions regarding claims procedures and forms.

Generally, unless otherwise indicated below or as provided in **Appendix B**, an eligible employee under the Plan is any regular common-law employee of Misericordia University who is not a leased employee, contract worker or independent contractor, seasonal employee, variable hour employee, or former employee, and such regular common-law employee is eligible to participate in and receive benefits under one or more of the Component Benefit Plans. Non-resident aliens are also not eligible unless specifically included under "Eligible Employees" below. To determine whether you are eligible to participate in a Component Benefit Plan, please read the eligibility information below for the applicable Component Benefit Plan.

Group Medical PPO Attachment 1	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, Subject to Employer's Section 125 Cafeteria/POP Plan Document
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Geisinger Health; P.O. Box 8200; Danville, PA 17821; 800-504-0443
Grandfathered Health Plan	No
Look-Back Provisions	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Group Medical HMO Attachment 2	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, Subject to Employer's Section 125 Cafeteria/POP Plan Document
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Geisinger Health; P.O. Box 8200; Danville, PA 17821; 800-504-0443
Grandfathered Health Plan	No
Look-Back Provisions	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Group Dental Attachment 3	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, Subject to Employer's Section 125 Cafeteria/POP Plan Document
Funding Arrangements	Insured Benefit Program
Insurance Carrier	United Concordia; P.O. Box 69421; Harrisburg, PA 17106-9421; 800-332-0366
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Group Vision Attachment 4	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, Subject to Employer's Section 125 Cafeteria/POP Plan Document
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Vision Benefits of America; P.O. Box 6400272; Pittsburgh, PA 15264-0272; 800-432-4966
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Group Life with Employee Assistance Program Attachment 5	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Group Life: None EAP: All Members of Household
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna Group Insurance; Lehigh Valley Service Center; P.O. Box 20643; Lehigh Valley, PA 18002-0643; 800-331-9548
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Group AD&D Attachment 6	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna Group Insurance; Lehigh Valley Service Center; P.O. Box 20643; Lehigh Valley, PA 18002-0643; 800-331-9548
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Voluntary Life Attachment 7	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna Group Insurance; Lehigh Valley Service Center; P.O. Box 20643; Lehigh Valley, PA 18002-0643; 800-331-9548
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Voluntary AD&D Attachment 8	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna Group Insurance; Lehigh Valley Service Center; P.O. Box 20643; Lehigh Valley, PA 18002-0643; 800-331-9548
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Long Term Disability Attachment 9	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna Group Insurance; Lehigh Valley Service Center; P.O. Box 20643; Lehigh Valley, PA 18002-0643; 800-331-9548
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Health Flexible Spending Account Attachment 10	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week or at Least 130.0 Hours of Service in a Calendar Month
Participation Begins *	On 1st of Month Coinciding with or Following Date of Employment
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	Part-Time Employees, Temporary Employees, and Seasonal Employees
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	Yes, Subject to Employer's Section 125 Cafeteria/POP Plan Document
Funding Arrangements	Insured Benefit Program
Insurance Carrier	TASC; 2302 International Lane; Madison, WI 53704; 800-422-4661
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Appendix B: Look-Back Provisions

Please see your Plan Administrator for additional information on whether your Employer has adopted the optional look-back language.

INSERT

**GEISINGER HEALTH
GROUP MEDICAL PPO
CERTIFICATE OF COVERAGE**

HERE

INSERT

**GEISINGER HEALTH
GROUP MEDICAL HMO
CERTIFICATE OF COVERAGE**

HERE

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366 (TTY: 711) まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.

UNITED CONCORDIA

UNITED CONCORDIA

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan Certificate of Insurance

Network Plan

Misericordia University
250097000
July 1, 2017

In AL, United Concordia is underwritten by
United Concordia Dental Corporation of Alabama

In AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MN, MI, MS,
MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY,
United Concordia is underwritten by
United Concordia Insurance Company

In DE, DC, IL, KY, MD, MO, NC, NJ, PA, United Concordia is underwritten by
United Concordia Life and Health Insurance Company

In NY, United Concordia is underwritten by
United Concordia Insurance Company of New York

**Notice to Florida residents: The benefits of the policy providing your
coverage are governed by a state other than Florida.**

CERTIFICATE OF INSURANCE

INTRODUCTION

This Certificate of Insurance provides information about Your dental coverage. Read it carefully and keep it in a safe place with Your other valuable documents. Review it to become familiar with Your benefits and when You have a specific question regarding Your coverage.

To offer these benefits, Your Group has entered into a Group Policy of insurance with United Concordia. The benefits are available to You as long as the Premium is paid and obligations under the Group Policy are satisfied. In the event of conflict between this Certificate and the Group Policy, the Group Policy will rule. This Certificate is not a summary plan description under the Employee Retirement Income Security Act (ERISA).

If You have any questions about Your coverage or benefits, please call our Customer Service Department toll-free at:

800-332-0366

For general information, Participating Dentist or benefit information, You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421

9804-B (02/13)

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Attached:

- Appeal Procedure Addendum
- State Law Provisions Addendum
- Schedule of Benefits
- Schedule of Exclusions and Limitations

DEFINITIONS

Certain terms used throughout this Certificate begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and the way the dental Plan works.

Annual Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits.

Authorized Entity – A Health Insurance Marketplace or other entity authorized by law or regulation through which individuals and groups can purchase insurance to meet the requirements of the federal Affordable Care Act.

Certificate Holder(s) - An individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid. In the case of a Group Policy that covers only dependent children, the Certificate Holder must be the child's or children's parent, stepparent, legal guardian, or legal custodian.

Certificate of Insurance ("Certificate") - This document, including riders, schedules, addenda and/or endorsements, if any, which describes the coverage purchased from the Company by the Policyholder.

Coinsurance - Those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of either the Certificate Holder or his/her enrolled Dependents after the Company pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

Company - United Concordia, the insurer.

Contract Year- The period of twelve (12) months beginning on the Group Policy's Effective Date or the anniversary of the Group Policy's Effective Date and ending on the day before the Renewal Date.

Coordination of Benefits ("COB") - A method of determining benefits for Covered Services when the Member is covered under more than one plan. This method prevents duplication of payment so that no more than the incurred expense is paid.

Cosmetic - Services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

Covered Service(s) - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a Dentist.

Deductible(s) - A specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Company will pay any benefit.

Dentally Necessary - A dental service or procedure is determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the Dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final.

Dentist(s) – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dependent(s) – Those individuals eligible to enroll for coverage under the Group Policy because of their relationship to the Certificate Holder.

This Group Policy is a Family Policy. Dependents eligible for coverage in this Family Policy include:

1. The Certificate Holder's spouse; and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
 - (a) until the end of the month that the child reaches age 26; or
 - (b) until the end of the month that the child reaches age 26 if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
 - (c) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

Effective Date - The date on which the Group Policy begins or coverage of enrolled Members begins.

Exclusion(s) – Services, supplies or charges that are not covered under the Group Policy as stated in the Schedule of Exclusions and Limitations.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company, determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The Company will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

Family Policy – A Group Policy that covers the Policyholder's Certificate Holders and may also cover eligible Dependents, as defined in this Certificate. A Group Policy that covers only Certificate Holders' children is not a Family Policy.

Grace Period - A period of no less than thirty-one (31) days after Premium payment is due under the Group Policy, in which the Policyholder may make such payment and during which the protection of the Group Policy continues, subject to payment of Premium by the end of the Grace Period.

Group Policy - The agreement between the Company and the Policyholder, under which the Certificate Holder is eligible to enroll him/herself and/or his/her Dependents.

Lifetime Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Group Policy, as shown on the Schedule of Benefits.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between Us and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit Out-of-Pocket Expenses of Members choosing Non-Participating Dentists.

Member(s) – Enrolled Certificate Holder(s) and their enrolled Dependent(s). Also referred to as “You” or “Your” or “Yourself”.

Non-Participating Dentist - A Dentist who has not signed a contract with Us to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policy's Limitations or Maximums, or for services that are Exclusions. The Certificate Holder is responsible to pay for Out-of-Pocket Expenses.

Out-of-Pocket Maximum – The limit on the Deductibles and Coinsurance for Covered Services provided by Participating Dentists that the Certificate Holder is required to pay in a calendar year or Contract Year, as shown on the Schedule of Benefits. After this limit is reached, Covered Services from Participating Dentists are paid 100% by Us for the remainder of the calendar year or Contract Year unless subject to the Schedule of Exclusions and Limitations.

Participating Dentist - A Dentist who has executed a Participating Dentist Agreement with Us, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder - Organization that executes the Group Policy. Also referred to as "Your Group".

Premium - Payment made by the Policyholder in exchange for coverage of the Policyholder's Members under this Group Policy.

Renewal Date - The date on which the Group Policy renews. Also known as "Anniversary Date".

Schedule of Benefits - Attached summary of Covered Services, Coinsurances, Deductibles, Waiting Periods and maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations – Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

Special Enrollment Period – The period of time outside Your Group's open enrollment period during which eligible individuals who experience certain qualifying events may enroll as Certificate Holders or Dependents in this Group Policy.

Spouse – The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in the state where this Group Policy is issued.

State Law Provisions Addendum – Attached document, if any, containing state law requirements that modify, delete, and/or add provisions to the Certificate of Insurance.

Termination Date - The date on which the dental coverage ends for a Member or on which the Group Policy ends.

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for certain Covered Services as shown on the attached Schedule of Benefits.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Policy. If You are enrolling through an Authorized Entity, You must meet any additional eligibility requirements of that Authorized Entity and supply enrollment information to it. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Policyholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Policy Effective Date and Your enrollment information and applicable Premium are supplied to Us, Your coverage will begin on the Group Policy Effective Date.

If You are not eligible to be a Member on the Group Policy Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within thirty-one (31) days of the date You meet all applicable eligibility requirements.

Coverage for Members enrolling after the Group Policy Effective Date will begin on the date specified in the enrollment information supplied to Us provided Premium is paid.

The Company is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents. These Special Enrollment Period life change events include:

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- loss of other coverage;
- marriage or other lawful union between two adults.

If You enrolled through Your Group, to enroll a new Dependent as a result of one of these events, You must supply the required enrollment change information within the Special Enrollment Period that is thirty-one (31) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

If You enrolled through an Authorized Entity, there are additional life change events that may permit You to add or remove Dependents or change Plans. In addition to the life change events noted above, the additional Special Enrollment Period events that apply to participation through an Authorized Entity include changes in:

- state of residence;
- incarceration status;
- citizenship, status as a national or lawful presence;
- income, except when You did not request from the Authorized Entity an eligibility determination for insurance affordability programs.

The Special Enrollment Period during which You must supply the required enrollment change information to the Authorized Entity is thirty (30) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to Us or on the date dictated by the Authorized Entity, as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day

period, the child's enrollment information must be provided to Us and the required Premium must be paid within the thirty-one (31) day period.

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within ninety (90) days after the child attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must be supplied to Us within thirty (30) days after the child attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within thirty (30) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member's physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods.

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group unless otherwise permitted by applicable law or regulation intended to implement the federal Affordable Care Act, or specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Participating Dentist, You may limit Your Out-of-Pocket Expense. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Plan. Participating Dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit Our website at www.unitedconcordia.com or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

If You use a Non-Participating Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

BENEFITS

Covered Services

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary unless otherwise specified in a Rider to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

Predetermination

A predetermination is a request for Us to estimate benefits for a dental treatment You have not yet received. Predetermination is not required for any benefits under the Plan. In estimating benefits, We look at patient eligibility, Dental Necessity and the Plan's coverage for the treatment. Payment of benefits for a predetermined service is subject to Your continued eligibility in the Plan. At the time the claim is paid, We may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with Your current Plan and applicable Annual Maximums, Lifetime Maximums, or Out-of-Pocket Maximums on the date of service.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Participating Dentist rendering the service.

