

Hallmark Cards Incorporated

CIGNA VISION
Standard Plan
Retiree Plan

EFFECTIVE DATE: January 1, 2019

CN019
3328437

This document printed in April, 2019 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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*Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152*

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Hallmark Cards Incorporated

GROUP POLICY(S) — COVERAGE

3328437 - VISS CIGNA VISION

EFFECTIVE DATE: January 1, 2019

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy. If questions arise, the policy will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.


Anna Krishdul, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Important Notices

Missouri Utilization Review Decisions and Procedures.

For initial determinations, Cigna shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

- In the case of a determination to certify an admission, procedure or service, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within two working days of making the initial certification;
- In the case of an adverse determination, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within one working day of making the adverse determination.

For concurrent review determinations, Cigna shall make the determination within one working day of obtaining all necessary information:

- In the case of a determination to certify an extended stay or additional services, Cigna shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the covered person and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;
- In the case of an adverse determination, Cigna shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the covered person and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For retrospective review determinations, Cigna shall make the determination within thirty working days of receiving all

necessary information. Cigna shall provide notice in writing of Cigna's determination to a covered person within ten working days of making the determination.

When conducting utilization review or making a benefit determination for emergency services, Cigna shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services. When a covered person receives an emergency service that requires immediate post evaluation or post stabilization services, Cigna shall provide an authorization decision within 60 minutes of receiving a request; if the authorization decision is not made within 30 minutes, such services shall be deemed approved.

A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. Cigna shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

Cigna shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, Cigna may deny certification of an admission, procedure or service.

If an authorized representative of Cigna authorizes the provision of health care services, Cigna shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition, the health benefit plan terminates before the health care services are provided or the covered person's coverage under the health benefit plan terminates before the health care services are provided.

Notice Regarding Provider Directories and Provider Networks - Vision

A Participating Provider network consists of a group of local practitioners who contract directly or indirectly with Cigna to provide services to members.

You may receive a listing of Participating Providers by calling the member services number on your benefit identification card, or by visiting www.myCigna.com.

Notice - Participating Provider Benefits

The Vision benefit plan includes the following options:

- If you select a Participating Provider Cigna will base its payment on the amount listed in the Schedule of Benefits. The Participating Provider will limit his/her charge to the Contracted Fee for the service.
- If you select a Non-Participating Provider Cigna will base its payment on the amount listed in the Out-of-Network section of the Schedule of Benefits. The Non-Participating Provider may balance bill up to his/her actual charge.

Notice – Emergency Services

Emergency Services rendered by a Non-Participating Provider will be paid at the Participating Provider benefit level in the event a Participating Provider is not available.

Discrimination is Against the Law

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

Cigna:

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

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

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

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

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human

Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HC-NOT99

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How To File Your Claim

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

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

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 365 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. Failure to furnish such proof of loss within 365 days will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

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

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as a retired Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire if you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing a written agreement with the Policyholder to make the required contribution, but no earlier than the date you become eligible.

To be insured for these benefits, you must elect the insurance for yourself no later than 30 days after your retirement.

Dependent Insurance

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing a written agreement with the Policyholder to make the required contribution, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured will become insured from the moment of his birth. You must notify Cigna of the birth of the newly born child and pay any premium, if required, within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. If an application or other form of enrollment is required by your Employer in order to continue coverage beyond the 31-day period after the date of birth, and you have notified Cigna of the birth, either orally or in writing, Cigna will, upon notification, provide you with all forms and instructions necessary to enroll the newly born child and will allow you an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. If you do not notify Cigna of the birth of the newly born child and pay any premium, if required, within such 31 days, coverage for that child will end on the 31st day, and no benefits for expenses incurred beyond the 31st day will be payable.

Cigna Vision		
The Schedule		
For You and Your Dependents		
Copayments Copayments are amounts to be paid by you or your Dependent for covered services.		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
	The Plan will pay 100% after any copayment, subject to any maximum shown below	The plan will reimburse you at 100%, subject to any maximum shown below
Examinations One Eye Exam every Calendar Year	\$10 Copay	\$35
Lenses & Frames	\$25 Copay* *Note: Lenses & Frames Copay does not apply to Contact Lenses	
Lenses One pair per Calendar Year		
Single Vision Lenses	100%	\$20
Bifocal Lenses	100%	\$40
Trifocal Lenses	100%	\$55
Lenticular Lenses	100%	\$55
Contact Lenses One pair per Calendar Year		
Elective	100% up to \$150	\$100
Therapeutic	100%	\$200
Frames One pair per Calendar Year	100% up to \$150	\$75
Note: Low vision coverage of 75% of billed charges up to \$1,000 every 24 months.		