If You receive treatment from a Non-Participating Dentist, We will send payment for Covered Services to You unless You the claim indicates that payment should be sent directly to Your treating Dentist. This is called assignment of benefits, and it is available for care delivered by Non-Participating Dentists outside of Pennsylvania and West Virginia. You will be notified of the services covered, Our payment and any Out-of-Pocket Expenses. You will be responsible to pay the Dentist any difference between Our payment and the

Dentist's full charge for the services. Non-Participating Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

The Company does not disclose claim or eligibility records except as allowed or required by law and then in accordance with federal and state law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You or from the person or Dentist to whom it was paid. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan, and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. When used in this Coordination of Benefits section, the following words and phrases have the definitions below:
 - A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
 - B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
 - C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of \$100 per day or less.
 - D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
 - E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
 - F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.
2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.
3. In order to determine which plan is primary, this Plan will use the following rules.
 - A) If the other plan does not have a provision similar to this one, then that plan will be primary.

- B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
- C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
- 1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - 2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
 - 3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
 - 4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
- D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
- 1) First, the plan of the parent with custody of the child.
 - 2) Then, the plan of the Spouse of the parent with the custody of the child; and
 - 3) Finally, the plan of the parent not having custody of the child.
 - 4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
 - 5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
- E) Active/Inactive Member
- 1) For actively employed Members and their Spouses over the age of sixty-five (65) who are covered by Medicare, the plan will be primary.
 - 2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
- F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
- G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.
4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.
5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.
6. Right of Recovery -- If the payment made by the Company is more than it should have paid under this COB provision, the Company may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

Review of a Benefit Determination

If You are not satisfied with a benefit determination or payment, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate or on Your ID card. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

Value-Added Programs and Services

From time to time, We offer Members access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact Your Group or call Customer Service for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Members.

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

- when You no longer meet Your Group's eligibility requirements; or
- when Premium payment ceases for You; or
- when you no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate; or
- when You no longer meet other eligibility requirements imposed by an Authorized Entity; or
- on the termination date specified for You by Authorized Entity.

On the date the Certificate Holder's coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end unless otherwise specified in any applicable addendum or endorsement to this Certificate. If the Group Policy is cancelled, Certificate Holder and Dependent coverage will end on the Group Policy Termination Date.

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.

Benefits After Coverage Terminates

We are not liable to pay any benefits for services, including those predetermined, that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Certificate Holder's reduction of work hours or termination of employment for any reason other than gross misconduct. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If applicable, You must elect to continue coverage within sixty (60) days from Your qualifying event or from notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing and thereafter attached hereto as part of this Certificate.

The Company may assign this Certificate and its rights and obligations hereunder to any entity under common control with the Company.

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the state indicated on the State Law Provisions Addendum.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

This Addendum is effective on the Effective Date stated in the Group Policy. It is attached to and made part of the Certificate.

If You are dissatisfied with Our benefit determination on a claim, You or Your Authorized Representative may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your Authorized Representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your Authorized Representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

“Adverse Benefit Determination” is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not Medically Necessary or not appropriate.

“Authorized Representative” is a person granted authority by You and the Company to act on Your behalf regarding a Claim for Benefits or an appeal of an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

“Claim for Benefits” is a request for a plan benefit or benefits by You in accordance with the Plan’s reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

“Pre-service Claim” is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

“Post-service Claim” (“Claim”) is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

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

- a) if it was relied on in making the benefit determination;
- b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
- c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
- d) or if it is a statement of the Plan’s policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURE FOR PRE-SERVICE CLAIM

You or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

- a) The specific reason for the appeal decision;
- b) A reference to specific plan provisions on which the decision was based;
- c) A statement that You or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
- d) A statement of Your or Your Authorized Representative's right to bring a civil action under ERISA; and
- e) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

PROCEDURE FOR POST-SERVICE CLAIM

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

- a) the specific reason for the appeal decision;
- b) reference to specific plan provisions on which the decision was based;
- c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
- d) a statement of Your right to bring a civil action under ERISA; and
- e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

PENNSYLVANIA STATE LAW PROVISIONS ADDENDUM

TO

CERTIFICATE OF INSURANCE

This addendum is effective on the Effective Date as stated in the Certificate of Insurance "Certificate" and attached to and made part of the Certificate.

The following provision is substituted for the Dependents definition in the section entitled DEFINITIONS in this Certificate:

Dependent(s) – Those individuals eligible to enroll for coverage under the Group Policy because of their relationship to the Certificate Holder.

This Group Policy is a Family Policy. Dependents eligible for coverage in this Family Policy include:

1. The Certificate Holder's spouse; and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
 - (a) until the end of the month that the child reaches age 26; or
 - (b) until the end of the month that the child reaches age 26 if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
 - (c) when an enrolled full-time student's education is interrupted by military service, until the end of the period beyond the limiting age, equal to the duration of the enrolled full-time student's service of thirty (30) or more consecutive days on active duty for any reserve component of the United States armed forces or the Pennsylvania National Guard, including State duty or until said enrollee is no longer a full-time student, whichever is sooner; or
 - (d) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

The following provision is added to the Enrollment Changes sub-section of the ELIGIBILITY AND ENROLLMENT section of this Certificate:

Adoptive children may be enrolled up to 60 days from placement.

When an enrolled, full-time student's education is interrupted by military service as detailed in the Definition of Dependent of this Certificate, enrollment may be extended beyond the limiting age for dependent children. To qualify for the extension, the Member must submit the required Department of Military and Veterans Affairs (DMVA) forms to notify Us of placement on active duty, of completion of active duty and of re-enrollment as a full-time student for the first term or semester starting sixty (60) or more days after release from active duty. The DMVA forms are available online at www.dmv.state.pa.us.

The restriction on enrolling new Dependents only during open enrollments when the Member fails to enroll them within thirty-one (31) days of a life change event does not apply to Dependent children of a Member subject to a court or administrative order of support relating to the provision of health care coverage.

The following sub-sections are added to the section entitled **HOW THE DENTAL PLAN WORKS** in this Certificate:

Notice of Claim

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than thirty (30) days from receipt of due written proof of such loss. The Company may extend this thirty-day period by no more than fifteen (15) days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

All benefits under this policy shall be payable to the Participating Dentist or the Member, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Member be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

Physical Examinations

The Company at its own expense shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been filed in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

The following provisions are added to the GENERAL PROVISIONS section of this Certificate:

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of Commonwealth of Pennsylvania.

All statements made by the Policyholder or applicant or Member shall, in the absence of fraud, be deemed representations and not warranties. No statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in a written instrument and signed by the Policyholder, a copy of which has been furnished to the Policyholder or the Certificate Holder or his/her beneficiary.

Termination – When Coverage Ends

The following provision under the Termination- When Coverage Ends section of this certificate,

“If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.”

Is replaced with:

“If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the first day following the end of the Grace Period.”

FEDERAL LAW SUPPLEMENT
TO
CERTIFICATE OF INSURANCE

This Supplement amends your Certificate by adding the following provisions regarding special enrollment periods and extended coverage requirements currently mandated or that may be mandated in the future under federal law.

You may enroll for dental coverage at any time for yourself and your dependents if:

- (1) You or your dependent either loses eligibility for coverage under Medicaid or the Children's Health Insurance Program ("CHIP"); or
- (2) You or your dependent becomes eligible for premium assistance from Medicaid or CHIP allowing enrollment in a benefit program.

In order to enroll, you must submit complete enrollment information to your group or its plan administrator within sixty (60) days from your or your dependent's loss of coverage or eligibility for premium assistance, as the case may be.

Other special enrollment periods and rights may apply to you or your dependents under new or existing federal laws. Consult your group, its plan administrator or your group's summary plan description for information about any new or additional special enrollment periods, enrollment rights or extended coverage periods for dependents mandated under federal law.

UNITED CONCORDIA
ADDENDUM
TO
GROUP POLICY AND CERTIFICATE OF INSURANCE

This Addendum is effective on the Effective Date as stated in the Group Policy and attached to and made part of the Group Policy and Certificate of Insurance.

The following language is added to the Group Policy and Certificate of Insurance:

The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.

Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.

Schedule of Benefits

Concordia Flexsm

Group Name: *Misericordia University*

Group Number: 250097000

Effective Date: July 1, 2017

	<u>Plan Pays</u>
<i>Class I Services</i>	
• Exams	100%
• All X-Rays	100%
• Cleanings & Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
<i>Class II Services</i>	
• Space Maintainers	100%
• Basic Restorative (Fillings, etc.)	100%
• Endodontics	100%
• Simple Extractions	100%
• Complex Oral Surgery	100%
• General Anesthesia	100%
<i>Class III Services</i>	
• Non-Surgical Periodontics	50%
• Repairs of Crowns, Inlays, Onlays	50%
• Repairs of Bridges	50%
• Denture Repairs	50%
• Surgical Periodontics	50%
• Inlays, Onlays, Crowns	50%
• Prosthetics (Bridges, Dentures)	50%
<i>Orthodontics</i>	
• Diagnostic, Active, Retention Treatment	50%
• Limited to Dependent children under the age of 19	

Deductibles & Maximums

- \$0 per Contract Year Deductible per Member
- \$1000 per Contract Year Maximum per Member
- \$800 Lifetime Maximum per Member for Orthodontics

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

For Group Policies issued and delivered in Maryland, this exclusion does not apply.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (night grinding of teeth).
22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:
 - part of a service but are reported as separate services; or
 - reported in a treatment sequence that is not appropriate; or
 - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".

28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every 36 months.
2. Bitewing x-rays – one (1) set(s) per 6 months.
3. Oral Evaluations:
 - Comprehensive and periodic – one (1) of these services per 6 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
 - Limited problem focused and consultations – one (1) of these services per dentist per patient per 12 months.
 - Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis – one (1) per 6 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment – one (1) per 6 months under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants – one (1) per tooth per 3 year(s) under age eleven (11) on permanent first molars and under age sixteen (16) on permanent second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fourteen (14).
9. Periodontal Services:
 - Full mouth debridement – one (1) per lifetime.
 - Periodontal maintenance following active periodontal therapy – four (4) per 12 months in addition to routine prophylaxis.
 - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
 - Surgical periodontal procedures – one (1) per 24 months per area of the mouth.
 - Guided tissue regeneration – one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
 - Basic restorations – not within 12 months of previous placement of any basic restoration.
 - Single crowns, inlays, onlays – not within 5 year(s) of previous placement of any of the procedures in this category.
 - Buildups and post and cores – not within 5 year(s) of previous placement of any of the procedures in this category.
 - Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 36 months thereafter.
12. Pulpal therapy – one (1) per eligible tooth per lifetime only when there is no permanent tooth to replace it.
13. Root canal retreatment – one (1) per tooth per lifetime.
14. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Payment for orthodontic services shall cease at the end of the month after termination by the Company.

This limitation does not apply to Group Policies issued and delivered in Maryland.

17. Intraoral Films:

- Occlusal – two (2) per 24 months under age eight (8).

18. General anesthesia and IV sedation: a total of sixty 60 minutes per session.

INSERT

**VISION BENEFITS OF AMERICA
GROUP VISION
CERTIFICATE OF COVERAGE**

HERE

**Group Life
Insurance Certificate**

Misericordia University

IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of Delaware and will be governed by its laws. If you reside in a state other than Delaware, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Texas residents:

IMPORTANT NOTICE: To obtain information or make a complaint:

You may call Special Marketing Division's toll-free telephone number for information or to make a complaint at 1-800-441-1832.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:

P O Box 149091

Austin, TX 78714-9104

FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE: Para solicitar información o presentar una queja:

Llame a la línea gratuita de la División Especial de Marketing para obtener información o presentar una queja al 1-800-441-1832.

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al 1-800-252-3439.

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas):

P O Box 149091

Austin, TX 78714-9104

FAX: (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

Washington Residents:

(In Accordance With WAC 284-23-610, 620, 650, 730)

The accelerated life benefit in this policy does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

If an Insured receives payment of accelerated benefits from a life insurance policy, he or she may lose the right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for the Insured. We cannot give advice about this. The Insured may wish to obtain advice from a tax professional or an attorney before he or she decides to receive accelerated benefits under a life policy.

NOTICE

Benefits paid under the Accelerated Benefits provision will reduce the Death Benefit payable for life insurance.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Employee or the Employee's beneficiary may incur a tax obligation. As with all tax matters, an Employee should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

TL-004788

FOREWORD

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

The need for life insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the life insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.

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

**GROUP INSURANCE
CERTIFICATE**

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-961818, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE SERVICES INDUSTRY on behalf of Misericordia University.

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

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

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

A handwritten signature in black ink that reads "Matthew G. Manders". The signature is written in a cursive style with a large initial 'M'.

Matthew G. Manders, President

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SCHEDULE OF BENEFITS

Policy Effective Date: July 1, 2007
Certificate Effective Date: February 1, 2017
Policy Anniversary Date: July 1
Policy Number: FLX-961818

Class Definition

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

All active, Full-time Staff and Faculty Employees of the Employer regularly working a minimum of 35 hours per week for at least 10 months per year.

Your Eligibility Waiting Period

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

If you were hired on or before the Policy Effective Date:
The first of the month following the date of hire

If you were hired after the Policy Effective Date:
The first of the month following the date of hire

LIFE INSURANCE BENEFITS

Employee Benefits

Basic Benefit	1 times your Annual Compensation rounded to the next higher \$1,000, if not already a multiple thereof.
Guaranteed Issue Amount:	the lesser of 1 times Annual Compensation or \$100,000
Maximum Benefit:	the lesser of 1 times Annual Compensation or \$100,000
Voluntary Benefit	An amount elected in units of \$10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) \$100,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	the lesser of 5 times Annual Compensation or \$300,000
Benefit Level:	1 times Annual Compensation to a maximum of \$50,000 in \$10,000 increments
Age Based Reductions	When you are age 70 or older, your Life Insurance Benefit will reduce to: 45% of the Life Insurance Benefit at age 70 35% of the Life Insurance Benefit at age 75 25% of the Life Insurance Benefit at age 80

Terminal Illness Benefit
Maximum Benefit: \$100,000

Re-enrollment Period

During a Re-enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit by one Benefit Level, as long as the total Benefit does not exceed the Guaranteed Issue Amount, without satisfying the Insurability Requirement. Benefit Levels and Guaranteed Issue Amounts are shown above. Such increases will become effective on the Policy Anniversary following the Re-enrollment Period.

You may increase coverage for a Benefit in excess of amounts described above, only if you satisfy the Insurability Requirement. Any excess amounts will be effective on the later of the Policy Anniversary following the Re-enrollment Period or the date we agree in writing to insure you.

You may reduce Insurance Benefits at any time. A request for a Benefit reduction received during a Re-enrollment Period will become effective on the Policy Anniversary following the Re-enrollment Period. Any other Benefit reduction will be effective on the date we receive the completed change form.

Spouse Benefits

Voluntary Benefit An amount elected in units of \$10,000
Guaranteed Issue Amount: the greater of a) or b) below:
a) \$30,000, or
b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit: \$300,000

Terminal Illness Benefit
Maximum Benefit: \$100,000

Dependent Child Benefits

Voluntary Benefit An amount elected in units of \$2,500
Maximum Benefit: \$10,000
The Maximum Benefit for a Dependent Child who is less than 6 months old is \$500.

All Dependent Child benefits are Guaranteed Issue.

TL-004774

WHO IS ELIGIBLE

Classes of Eligible Persons

A person may be insured only once under the Basic Life portion of the Policy even though he or she may be eligible under more than one class. A person may also be insured only once under the Voluntary Life portion of the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

Employee

If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured under the Policy on the Policy Effective Date, or the day after you complete the applicable Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply if you are in Active Service on the Policy Effective Date and you satisfied the Eligibility Waiting Period, if any, of the Prior Plan. Credit will be given for any time you satisfied.

If you have previously converted your insurance under the Policy, you will not become eligible until your converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of insurance available to you.

Except as noted in the Reinstatement Provision, if you terminate coverage and later wish to reapply, or if you are a former Employee who is rehired, a new Eligibility Waiting Period must be satisfied. You are not required to satisfy a new Eligibility Waiting Period, if insurance ends because you are no longer in a Class of Eligible Employees, but continue to be employed by the Employer, and within one year you become a member of an eligible class.

Spouse

Your Spouse is eligible to be insured on the date you are eligible or the date he or she becomes your Spouse, if later. You must be insured for Voluntary Life Insurance in order to elect spouse coverage.

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you. He or she must be under age 70 to be eligible.

Dependent Child

Your Dependent Child is eligible to be insured on the date you are eligible or the date the child becomes a Dependent Child, if later.

In no event will a Dependent Child be eligible to be insured more than once under the Policy.

TL-004710

WHEN COVERAGE BEGINS

You, your Spouse and Dependent Children will be insured for an amount not to exceed the Guaranteed Issue Amount on the date you become eligible, if you are not required to contribute to the cost of this insurance.

You and your Spouse will be insured for an amount that exceeds the Guaranteed Issue Amount on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:

1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

If you or your Spouse elect insurance in an amount that exceeds the Guaranteed Issue Amount or if your enrollment form is received more than 31 days after you become eligible to elect coverage, this insurance is effective on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date he or she qualifies as a Dependent Child.

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

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
 2. confined to his or her home under the care of a Physician
- on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service

If you are not in Active Service on the Policy Effective Date, you are not covered under the Policy. However, We agree to provide a death benefit equal to the lesser of:

1. the amount due under this Policy (without regard to the Active Service provision), or
2. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the When Coverage Ends provision;
3. 12 months after the Policy Effective Date; or
4. the last day you would have been covered under the Prior Plan if that plan was still in force.

TL-009020

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

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

TL-004714

WHEN COVERAGE CONTINUES

Continuation for Family Medical Leave

If you are an Employee and your Active Service ends due to an Employer approved family medical leave, your insurance will continue for up to 12 weeks if the required premium is paid.

Continuation for Disability for Employees

If you become Disabled, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date following 6 months from the date you are Disabled.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated by the Insurance Company.

Amount of Insurance

If you die while Disabled and coverage is continued under this provision, the Insurance Company will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while coverage is continued under this provision. The Insurance Company will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

“Disability”/“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 the Employer’s plan.

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

TL-009745

Waiver of Premium

If you are an Employee under age 60 and your Active Service ends due to Disability, Life Insurance Benefits will continue for you, your Spouse and Dependent Children, if any until the earliest of the following dates.

1. The date you are no longer Disabled.
2. The day after the end of the period for which required premiums are paid.
3. The date you no longer qualify for Waiver of Premium.
4. To Age 65.

If you die while premiums are waived, we will pay a Death Benefit only if due proof of continuous Disability is received within one year of your death.

In order to qualify for Waiver of Premium, you must submit due proof that you have been Disabled for 9 months. Such proof must be submitted to us no later than 12 months from the date your Active Service ends. Premiums will be waived from the date the Insurance Company agrees in writing to waive your premiums. After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled and submit due proof that your Disability continues. Satisfactory proof must be submitted to us 3 months before the end of the 12 month period.

The Death Benefit will be equal to the Life Insurance Benefit in effect on the date you became Disabled. However, this benefit will be subject to the provisions of the Policy that reduce or terminate coverage because of age, retirement, acceleration or a change in eligible class. Automatic increases in Life Insurance Benefits will end while premiums are waived.

Termination of Waiver

Your insurance will end on the earliest of the following dates.

1. The date you are no longer Disabled.
2. The date you refuse to submit to any physical examination required by us.
3. The last day of the 12 month period of Disability during which you fail to submit satisfactory proof of your continued Disability.
4. To Age 65.

TL-004716

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

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

TL-004730

Accelerated Benefits

Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.

Terminal Illness Benefit

We will pay a Terminal Illness Benefit if we determine you or your Spouse are Terminally Ill. The amount of this benefit is 50% of the Life Insurance Benefit in effect for you or your Spouse on the date we determine you are Terminally Ill up to the Maximum Benefit Amount shown in your Schedule of Benefits for this option. The Terminal Illness Benefit is payable only once in an Insured's lifetime.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, we will require you to submit the following proof.

1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to us, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, you to be examined and a review of the documented evidence by a Physician of our choice.

"Terminal Illness" means a person is diagnosed by a Physician to have a prognosis of 12 months or less to live.

TL-004748

Conversion Privilege for Life Insurance

If coverage ends for any reason except non-payment of premium, any Insured may apply for a conversion policy of life insurance.

The conversion insurance may be a type of life insurance currently being offered for conversion by us at your age and in the amount requested. It may not be term insurance and it may not be for an amount greater than the Life Insurance Benefits in force under the Policy. Conversion life insurance will not provide accident, disability or other benefits.

However, if coverage ends because the Policy is terminated or amended to terminate any class of Insureds, or the Employer cancels participation under the Policy, coverage cannot be converted unless you have been insured under the Policy for at least 3 years. In this case, the amount of conversion insurance will be the lesser of Life Insurance Benefit in force under the Policy or \$10,000.

To apply for conversion insurance, you must submit an application to us and pay the required premium within 31 days after coverage under the Policy ends. Evidence of insurability is not required. Premium for the conversion insurance will be based on your age and class of risk and the type and amount of coverage issued.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends, if your application is received by us and the required premium is paid on that date.

If you die during the 31 day conversion period, the Death Benefit will be paid under the Policy regardless of whether you applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that type and amount of insurance under the Policy.

Extension of Conversion Period

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

If you die during the extended conversion period, but more than 31 days after your coverage under the Policy terminates, Life Insurance Benefits will not be paid under the Policy. If your application for conversion insurance is received by us and the required premium is paid, Life Insurance Benefits will be payable under the conversion insurance.

Prior Conversion Limitation

If you are covered under a life insurance conversion policy previously issued by us under the Policy, you will not be eligible to exercise this Conversion Privilege unless the prior coverage has ended. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class.

TL-004750

LIFE INSURANCE EXCLUSIONS

If an Insured commits suicide, while sane or insane, within 2 years from the date the Insured's insurance under the Policy becomes effective, Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to you if you were covered under the Prior Plan for more than two years. If you were not insured for two years under the Prior Plan, credit will be given for the time you were insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under your certificate, no refund of premiums will be paid.

TL-004752

CLAIM PROVISIONS

Notice of Claim

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

Written notice, or any other electronic/telephonic means authorized by us, of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice, or any other electronic/telephonic means authorized by us, was given as soon as reasonably possible.