HC-VIS19

Vision Benefits

For You and Your Dependents

Covered Expenses

Benefits Include:

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

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

- Oversize lenses;
- Rose #1 and #2 solid tints.
- Progressive lenses covered up to bifocal lenses amount.

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

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

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

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

Expenses Not Covered

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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Charges incurred after the Policy ends or the insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.

- Charges in excess of the usual and customary charge for the service or materials.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related.
- Claims submitted and received in-excess of 12 months from the original date of service.
- VDT (video display terminal)/computer eyeglass benefit.
- Magnification or low vision aids.
- Spectacle lens treatments, "add ons", or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.

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

Exclusions and General Limitations

Exclusions

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

- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- for or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.

- for charges which would not have been made if the person had no insurance.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

Coordination Of Benefits

I. APPLICABILITY

- A. This Coordination of Benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. Plan and this plan are defined here.
- B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:
 - (1) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
 - (2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in Section IV. Effect on the Benefits of This Plan.

II. DEFINITIONS

- A. Plan is any of these which provide benefits or services for, or because of, medical treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
- B. This plan is the part of the group contract that provides benefits for health care expenses.
- C. Primary plan/secondary plan. The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a

secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan.

- D. Allowable expense means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.
- E. Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

- A. General. When there is a basis for a claim under this plan and another plan. This plan is a secondary plan which has its benefits determined after those of the other plan, unless:
 - (1) The other plan has rules coordinating its benefits with those of this plan; and
 - (2) Both those rules and this plan's rules, in subsection III.B., require that this plan's benefits be determined before those of the other plan.

B. Rules. This plan determines its order of benefits using the first of the following rules which applies:

- (1) Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that—if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (a) Secondary to the plan covering the person as a dependent; and
 - (b) Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
- (2) Dependent child/parents not separated or divorced. Except as stated in paragraph III.B.(3), when this plan and another plan cover the same child as a dependent of different persons, called parents:
 - (a) 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; but
 - (b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plans which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described previously in III.B.(2)(a) or (b) and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (3) Dependent child/separated or divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) First, the plan of the parent with custody of the child;
 - (b) Then, the plan of the spouse of the parent with the custody of the child; and
 - (c) Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse

of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- (4) Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph III.B.(2).
- (5) Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.
- (6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
 - (a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent); and
 - (b) Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule (b) is ignored.
- (7) Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This Section Applies. This section IV. applies when, in accordance with section III., Order of Benefit Determination Rules, this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this section. Other plans are referred to as the other plans in IV.B. immediately following.

- B. Reduction in this plan's benefits. The benefits of this plan will be reduced when the sum of:
- (1) The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Cigna has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Cigna need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Cigna any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under this plan. If it does, Cigna may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this plan. Cigna will not have to 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 benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by Cigna is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- A. The person it has paid or for whom it has paid;
 - B. Insurance companies; or
 - C. Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.
- VIII. Subrogation will not be allowed in any plan as distinguished from the rights to recovery.

Medicare Eligibles

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

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) a retired Employee or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

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

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

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

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

Payment of Benefits

To Whom Payable

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

providers, all claims from contracted providers should be assigned.

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

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

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

Benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by Cigna to be equitably entitled thereto.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will, within 12 months of having made an overpayment, have the right to recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. The 12 month limitation will not apply in cases of fraud or misrepresentation by health care provider.

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

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

Dependents

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

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

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

Continuation

Special Continuation of Medical Insurance

For Employees

If your insurance ceases due to termination of employment for any reason and if you have been insured for at least 3 consecutive months, you may continue the insurance by paying the required premiums to the Policyholder. In no event will the insurance be continued beyond the earliest of the following dates:

- the expiration of 9 months from the date the insurance would otherwise terminate;
- the last day of the period for which you have paid the required contribution;
- the date you become eligible for similar group coverage;
- the date you become eligible for Medicare;
- the date the group policy cancels.