Claim Forms

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

Claimant Cooperation Provision

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

Insurance Data

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

Proof of Loss

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

Written proof, or any other electronic/telephonic means authorized by us, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment

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

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

To Whom Payable

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

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

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

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

Change of Beneficiary

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

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

Physical Examination and Autopsy

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

Legal Actions

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

Time Limitations

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

Physician/Patient Relationship

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

TL-004724

ADMINISTRATIVE PROVISIONS**Premiums**

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

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

Your Grace Period

If your required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance

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

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

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

TL-004722

GENERAL PROVISIONS

Incontestability

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

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

Misstatement of Age

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

Workers' Compensation Insurance

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

Assignment of Benefits

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

Clerical Error

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

TL-004728

DEFINITIONS

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

Accident

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

Active Service

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

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

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

Annual Compensation

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

Dependent Child

Your unmarried child if he or she meets the following requirements:

1. A child from live birth to 19 years old;
2. A child who is 19 or more years old but less than 25 years old, enrolled in a school as a full-time student and primarily supported by you;
3. A child who is 19 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

The term "child" means a child born to or legally adopted by you. It includes a child during any waiting period prior to the finalization of the child's adoption. It also means a stepchild living with and financially dependent upon you.

Disabled

You are Disabled, if, because of Injury or Sickness, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

Employee

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

Employer

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

Full-time

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

Injury

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

Insurability Requirement

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

Insurance Company

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

Insured

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

Physician

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

Prior Plan

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

Sickness

The term Sickness means a physical or mental illness.

Spouse

Your current lawful spouse under age 70.

TL-004708

**SUPPLEMENTAL INFORMATION
for**

College Misericordia Life & Accidental Death & Dismemberment Plan

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

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

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Misericordia University, the Plan Sponsor.
- The Employer Identification Number (EIN) is 24-0795406.
- The Plan Number is 506.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-961818, issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.
- The Plan Administrator is: Misericordia University
 301 Lake Street
 Dallas, PA 18612
 570-674-3363

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employer and Employees.
- The date of the end of the Plan Year is June 30.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

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

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company's written notice must include the following information:

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

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

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

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

California Residents:

Conversion Privilege for Life Insurance

Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

- a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
- b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
- c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
- d. The person meets all other conditions for converting the insurance.

Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee's Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

Missouri residents:

Regardless of any language to the contrary in the Policy, suicide is no defense to payment of life insurance benefits. However, if an Insured commits suicide within 2 years from the date his or her insurance under the Policy becomes effective, and the Insurance Company can show that the Insured intended suicide at the time he or she applied for the insurance, life insurance benefits will be limited to a refund of premium paid on the Insured's behalf.

North Dakota residents:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a CIGNA company**

Class 1
02/2017



**LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)**

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Policyholder: Trustee of the Group Insurance Trust for Employers in the Services Industry
Participating Subscriber: Misericordia University
(herein called the Subscriber)

Policy No.: FLX - 961818

PLEASE READ

IMPORTANT: The attached amendment to your policy has been made at your request, and will be effective on the date shown within the amendment. Please review this amendment immediately and confirm that it accurately reflects your request and is consistent with your intentions. If amended certificates have been provided, please review these as well. If there are any errors or discrepancies, please notify your account manager or account service representative immediately. If you have not notified your account manager or account service representative of any errors or concerns, continued payment of premium more than 31 days after delivery of this amendment will be deemed acceptance of this amendment.

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Policyholder: Trustee of the Group Insurance Trust for Employers in the Services Industry
Participating Subscriber: Misericordia University
(herein called the Subscriber)

Policy No.: FLX - 961818

This Amendment will be in effect on the Effective Date(s) shown below only for insured Employees in Active Service on that date. If an Employee is not in Active Service on the date his insurance would otherwise become effective, it will be effective on the date he returns to Active Service.

The Company and the Subscriber hereby agree that the Policy is amended as follows:

Effective July 1, 2017, **Schedule of Benefits – Classes of Eligible Employees - Class 1** is replaced by the following:

Class 1 All active, Full-time Employees of the Employer regularly working a minimum of 30 hours per week or 130 hours of Active Service in a calendar month.

Except for the above, this Amendment does not change the Policy in any way.

FOR THE COMPANY



Matthew G. Manders, President

Date: May 16, 2017

Amendment No. 07

TL-004780

Assistance Program

24/7



Assistance Program



Assistance Program

Self-service support – at your fingertips. Educational materials on work/life topics such as caregiving, daily living and working smarter are available online, including a savings center and relocation center.

Extra flexibility. For assistance with your search, we can email you. Include your email address when you request support via the web. It's just one more way for us to meet your needs.

Call us any time, any day or go online for confidential assistance, information or resources to help resolve life's challenges.



*Some Health Rewards programs are not available in all states. If your CIGNA plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. **A discount program is NOT insurance, and you must pay the entire discounted charge.**

"CIGNA" and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include International Rehabilitation Associates, Inc. (Intracorp), CIGNA Behavioral Health, Inc., Wellife Limited, Connecticut General Life Insurance Company and HMO subsidiaries of CIGNA Health Corporation.

591220 c 10/09 © 2009 CIGNA



Whatever life throws at
you – throw it our way.



Life.

Just when you think you have it figured out, along comes a challenge. But whether those challenges are big or small, your **Life Assistance & Work/Life Support Program** is available to help you and your family find a solution and restore your peace of mind.

Call us any time, any day. We're just a phone call away whenever you need us - at no cost to you. An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. He or she can also direct you to an array of resources in your community and online tools.

Visit a specialist. For face-to-face assistance, you have 3 sessions available to you and your household members. Call us to request a referral.

Reward yourself. Access your Healthy Rewards** amenities program for discounts on a range of health and wellness services and products from participating providers.

Achieve Work/Life Balance. Get extra support for handling life's demands. Call for advice or a referral to a service in your community on topics such as:

- **Legal Consultation.** Receive a 30-minute free consultation and up to a 25% discount on select fees.
- **Parenting.** Receive guidance on child development, sibling rivalry, separation anxiety, and much more.
- **Senior Care.** Learn about challenges and solutions associated with caring for an aging loved one.
- **Child Care.** Whether you need care all day or just after school, find a place that's right for your family.
- **Pet Care.** From grooming to boarding to veterinary services, find what you need to care for your pet.
- **Temporary Back-up Care.** Don't let an unplanned event get the best of you -- find back-up childcare.

These are just a few examples of the support available to you. Call to get the assistance you need to help resolve life's challenges.
800.538.3543

Log on to www.cignabehavioral.com/GI

Click on the Healthy Rewards link to access discount information:

User name: rewards
Password: savings

Assistance Program
24/7



Call us or reach us online.
800.538.3543

www.cignabehavioral.com/GI

Click on the Healthy Rewards link to access discount information:

User name: rewards
Password: savings



Call us or reach us online.
800.538.3543

www.cignabehavioral.com/GI

Click on the Healthy Rewards link to access discount information:
User name: rewards
Password: savings

To do list

- 1. Jack's new foster*
- 2. Schedule appointments*
- 3. Dog sitter*

**Group Accident
Insurance Certificate**

Misericordia University

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP ACCIDENT CERTIFICATE

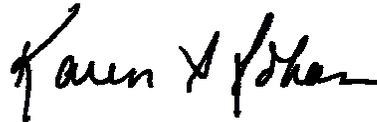
**THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.**

We, the Life Insurance Company of North America, have issued a Group Policy, OK 961904 to Trustee of the Group Insurance Trust for Employers in the Services Industry.

We certify that we insure all eligible persons who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Eligibility and Effective Date* provision.

This Certificate describes the benefits and basic provisions of your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Subscriber.

This Certificate replaces all prior Certificates issued to you under the Group Policy.



Karen S. Rohan, President

**THIS CERTIFICATE IS ISSUED UNDER AN ACCIDENT ONLY POLICY. IT DOES NOT PAY
BENEFITS FOR LOSS CAUSED BY SICKNESS.**

GA-00-CE1000.00

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GA-00-CE1000.00

SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions carefully.

The *Schedule of Benefits* provides a brief outline of your coverage and benefits. Please read the *Description of Coverages and Benefits* Section for full details.

Subscriber: Misericordia University

Effective Date of Subscriber Participation: July 1, 2007

Covered Class: Class 1 - All active, full-time staff and faculty Employees of the Employer regularly working a minimum of 35 hours per week for at least 10 months per year.

SCHEDULE OF BENEFITS

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date: First of the Month following the Date of Hire.

For Employees hired after the Policy Effective Date: First of the Month following the Date of Hire.

Time Period for Loss:

Any Covered Loss must occur within: 365 days of the Covered Accident

Maximum Age for Insurance: None

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum: 1 times Annual Compensation rounded to the next higher \$1,000, if not already a multiple thereof
Maximum: \$100,000

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Compensation take effect, subject to any Active Service requirement, on the first day of the month following the change in Annual Compensation.

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	50% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12 th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	25% of the Principal Sum

Age Reductions

A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
70 but less than 75	45%
75 but less than 80	35%
80 and over	25%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE provides the Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of \$10,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of \$5,000
Default Benefit	\$1,000

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum:	\$10,000 units
Maximum:	\$500,000; Benefit amounts in excess of \$250,000 are limited to 10 times Annual Compensation
Spouse Principal Sum:	50% or 100% of the Employee's Principal Sum
Maximum:	\$300,000
Dependent Child Principal Sum:	10% of the Employee's Principal Sum
Maximum:	\$50,000

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Compensation take effect, subject to any Active Service requirement, on the first day of the month following the change in Annual Compensation.

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	50% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12 th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	25% of the Principal Sum

Age Reductions

A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
70 but less than 75	45%
75 but less than 80	35%
80 and over	25%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE provides the Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

CHILD CARE CENTER BENEFIT

Benefit Amount	3% of the Employee's Principal Sum subject to a maximum of \$2,000 per year
Maximum Benefit Period	4 years but not beyond age 13 for each surviving Dependent Child

COMMON ACCIDENT BENEFIT

Covered Spouse Benefit	up to 100% of the Employee's Principal Sum subject to a maximum of \$500,000
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REHABILITATION BENEFIT

Benefit per Covered Accident	5% of the Principal Sum subject to a maximum of \$5,000
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SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of \$25,000
Airbag Benefit	10% of the Principal Sum subject to a Maximum Benefit of \$10,000
Default Benefit	\$1,000

SPECIAL EDUCATION BENEFIT

Surviving Dependent Child Benefit	5% of the Principal Sum subject to a Maximum Benefit of \$5,000
Maximum Number of Annual Payments For Each Surviving Dependent Child	4
Default Benefit	\$1,000

SPOUSE RETRAINING BENEFIT

Benefit	5% of the Principal Sum subject to a Maximum Benefit of \$5,000
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GA-00-1100.00

GENERAL DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. The words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Active Service

An Employee will be considered in Active Service with the Employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing his regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel;
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

A person other than an Employee is considered in Active Service if he is none of the following:

1. an Inpatient in a Hospital or receiving Outpatient care for chemotherapy or radiation therapy;
2. confined at home under the care of a Physician for Sickness or Injury;
3. Totally Disabled.

Age

A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is his Age attained on his last birthday.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Annual Compensation

An Employee's annual earnings for normal work established by the Subscriber for his job classification, excluding commissions, bonuses or overtime.

Covered Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

Covered Injury

Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Loss

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the *Schedule of Covered Losses*;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.

Covered Person

An eligible person, as defined in the *Schedule of Benefits*, for whom an enrollment form has been accepted by Us and required premium has been paid when due and for whom coverage under this Policy remains in force. The term Covered Person shall include, where this Policy provides coverage, an eligible Spouse and eligible Dependent Children.

Dependent Child(ren)

An Employee's unmarried child who meets the following requirements:

1. A child from live birth to 19 years old;
2. A child who is 19 or more years old but less than 25 years old, enrolled in a school as a full-time student and primarily supported by the Employee;
3. A child who is 19 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us within 31 days after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

A child, for purposes of this provision, includes an Employee's:

1. Natural child;
2. Adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. Stepchild who resides with the Employee;
4. Child for whom the Employee is legal guardian, as long as the child resides with the Employee and depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.

Employee

For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer

The Subscriber and any affiliates, subsidiaries or divisions shown in the *Schedule of Covered Affiliates* and which are covered under this Policy on the date of issue or subsequently agreed to by Us.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person incurs an expense.

Inpatient

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term 'Inpatient' shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse

A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Outpatient

A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Prior Plan

The plan of insurance providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.

Physician

A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of the Covered Person.

Sickness

A physical or mental illness.

Spouse

The Employee's lawful spouse under age 70.

Subscriber

Any participating organization that subscribes to the trust to which this Policy is issued.

Totally Disabled or Total Disability

Totally Disabled or Total Disability means either:

1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

We, Us, Our

Life Insurance Company of North America.

You, Your

The person to whom the certificate is issued.

GA-00-1200.00

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Subscriber Effective Date

Accident Insurance Benefits become effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Insurance coverage for the Subscriber becomes effective on the Effective Date of Subscriber Participation.

Eligibility

An Employee becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. A Spouse and Dependent Children of an eligible Employee become eligible for any dependent insurance provided by this Policy on the later of the date the Employee becomes eligible and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of this Policy. No person may be eligible for insurance under this Policy as both an Employee and a Spouse or Dependent Child at the same time.

Effective Date for Individuals

Basic Accidental Death and Dismemberment Benefits

Insurance becomes effective for an eligible Employee, subject to the *Deferred Effective Date* provision below, on the latest of the following dates:

1. the effective date of this Policy;
2. the date the Employee becomes eligible.

Voluntary Accidental Death and Dismemberment Benefits

Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions within 31 days of eligibility, and subject to the *Deferred Effective Date* provision below, on the latest of the following dates:

1. the effective date of this Policy;
2. the date the Employee becomes eligible;
3. the date We receive the Employee's completed enrollment form and the required first premium, during his lifetime.

Insurance becomes effective for an Employee's eligible dependents if the Employee applies and agrees to make required contributions within 31 days of the date his dependents become eligible and, subject to the *Deferred Effective Date* provision below, on the latest of the following dates:

1. the effective date of this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's insurance becomes effective;
4. the date the dependent meets the definition of Spouse or Dependent Child, as applicable;
5. the date We receive a completed enrollment form for Spouse and Dependent Child coverage and the required first premium, during each dependent's lifetime.

Insurance becomes effective for a newborn Dependent Child automatically from the moment of the child's live birth. Insurance for that Dependent Child automatically ends 31 days later unless the Employee is insured under a plan under this Policy that includes Dependent Child insurance or makes a request to cover the child and pays the required initial premium, during the child's lifetime.

DEFERRED EFFECTIVE DATE

Active Service

The effective date of insurance will be deferred for any Employee or any eligible Spouse or Dependent Child who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Annual Re-Enrollment

An Employee currently insured under this Policy, and a person who is eligible but has not previously enrolled, may increase or become insured for coverage under this Policy during an annual re-enrollment period as agreed to by Us and the Subscriber. An Employee who is insured under this Policy may also elect or increase coverage for his eligible dependents. Coverage elected during an Annual Re-Enrollment Period will become effective, subject to the *Active Service* section of the *Deferred Effective Date* provision, on the Policy Anniversary following the date We receive a request and any required premium payment.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE

The insurance on a Covered Person will end on the earliest date below:

1. the date this Policy or insurance for a Covered Class is terminated;
2. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
3. the last day of the last period for which premium is paid;
4. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy;
5. with respect to a Spouse or Dependent Child, the date of the death of the covered Employee or the date of divorce from the covered Employee.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Continuation for Family Medical Leave

Insurance for an Employee and Covered Dependents may be continued until the earliest of the following dates if: (a) an Employee is on an Employer-approved family medical leave; and (b) required premium contributions are paid when due.

1. for an Employer-approved family medical leave: 12 weeks in a consecutive 12-month period.

GA-00-1300.00

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
 - a. except as a passenger on a regularly scheduled commercial airline;
 - b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
 - c. being used for:
 - i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
 - ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
 - d. designed for flight above or beyond the earth's atmosphere;
 - e. an ultra-light or glider;
 - f. being used for the purpose of parachuting or skydiving;
 - g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
7. 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;
8. travel in any Aircraft owned, leased or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.
10. 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. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
11. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
12. in addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
 - a. employed or retained by the Subscriber;
 - b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
 - c. living in the Covered Person's household;
 - d. a parent, sibling, spouse or child of the Covered Person.

GA-00-1401.00

CONVERSION PRIVILEGE

1. If the Covered Person's insurance or any portion of it ends for any of the following reasons:
 - a. employment or membership ends;
 - b. eligibility ends (except for age);the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated group policy. The Covered Person may apply for an amount of coverage that is:
 - a. in \$1,000 increments;
 - b. not less than \$25,000, regardless of the amount of insurance under the group policy; and
 - c. not more than the amount of insurance he had under the group policy, except as provided above, up to a maximum amount of \$250,000.

The Covered Person must be under age 70 to get a converted policy.

If the Covered Person's insurance or any portion of it ends for non-payment of premium, he may not convert. If the Covered Person's insurance ends for a reason described in 2. below, conversion is subject to that section.

The converted policy or certificate will cover accidental death and dismemberment. The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

If the Covered Person has converted his group coverage and later becomes insured under the same group plan as before, he may not convert a second time unless he provides, at his own expense, proof of insurability or proof the prior converted policy is no longer in force.

The Covered Person must apply for the individual policy within 31 days after his coverage under this Group Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk. If the Covered Person has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

If the Covered Person dies during this 31-day period as the result of an accident that would have been covered under this Group Policy, We will pay as a claim under this Group Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Group Policy.

The individual policy or certificate will take effect on the day following the date coverage under the Group Policy ended; or, if later, the date application is made.

Exclusions

The converted policy may exclude the hazards or conditions that apply to the Covered Person's group coverage at the time it ends. We will reduce payment under the converted policy by the amount of any benefits paid under the group policy if both cover the same loss.

2. If the Covered Person's insurance ends because this Group Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Group Policy for at least five years, the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
 - a. coverage under this Group Policy less any amount of group accident insurance for which he is eligible on the date this Group Policy is terminated or for which he became eligible within 31 days of such termination, or
 - b. \$10,000.

GA-01-1500.00

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber's name and policy number and the Covered Person's name, address, policy and certificate number.

Claim Forms

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the *Beneficiary* provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered Employee or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine You, Your Spouse and/or Dependent Child when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Beneficiary

The beneficiary is the person or persons You name or change on a form executed by You and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Subscriber. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy. Any Accidental Death Benefit payable at the death of Your Spouse or Dependent Child will be paid to You or Your estate.

A beneficiary designation or change will become effective on the date You execute it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless You have specified otherwise. The share of any beneficiary who does not survive You, Your Spouse or Dependent Child will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if You die while benefits are payable to You, We may make direct payment to the first surviving class of the following classes of persons:

1. spouse;
2. child or children;
3. mother or father;
4. sisters or brothers;
5. your estate or the estate of your Spouse and/or Dependent Children.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when You, Your Spouse or Dependent Children die, We may recover the overpayment from Your, Your Spouse's or Dependent Child's estate.

GA-00-CE1600.00

ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the Policy, the plan and amounts of insurance in effect. If Your, Your Spouse's and/or Dependent Child's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day before the reduction took place.

Grace Period

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. Insurance under this Policy for You, Your Spouse and/or Dependent Children will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If no such claims are incurred and premium is not paid during the grace period, insurance will end on the last day of the period for which premiums were paid.

GA-00-CE1700.00

GENERAL PROVISIONS

Misstatement of Fact

If You, Your Spouse or Dependent Children have misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Multiple Certificates

You may have in force only one certificate of insurance at a time under this Policy. If at any time You have been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment

We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and the Covered Person's certificate remains in force.

Incontestability of Your, Your Spouse's and/or Dependent Child's Insurance

All statements made by You, Your Spouse and/or Dependent Children are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from Your, Your Spouse's and/or Dependent Child's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Clerical Error

Insurance for You, Your Spouse and/or Dependent Children will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Policy Changes

We may agree with the Subscriber to modify a plan of benefits without Your, Your Spouse's and/or Dependent Child's consent.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

GA-00-CE1800.00

DESCRIPTION OF COVERAGES AND BENEFITS

This *Description of Coverages and Benefits* Section describes the Accident Coverages and Benefits provided to You. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within this Certificate and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions **Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means a profound state of unconsciousness which resulted directly and independently from all other causes from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

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

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* section.

GA-00-2100.00

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE

Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses*, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions The exclusions that apply to this coverage are in the *Common Exclusions* Section.
GA-00-2202.00

ADDITIONAL ACCIDENT BENEFITS

Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

CHILD CARE CENTER BENEFIT

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered Employee results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. coverage for his Dependent Children was in force on the date of the Covered Accident causing his death; and
2. one or more surviving Dependent Children is under Age 13 and:
 - a. was enrolled in a Child Care Center on the date of the Covered Accident; or
 - b. enrolls in a Child Care Center within 90 days from the date of the Covered Accident.

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each 12 month period that begins after the date of the covered Employee's death. A claim must be submitted to Us at the end of each 12 month period. A 12 month period begins:

1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered Employee's death; or
2. on the first of the month following the covered Employee's death, if the Dependent Child was enrolled in a Child Care Center before the covered Employee's death.

Each succeeding 12 month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

Definitions For purposes of this benefit:
Child Care Center is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2222.00

COMMON ACCIDENT BENEFIT

We will increase the Loss of Life benefit payable for the covered Spouse to 100% of the Employee's Principal Sum if both the Employee and the covered Spouse die directly and independently of all other causes from a Common Accident and are survived by one or more Dependent Children.

Definition For purposes of this benefit:
Common Accident means the same Covered Accident or separate Covered Accidents that occur within the same 24-hour period.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2224.00

REHABILITATION BENEFIT

We will pay the Rehabilitation Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person requires Rehabilitation after sustaining a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Covered Person must require Rehabilitation within two years after the date of the Covered Loss.

Definition For purposes of this benefit:
Rehabilitation means medical services, supplies, or treatment, or Hospital confinement (or part of a Hospital confinement) that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the Covered Person's Covered Loss;
2. meet generally accepted standards of medical practice;
3. are performed under the care, supervision or order of a Physician;
4. prepare the Covered Person to return to his or any other occupation.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2248.00

SEATBELT AND AIRBAG BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Definitions For purposes of this benefit:
Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2251.00

SPECIAL EDUCATION BENEFIT

We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for each qualifying Dependent Child who is insured under the covered Employee's certificate on the date he dies. The Covered Person's death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit is payable under this Policy. This benefit is subject to the conditions and exclusions described below.

A qualifying Dependent Child must:

1. a. be enrolled as a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the covered Employee's Covered Accident; or
- b. be at the 12th grade level on the date of the covered Employee's Covered Accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the Covered Accident and continue his education as a full-time student.
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered Employee died, if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If no Dependent Child qualifies for Special Education Benefits within 365 days of the covered Employee's death, We will pay the default benefit shown in the *Schedule of Benefits* to the covered Employee's beneficiary.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2252.00

SPOUSE RETRAINING BENEFIT

We will pay expenses incurred, as described below, up to the Maximum Benefit shown in the *Schedule of Benefits*, to enable the covered Employee's Spouse to obtain occupational or educational training needed for employment if the covered Employee dies directly and independently of all other causes from a Covered Accident. A covered Spouse must have been insured under this Policy on the date of the covered Employee's death to be eligible for this benefit. This benefit is subject to the conditions and exclusions described below.

This benefit will be payable if the covered Employee dies within one year of a Covered Accident and is survived by his Spouse who:

1. enrolls, within three years after the covered Employee's death in any accredited school for the purpose of retraining or refreshing skills needed for employment; and
2. incurs expenses payable directly to, or approved and certified by, such school.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2254.00

**SUPPLEMENTAL INFORMATION
for**

**Misericordia University Life & Accidental Death & Dismemberment Plan
required by the Employee Retirement
Income Security Act of 1974**

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

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Misericordia University, the Plan Sponsor.
- The Employer Identification Number (EIN) is 240795406.
- The Plan Number is 506.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, OK 961904, issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.
- The Plan Administrator is: Misericordia University
 301 Lake Street
 Dallas, PA 18612

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by Employer and Employees.
- The date of the end of the Plan Year is June 30.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

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

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company's written notice must include the following information:

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

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

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

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (or 45 days, in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a CIGNA company**

Class 1

09/2007



CIGNA Group Insurance
Life • Accident • Disability

Group Insurance Plan

Misericordia University

IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of Pennsylvania and will be governed by its laws. If you reside in a state other than Pennsylvania, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Texas residents:

IMPORTANT NOTICE: To obtain information or make a complaint:

You may call the Life Insurance Company of North America, Group Insurance's toll-free telephone number for information or to make a complaint at 1-800-547-5515.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:
P O Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE: Para obtener informacion o para someter una queja:

Usted Puede llamar al numero de telefono gratis del Life Insurance Company of North America, Group Insurance Division para informacion o para someter una queja al 1-800-547-5515.

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas:
P O Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

FOREWORD

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

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

In an effort to make your benefit program more comprehensive and responsive to your needs, your Employer is providing this insurance to you at no cost.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

**GROUP INSURANCE
CERTIFICATE**

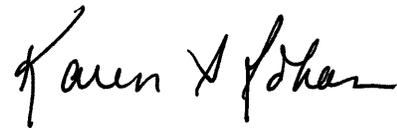
We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, certify that we have issued a Group Policy, LK-960238, to Misericordia University.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

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

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

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

A handwritten signature in black ink that reads "Karen S. Rohan". The signature is written in a cursive style with a large initial 'K' and 'R'.

Karen S. Rohan, President

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SCHEDULE OF BENEFITS

Policy Effective Date: November 1, 2003

Certificate Effective Date: July 1, 2012

Policy Anniversary Date: November 1

Policy Number: LK-960238

Eligible Class Definition:

All Full-time, active Employees, who is a member of the faculty, clerical or administrative staff.

Eligibility Waiting Period

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

If you were hired after
the Policy Effective Date: The first of the month coinciding with or next following the date
of hire

Elimination Period the longer of 90 days or the end of accumulated sick leave during
which you receive your full monthly wage.

Gross Disability Benefit

The lesser of 60% of your monthly Covered Earnings rounded to the nearest dollar or your
Maximum Disability Benefit.

Maximum Disability Benefit \$8,000 per month.

Minimum Disability Benefit

The greater of \$100 or 10% of your Monthly Benefit prior to any reductions for Other Income
Benefits.

Disability Benefit Calculation

The Disability Benefit payable to you is figured using the Gross Disability Benefit, Other Income
Benefits, calculation of Optimum Ability and the Return to Work Incentive. Monthly Benefits are based
on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month you have no Disability Earnings, the monthly benefit payable is the Gross Disability
Benefit less Other Income Benefits, and less the calculation for Optimum Ability. During any month you
have Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not
be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section
Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you
receive on your own behalf or for your dependents, or which your dependents receive because of your
entitlement to Other Income Benefits.

Return to Work Incentive

During any month you have Disability Earnings, your benefits will be calculated as follows.

Your monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and you have Disability Earnings:

1. Add your Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to your Indexed Earnings.
3. If the sum from 1. exceeds 100% of your Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. Your Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits and the calculation for Optimum Ability.
5. If the sum from 1. does not exceed 100% of your Indexed Earnings, your Gross Disability Benefit will be reduced by Other Income Benefits and the calculation for Optimum Ability.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits, the calculation for Optimum Ability and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if we determine you are able to work under a modified work arrangement and you refuse to do so without Good Cause.

Calculation for Optimum Ability

The calculation for Optimum Ability is the earnings you could earn if working at Optimum Ability, minus Disability Earnings.

Maximum Benefit Period

Age When Disability Begins

Age 62 or under

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 or older

Maximum Benefit Period

Your 65th birthday or

the date the 42nd Monthly Benefit is payable, if later.

The date the 36th Monthly Benefit is payable.

The date the 30th Monthly Benefit is payable.

The date the 24th Monthly Benefit is payable.

The date the 21st Monthly Benefit is payable.

The date the 18th Monthly Benefit is payable.

The date the 15th Monthly Benefit is payable.

The date the 12th Monthly Benefit is payable.

WHO IS ELIGIBLE

If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the Policy Effective Date, or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. Your Eligibility Waiting Period will be extended by the number of days you are not in Active Service.

Except as noted in the Reinstatement Provision, if you terminate your coverage and later wish to reapply, or if you are a former Employee who is rehired, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if your insurance ends because you no longer qualify under your Class Definition, but you continue to be employed, and within one year you qualify again.

TL-004710

WHEN COVERAGE BEGINS

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

If you are not in Active Service on the date your insurance would otherwise be effective, it will be effective on the date you return to any occupation for your Employer on a Full-time basis.

TL-004712

WHEN COVERAGE ENDS

Your coverage ends on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date you are no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date you are no longer in Active Service;
6. the date benefits end because you did not comply with the terms and conditions of the insurance coverage.

If you are entitled to receive Disability Benefits when the Policy terminates, Disability Benefits will be payable to you if you remain disabled and meet the requirements for the insurance. Any later period of Disability, regardless of cause, that begins when you are eligible under another disability coverage provided by any employer, will not be covered.

TL-007505.00

WHEN COVERAGE CONTINUES

This provision modifies the When Coverage Ends provision to allow insurance to continue under certain circumstances if you are no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the When Coverage Ends provisions.

Your Disability Insurance will continue if your Active Service ends because of a Disability for which benefits under the Policy are or may become payable. Your premiums will be waived while Disability Benefits are payable. If you do not return to Active Service, this insurance ends when your Disability ends or when benefits are no longer payable, whichever occurs first.

If your Active Service ends due to any leave of absence, including sabbatical, approved in writing by the Employer prior to the date you cease work insurance will continue for you for the length of the Sabbatical if the required premium is paid. An approved leave of absence does not include layoff or termination of employment.

If your Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, your insurance will continue until the earlier of:

- a. the date your employment relationship with the Employer terminates;
- b. the date premiums are not paid when due;
- c. the end of the 30 day period that begins with the first day of such excused absence;
- d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if your Active Service ends due to layoff, termination of employment, or any other termination of the employment relationship, insurance will terminate and continuation of insurance under this provision will not apply.

If your insurance is continued pursuant to this When Coverage Continues provision, and you become Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date you are scheduled to return to Active Service.

TL-004716

TAKEOVER PROVISION

This provision applies to you only if you are eligible under this Policy and were covered for long term disability coverage on the day prior to the effective date of this Policy under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

- A. This section A applies to you if you are not in Active Service on the day prior to the effective date of this Policy due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, we will insure an Employee to which this section applies against a disability that occurs after the effective date of this Policy for the affected employee group. This coverage will be provided until the earlier of the date: (a) you return to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day you were not in Active Service. The Policy will provide this coverage as follows:
 1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.
 2. If the disability is not a covered disability under the Prior Plan solely because the plan terminated, benefits payable under this Policy for that disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods and partial satisfaction of pre-existing condition limitations.
- B. The Elimination Period under this Policy will be waived for a Disability which begins while you are insured under this Policy if all of the following conditions are met:
 1. The Disability results from the same or related causes as a Disability for which monthly benefits were payable under the Prior Plan;
 2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
 3. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;

4. The Disability begins within 6 months of your return to Active Service and your insurance under this Policy is continuous from this Policy's Effective Date.

C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply if you were covered under a Prior Plan and satisfied the pre-existing condition limitation, if any, under that plan. If you did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied.

Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TL-005108

DESCRIPTION OF BENEFITS WHAT IS COVERED

Disability Benefits

We will pay Disability Benefits if you become Disabled while covered under this Policy. You must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. You must provide to us, at your own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

We will require continued proof of your Disability for benefits to continue.

Elimination Period

The Elimination Period is the period of time you must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation

The Disability Benefit Calculation is shown in the Schedule of Benefits. Monthly Disability Benefits are based on a 30 day period. They will be prorated if payable for any period less than a month. If you are working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive

The Return to Work Incentive is shown in the Schedule of Benefits. You may work for wage or profit while Disabled. In any month in which you work and a Disability Benefit is payable, the Return to Work Incentive applies.

We will, from time to time, review your status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit

We will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits

If Disability Benefits are payable to you under this Policy, you may be eligible for benefits from Other Income Benefits. If so, we may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received (or assumed to be received*) by you or your dependents under:
 - the Canada and Quebec Pension Plans;
 - the Railroad Retirement Act;
 - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
 - any sick leave or salary continuation plan of the Employer;
 - any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay for our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts received (or assumed to be received*) by you or your dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits

Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating your Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits

We will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from Other Income Benefits. We will reduce your Disability Benefits by the amount from Other Income Benefits we estimate are payable to you and your dependents.

We will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while Disability Benefits are payable, if you:

1. provide satisfactory proof of application for Other Income Benefits;
2. sign a Reimbursement Agreement;
3. provide satisfactory proof that all appeals for Other Income Benefits have been made unless we determine that further appeals are not likely to succeed; and
4. submit satisfactory proof that Other Income Benefits were denied.

We will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Social Security Assistance

We may help you in applying for Social Security Disability Income (SSDI) Benefits, and may require you to file an appeal if we believe a reversal of a prior decision is possible.

We will reduce Disability Benefits by the amount we estimate you will receive, if you refuse to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment

We have the right to recover any benefits we have overpaid. We may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to us.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when you die, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability

A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, you return to work in your Regular Occupation for less than 6 consecutive months; and
3. if you earn less than the percentage of Indexed Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one month.

Any later period of Disability, regardless of cause, that begins when you are eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, you must satisfy a new Elimination Period.

LIMITATIONS

Limited Benefit Periods

We will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid during your lifetime, no further benefits will be payable for any of the following conditions:

1. Alcoholism
2. Anxiety disorders
3. Delusional (paranoid) disorders
4. Depressive disorders
5. Drug addiction or abuse
6. Eating disorders
7. Mental illness
8. Somatoform disorders (psychosomatic illness)

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-Existing Condition Limitation

We will not pay Disability Benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "pre-existing condition" means any Injury or Sickness for which you received medical advice or treatment within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are insured for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

TL-007500.39

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability

If we determine that you are a suitable candidate for rehabilitation, we may require you to participate in a Rehabilitation Plan and assessment at our expense. We have the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. We will work with you, the Employer and your Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

If you fail to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

TL-007501.00

Pension Contribution Benefit

We will pay a Pension Contribution Benefit of 10% of your Covered Earnings to your Employer's pension plan if you are Disabled. We will pay up to a Maximum Monthly Pension Benefit of \$1,000. These Pension Contribution Benefits will begin and end at the same time as your Disability Benefits.

TL-005103

Survivor Benefit

We will pay a Survivor Benefit if you die while Disability Benefits are payable and at least 6 Monthly Benefits have been payable to you for a continuous period of Disability. The Survivor Benefit will equal 100% of the sum of the last full Disability Benefit payable to you plus the amount of any Disability Earnings by which the benefit had been reduced for that month. A single lump sum payment equal to 3 monthly Survivor Benefits will be payable.

We will pay the Survivor Benefit to your Spouse. If you do not have a Spouse, we will pay your surviving Children in equal shares. If you do not have a Spouse or any Children, we will pay your estate.

"Spouse" means your lawful spouse. "Children" means your unmarried children under age 21 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

TL-005107

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:

1. the date you earn from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to you at that time;
2. the date we determine you are not Disabled;
3. the end of the Maximum Benefit Period;
4. the date you die;
5. the date you refuse, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date you are no longer receiving Appropriate Care;
7. the date you fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if you begin to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

TL-007502.00

WHAT IS NOT COVERED

We will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, we will not pay Disability Benefits for any period of Disability during which you are incarcerated in a penal or corrections institution.

TL-007503.39

CLAIM PROVISIONS

Notice of Claim

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

Claim Forms

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

Claimant Cooperation Provision

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

Insurance Data

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

Proof of Loss

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

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to us.

Time of Payment

Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

To Whom Payable

Disability Benefits will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to any of your following living relatives: your spouse, your mother, your father, your children, your brothers or sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

Physical Examination and Autopsy

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

Legal Actions

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

Time Limitations

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

Physician/Patient Relationship

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

TL-004724

ADMINISTRATIVE PROVISIONS**Premiums**

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

Reinstatement of Insurance

Your coverage may be reinstated if your insurance ends because you are on an Employer approved unpaid leave of absence. Your insurance may be reinstated only if reinstatement occurs within 12 weeks from the date it ends due to an Employer approved unpaid leave of absence or must be returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For your insurance to be reinstated the following conditions must be met.

1. You must qualify under the Class Definition.
2. The required premium must be paid.
3. A written request for reinstatement and a new enrollment form for you must be received by us within 31 days from the date you return to Active Service.

Your reinstated insurance is effective on the date you return to Active Service. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation (if any) before your insurance ended due to an unpaid leave of absence, you will receive credit for any time that was satisfied.

TL-004722

GENERAL PROVISIONS

Incontestability

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

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

Misstatement of Age

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

Workers' Compensation Insurance

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

Assignment of Benefits

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

Clerical Error

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

TL-004728

DEFINITIONS

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

Active Service

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

1. You are performing your regular occupation for the Employer on a full-time basis. You must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.

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

Appropriate Care

Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of your Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Consumer Price Index (CPI-W)

The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Covered Earnings

Covered Earnings means your wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date your Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

Disability/Disabled

You are considered Disabled if, solely because of Injury or Sickness, you are:

1. unable to perform the material duties of your Regular Occupation; and
2. unable to earn 80% or more of your Indexed Earnings from working in your Regular Occupation.

After Disability Benefits have been payable for 24 months, you are considered Disabled if, solely due to Injury or Sickness, you are:

1. unable to perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of your Indexed Earnings.

We will require proof of earnings and continued Disability.

Disability Earnings

Any wage or salary for any work performed for any employer during your Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee

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

Employer

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

Full-time

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

Good Cause

A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to us.

Indexed Earnings

For the first 12 months Monthly Benefits are payable, your Indexed Earnings are equal to your Covered Earnings. After 12 Monthly Benefits are payable, your Indexed Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of your Indexed Earnings during your preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury

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

Insurability Requirement

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

Insurance Company

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

Insured

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

Optimum Ability

1. for the first 24 months that benefits are payable, the greatest extent of work you are able to do in your Regular Occupation;
2. after 24 months, the greatest extent of work you are able to do in any occupation based on education, training or experience.

Your ability to work is based on the following:

1. medical evidence you submitted;
2. consultation with your Physician; and
3. evaluation of your ability to work by not more than three Independent Experts if required by us.

There is no cost to you for evaluation by an Independent Expert when required by us to determine Optimum Ability.

The Independent Expert must be:

1. licensed, registered or certified as required by the laws of the state in which the evaluation is made; and
2. acting within the scope of that license, registration or certificate.

Physician

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

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a company in effect on the day prior to that company's addition to this Policy after the Policy Effective Date.

Regular Occupation

The occupation you routinely perform at the time the Disability begins. In evaluating the Disability, we will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan

A written plan designed to enable you to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which we may provide, arrange or authorize education, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness

The term Sickness means a physical or mental illness.

TL-007500.39

**SUPPLEMENTAL INFORMATION
for**

Misericordia University Long Term Disability Plan

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

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

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

IMPORTANT INFORMATION ABOUT THE PLAN

The Plan is established and maintained by:
Misericordia University

The Employer Identification Number (EIN) is:
24-0795406.

The Plan Number is:
501.

The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, LK-960238, issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.

The Plan Administrator is:
Misericordia University
301 Lake Street
Dallas, PA 18612-1008

The Plan Administrator has authority to control and manage the operation and administration of the Plan. The Plan Administrator may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)

The agent for service of legal process is:
The Plan Administrator.

The Plan of benefits is financed by:
The Employer.

The date of the end of the Plan Year is:
June 30.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

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

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company's written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

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

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state, and only when the underlying provision is included in the certificate.

Louisiana residents:

The percentage of Indexed Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

Texas residents:

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a CIGNA company**

Class 1
05/2012



CIGNA Group Insurance
Life • Accident • Disability

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Misericordia University
(herein called the Policyholder)

Policy No.: LK - 960238

This Amendment will be in effect on the Effective Date(s) shown below only for insured Employees in Active Service on that date. If an Employee is not in Active Service on the date his insurance would otherwise become effective, it will be effective on the date he returns to Active Service.

The Company and the Policyholder hereby agree that the Policy is amended as follows:

Effective July 1, 2017, Class 1 under the Classes of Eligible Employees provision of the *Schedule of Benefits* section of the Policy are replaced by the following:

Class 1	All active, Full-time Employees of the Employer regularly working a minimum of 30 hours per week or 130 hours of Active Service in a calendar month.
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Except for the above, this Amendment does not change the Policy in any way.

FOR THE COMPANY



Matthew G. Manders, President

Date: July 12, 2017

Amendment No. 09

TL-004780



Summary Plan Description

Note to Employer: The United States Department of Labor requires this summary or a copy of it be given to each employee.

Plan Sponsor (Employer), Plan Administrator and Agent for Legal Service

Cara Humphreys
Misericordia University

301 Lake St

Dallas PA 18612

Plan Administrator accepts service of legal process.

Phone Number: 570-674-3363

Plan Number: 501

Federal Tax ID: 24-0795405

Employer's Plan Name: Flexible Compensation Plan for MISERICORDIA UNIVERSITY 15-16

Plan Year: 07/01/2016 - 06/30/2017

Carryover Maximum: \$500.00

Runout End Date: 12/14/2017

Client TASC ID: 4000-0923-2546

Group Name: MISERICORDIA UNIVERSITY 15-16

PURPOSE

Your Employer has adopted this Flexible Compensation Plan to allow you to select from among benefit options made available under the Flexible Compensation Plan and pay for the selected benefits for yourself, your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" benefits in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code, and the benefits you elect will be excluded from your income under Section 125(a).

BENEFITS OFFERED TO EMPLOYEES:

	Maximum Participant Salary Reduction	Grace Period End Date
Dependent Care Expenses	\$ 5000.00	09/15/2017
Medical (Out-of-Pocket) Expenses	\$ 2550.00	N/A

This Flexible Compensation Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits and (b) your contribution to any account based tax advantaged plan or fringe benefit plan offered by your Employer that is governed by the Internal Revenue Service (IRS) Code.

ELIGIBILITY REQUIREMENTS: The benefits offered above are available to the following employees as stipulated below:

Participant Entry Period	First of the Month after Date of Hire
Members of Bargaining Unit	N/A
Part-time Employees	Excluded
Seasonal Employees	Excluded

This Plan defines a Plan-eligible employee to be an individual classified by the Employer as a common-law employee who is on the Employer's W-2 payroll. Employees do not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Existing Employees. If you are employed by the Employer on the Plan's effective date, you shall be eligible to participate on the later of the Plan's Effective Date or on the date you satisfy the Eligibility Requirements stated above.

New Employees. If your employment begins after the Plan's Effective Date, you will be eligible to participate on the entry date noted above for Probationary Employees, following the date you satisfy the Eligibility Requirement stated above.

Re-employment of Former Employees.

A re-employed former employee will have the same probationary period as new employees.

Age Requirement. No maximum age requirement may be imposed for participation in the Plan.

GENERAL INFORMATION

This Flexible Compensation Plan allows you to pay your cost for the benefit plans you elected that are sponsored by your Employer through a Salary Reduction Agreement. This lowers your federal and state taxes. Under this Flexible Compensation Plan two types of benefit plans offered by your Employer may be funded by your salary reduction: premium benefits and reimbursement benefits. Premium benefits are the actual payments made to secure your participation in insurance plans. These are payments made from your Employer's general assets to an insurance company or a third-party administrator. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected to defer and pay you tax free benefits for certain qualified medical and dependent care expenses, as authorized under the Internal Revenue Code.

Administration. Your Employer or appointed Plan Administrator is responsible for the administration of your Employer Sponsored General Welfare Plans. Should you need to see any records or have any questions regarding these Plans, contact the Plan Administrator. The Plan Administrator has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. A health insurance issuer is not responsible for the Plan's administration (including payment of claims).

The Plan Administrator appoints TASC as a Service Provider to maintain certain Plan records and to be responsible for the Plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the Plan.

Plan Termination or Amendment. The Employer, or appointed Plan Administrator, has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. Upon the termination or partial termination of the Plan, Participants have no Plan benefits except with respect to covered events giving rise to benefits occurring prior to the date of Plan termination or partial termination, except as otherwise expressly provided in writing by the Employer.

Excess Payments. Upon any benefit payment made to a Participant in error under the Plan, said Participant will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid claim upon request is not provided. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and subtracting from future benefit reimbursement(s) the amount paid in error.

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No Continued Employment. No provisions either of the Plan or of this Summary shall grant any employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any employee covered by the Plan.

Non-Assignment Of Benefits. No Participant or beneficiary may transfer, assign or pledge any Plan benefits except as may be required pursuant to (a) a “Qualified Medical Child Support Order” (which provides for Plan coverage for an alternate recipient), (b) other applicable law, or (c) electronic payment made directly to a healthcare provider.

CONTRIBUTIONS AND ENROLLMENT

Participant Contributions. By participating in the Plan, you agree to have your annual compensation reduced by the total cost of the Plan benefits you elected.

Employer Contributions and Enrollment Elections. At its election, your Employer may pay part of the insurance premiums or other qualified benefits made available through this Plan. The annual enrollment materials will include: (1) the amount of any Employer contributions for the various Plans offered by the Employer that allow you to make pre-tax contributions, (2) the rules defining how the Employer contributions may be used, and (3) the enrollment procedures to make annual elections for your pretax contributions. These enrollment materials are incorporated in this Summary Plan Description by reference.

The various benefit plans offered by your Employer may operate under different plan years. For instance, an Employer may enter into an annual contract with an insurance company (to provide benefits to employees) under a contract year that differs from the Plan Year established for this Flexible Compensation Plan. If this is the case, different Plan benefit entry dates will apply.

If you are not eligible to participate in this Plan but are allowed to participate in another benefit plan offered by your Employer, under the eligibility terms of that Plan, your costs will be paid with taxable income, and your compensation will not be reduced by the Employer.

BENEFITS AND QUALIFYING CHANGE IN STATUS EVENTS

The laws governing Flexible Compensation Plans generally do not allow you to change your benefit and contribution elections during a Plan Year (except for Health Savings Account plans; see below). Your elections are irrevocable and any balance in your account at the close of the Plan Year is forfeited and becomes the property of your Employer (refer to your open enrollment materials if your Plan has a Grace Period or a Carryover); this irrevocable election rule does not apply if you experience a qualifying change in status event, in which case the election change requested must be on account of and consistent with the qualifying event.

Any request to change your election must be submitted in writing within 30 days of any applicable qualifying event. The new benefit elections may start only after your change in status has taken place and the new paperwork has been filed.

A qualifying change in status event may be one of the following:

A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).

The adoption, birth, or death of a child or dependent.

Dependent satisfies or ceases to satisfy dependent eligibility requirements.

The change in employment status of you, your spouse or dependent.

Change in your residence.*

Beginning or ending adoption proceedings.

Automatic changes upon cost increases or decreases.*

Significant cost increases.*

Significant curtailment of coverage.*

Addition or elimination of similar benefits package option.*

Change in coverage of a spouse or dependent under an employer plan.*

FMLA.

HIPAA special enrollment rights.*

COBRA qualifying event.

Loss of group health coverage sponsored by governmental or education institution.*

A judgment, decree or order requiring coverage for a spouse or child.

Medicare or Medicaid entitlement.

Termination of Medicaid or State Children’s Health Insurance Program (SCHIP) coverage.*

Eligibility for Employment Assistance under Medicaid or SCHIP.*

Exchange Event – a loss of eligibility under the terms of the plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the ‘Stabilization Period’ to satisfy the Affordable Care Act coverage requirements.*

Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period.*

* These qualifying events do not apply to the Medical Expenses Reimbursement Plan.

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If you are making tax free contributions to a Health Savings Account (HSA) under this Plan, you do not need a 'change in status' event to change your HSA election. You may prospectively change your HSA election at any time during the Plan Year.

Under the qualifying events of Termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

THE REIMBURSEMENT PLANS

If the BENEFITS OFFERED TO EMPLOYEES Section of this Summary Plan Description lists Medical (Out-of-Pocket) Expenses, Dependent Care Expenses and/or Non-Employer Sponsored Premiums, then your Plan includes that Reimbursement Plan.

The Participant Reference Guide, incorporated by express reference into this Summary Plan Description, includes all of the information you need to access your reimbursement accounts and submit claims for reimbursement. By visiting the Account Manager link addressed in this Guide you may access information about your reenrollment, your available funds, annual election, total contributions, and total reimbursements. These plans provide tax free benefits for medical, dependent daycare and/or non-employer sponsored health insurance premium claim reimbursements in accordance with IRS guidelines and protocols.

Medical (Out-of-Pocket) Expenses Reimbursement Plan. All medical claim expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, with certain limitations described under Services Not Covered; (b) incurred by an employee who has made a valid pre-tax election to participate in the Plan, such employee's spouse, or tax dependent for healthcare purposes as defined in Section 105(b), (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit program.

A medicine or drug that is available for purchase without a prescription is considered an over-the-counter medicine. Under new federal law, an over-the-counter medicine obtained on or after January 1, 2011 may be reimbursed tax free only if a Participant obtains and submits a prescription with their claim for reimbursement. A Participant must submit a 'prescription' that meets all state law requirements of the state in which the prescription was written. The person who wrote the prescription must be allowed to prescribe drugs under applicable state law. A medicine is any over-the-counter item the IRS determines is purchased for the primary purpose of applying the drug or biological contained in the item. Insulin will continue to be reimbursed without a prescription.

The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Medical Expenses Reimbursement Plan: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for a Participant's general wellbeing; items the Participant would have purchased even if the Participant had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

If you contribute to a Health Savings Account (HSA) then you may additionally enroll in a limited *Medical Expenses Reimbursement Plan* only. Qualified expenses under a limited Medical Expenses Reimbursement Plan are limited to dental and vision services or supplies excluded from coverage under your high deductible health plan. The limited Medical Expenses Reimbursement Plan will not provide reimbursement for any other service or supply regardless of whether that service or supply is allowed by the IRS as a medical expense, or allowed under a full Medical Expenses Reimbursement Plan.

Dependent Care Expenses Reimbursement Plan. This Plan provides employees with tax free dependent care assistance only when the assistance is necessary for the Participant to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care Expenses Reimbursement Plan include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of your payroll deduction on the date the claim is processed. The tax laws further limit how much you may contribute to this Plan. Under the law and the terms of the Plan, you may defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or \$5000 per year to this Program. A married Participant who files separate tax returns is limited to \$2500 per year.

Non-Employer Sponsored Premiums Reimbursement Plan. This account provides reimbursement for premiums you paid for employee-owned health insurance policies. Employer provided insurance plans do not qualify. Premiums eligible for reimbursement are for a period in which you were a covered Participant under this Plan.

HEALTH SAVINGS ACCOUNT (HSA)

If you elect Medical Expenses Reimbursement benefits, you cannot also elect HSA benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental) Medical Expenses Reimbursement Benefit. In addition, when the Medical Expenses Reimbursement Benefit includes a grace period and you have a Medical Expenses Reimbursement Benefit that is not a Limited Benefit, you cannot elect HSA benefits or make contributions to an HSA until the first day of the month following the last day of the grace period, unless the balance in your Medical Expenses Reimbursement Benefit is \$0 as of the last day of that Plan Year.

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If you have a Medical Expenses Reimbursement benefit with the Carryover feature that is not a Limited Benefit, you will need to elect the limited Medical Expenses Reimbursement Plan for the new Plan Year. Claims with service dates in the new Plan Year can only be reimbursed if they are covered under the Limited Benefit. In any event, you cannot contribute to an HSA in any month in which you are eligible for a Medical Expenses Reimbursement Benefit that is not a Limited Benefit.

QUALIFIED RESERVIST DISTRIBUTION

A Participant who is called to active duty in the US Armed Services and enrolled in the Medical Expenses Reimbursement Plan may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Medical Expenses Reimbursement Plan subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount you have contributed to the Plan that has not been used to reimburse you for claims submitted.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

LEAVE OF ABSENCE

Family and Medical Leave Act (FMLA). If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your benefit package options providing health coverage (including the Medical Expenses Reimbursement Plan) on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contribution to the extent you opt to continue coverage). Your Employer may require you to continue coverage while you are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If your coverage ceases while on FMLA leave, you will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as you had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which you did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave. If you are going on unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways:

- (1) Prepay. Your share of contributions due during your leave may be paid either pre-tax or after-tax before your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
- (2) Pay-as-you-go. Your share of contributions will be paid on the same schedule as if you were not on leave or under another schedule. Per the Department of Labor regulations, if you fail to make payments under this option, your Employer is not required to continue coverage. If your Employer chooses to make payment and thereby continue coverage, your Employer is entitled to recoup these amounts from you after you return from leave.
- (3) Catch-up. Your Employer may advance your share of contributions while you are on leave. Upon your return from leave, your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with your Employer to determine if this option is available under your Plan.

Non-FMLA Leave. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave. If you take a leave of absence due to military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

TERMINATION OF PARTICIPATION

Participants are enrolled in the Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be a Participant on the earliest of the following dates:

- a. Your death, resignation or termination of employment with the Employer;
- b. The date the Plan terminates;
- c. The date on which you fail to pay any required premium (including payment by salary reduction) under the Plan;
- d. The date you no longer meet the requirements for eligibility in the Plan; or,
- e. The date you revoke your election under a qualifying change in status event.

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When participation has terminated, you are eligible to incur claims against any positive account balance through the eligibility end date.

Positive Balance: Upon termination your annual election amount will be limited to the greater of the amount paid for coverage (total contributions) less previously paid reimbursements or the total of paid reimbursements from the Plan.

As a terminated participant, you are not eligible for the Grace Period unless your eligibility end date is the same as the last day of the Plan Year.

As a terminated Participant, you are not eligible for carryover.

When your participation has terminated, you may submit eligible claims for reimbursement through your run out end date as noted in the Claims Procedure section of this document.

CLAIMS PROCEDURE

Unless otherwise noted in this section, if you have elected reimbursement coverage, you may submit eligible claims for reimbursement through the Plan's runout period which ends on: 12/14/2017

All other claim procedures for the Plan are provided in a separate administrative document upon the original enrollment in the Plan. An additional copy may be provided without charge upon request.

CLAIM DENIALS

Medical and Dental Insurance Benefits. The applicable insurance company will determine your claim in accordance with its claims procedures.

Claims Under the Medical (Out-of-Pocket) Expenses, Dependent Care Expenses or Non-Employer Sponsored Premiums Reimbursement Benefits. The claims procedure described below will apply if (a) a claim for reimbursement under the Medical (Out-of-Pocket) Expenses, Dependent Care Expenses or Non-Employer Sponsored Premium components of the salary reduction plan is wholly or partially denied, or (b) you are denied a benefit under the salary reduction plan due to an issue germane to your coverage under the Plan.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete.) The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. When a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

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Decision on Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA §502(a) (where applicable).

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean 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 the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).

ERISA RIGHTS

The Medical Expenses Reimbursement Plan or Medical Insurance Plan sponsored by your Employer are subject to the Employee Retirement Income Security Act of 1974 (ERISA). (The Medical Premium Plan is not subject to ERISA.) Some of your basic rights under ERISA are described in this Summary Plan Description. Your rights under ERISA and other federal and state law as related to the qualified benefit plans you elected are fully detailed in the Summary Plan Descriptions that are maintained by your Employer for those Plans.

As a participant in the Company's Medical and Dental Expense Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all Plan participants shall be entitled to the following:

To examine, without charge, at the Plan Administrator's office and at other specified locations such as work-sites and union halls, all plan documents including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. Plan documents and other Plan information will be provided upon written request of the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. A summary of the Plan's annual financial report will be automatically sent when such a report is required by law.

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

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can 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 Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court as above. If it should happen that Plan fiduciaries or if you are discriminated against for asserting your rights you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose or if your claim is found to be frivolous, the court may order you to pay these costs and fees. If you have any questions about the Plan, you should contact the Plan Administrator.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes your rights for the Medical Reimbursement Plan. Your rights under any of the other Qualified Benefits Plans offered by your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from your Plan Administrator.

If you elect to participate under the Medical Expenses Reimbursement Plan and are considered a Participant on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of your qualifying event, the amount of your annual election less any reimbursed claims is less than the amount of premium required to continue the Medical Expenses Reimbursement Plan until the end of the Plan Year. COBRA continuation under an excepted Medical Expenses Reimbursement Plan is available until the end of the Plan Year in which the qualifying event occurs.

A Participant who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, you will lose your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of your monthly contribution. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

- (1) Termination of employment (for reason other than "gross misconduct"); and
- (2) Reduction of employee's work hours.

Questions

If you have questions about your COBRA continuation coverage, you should contact your Employer or you may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA); addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.