For Dependents

If your insurance is being continued as described above, the insurance for any one of your Dependents insured on the date your insurance would otherwise cease may be continued under the same conditions shown above, until the date your

insurance ceases, or with respect to any one Dependent, the date that Dependent ceases to qualify as a Dependent, whichever comes first.

For Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their insurance by paying the required contribution to the Policyholder, but in no event beyond the earliest of the following dates:

- the expiration of 9 months from the date of your death;
- the last day of the period for which the required contribution has been paid;
- the date your insurance would otherwise have terminated as provided in the Special Continuation of Medical Insurance For Employees section;
- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage;
- the date this policy cancels.

For Spouse Upon Divorce From Employee

If your spouse's insurance would otherwise terminate because of divorce or annulment of marriage, your spouse may continue the insurance by paying the required contribution to the Policyholder, but in no event beyond the earliest of the following dates:

- the expiration of 9 months from the date the insurance would otherwise terminate;
- the last day of the period for which the required contribution has been paid;
- the date that your spouse becomes eligible for similar group coverage;
- the date you, if your spouse obtained coverage through you, are no longer insured under the policy;
- the date this policy cancels.

If the insurance on your former spouse is being continued under a group policy that was replaced by this policy, such spouse will be eligible for continuance under this policy, subject to the other provisions of this policy. However, the insurance will not be continued beyond a period of time totaling more than 9 months under both policies combined.

Provision Regarding Notification of Special Continuance

The Policyholder will notify in writing any eligible person, no later than the date that person's insurance would otherwise terminate, of his right to elect the continuance. The eligible person may elect the continuance by applying in writing and sending the required contribution to the Policyholder within 30 days after the day his insurance would otherwise terminate.

Conversion Available Following Continuation

The terms of the section entitled "Medical Conversion Privilege" will apply following the termination of insurance.

The terms of this section will not reduce any continuation of insurance otherwise provided.

Termination of Insurance

Employees and Dependents

Special Continuation of Dental Insurance

For Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their insurance by paying the required contribution to the Policyholder. Continuation shall begin only after the continuation required by federal law has expired, provided your spouse is at least 55 years of age at such time. Such coverage shall not continue beyond the earliest of the following dates:

- your spouse's 65th birthday;
- the last day of the period for which the required contribution has been paid;
- the date that your spouse becomes insured under any other group health plan, including Medicare;
- with respect to any one Dependent: the date that Dependent becomes eligible for similar group coverage or the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you; or
- the date this policy cancels.

For Spouse Upon Legal Separation or Divorce From Employee

If your spouse's insurance would otherwise terminate because of legal separation, divorce or annulment of marriage, your spouse may continue their insurance, and the insurance of any eligible Dependent children, by paying the required contribution to the Policyholder. Continuation shall begin only after the Continuation Required by Federal Law has expired, provided your spouse is at least 55 years of age at such time. Such coverage shall not continue beyond the earliest of the following dates:

- your spouse's 65th birthday;
- the last day of the period for which the required contribution has been paid;
- the date that your spouse becomes insured under any other group health plan, including Medicare;
- with respect to any one Dependent: the date that Dependent becomes eligible for similar group coverage or the date that

- Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you; or
- the date this policy cancels.

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Federal Requirements

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

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10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

Payment of Benefits

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

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10-10

Eligibility for Coverage for Adopted Children

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

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

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

HC-FED67

09-14

Group Plan Coverage Instead of Medicaid

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

HC-FED13

10-10

Claim Determination Procedures under ERISA

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

Postservice Determinations

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

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

HC-FED79

03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

- your death;

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

Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you).

Medicare Extension for Your Dependents

If you retire and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before retirement, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare.

Termination of COBRA Continuation

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

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

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

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

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries.

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

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

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

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

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

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ERISA Required Information

The name of the Plan is:

Health and Welfare Benefit Plan of Hallmark Cards, Incorporated

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Hallmark Cards, Incorporated
2501 McGee Trafficway
MD 510
Kansas City, MO 64108
888-545-6200

Employer Identification Number (EIN):

440272180

Plan Number:

514

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Hallmark Benefit Plans Welfare Committee
2501 McGee Trafficway
MD 510
Kansas City, MO 64108
888-545-6200

The name, address and ZIP code of the person designated as agent for service of legal process is:

Health and Welfare Benefit Plan of Hallmark Cards, Incorporated
2501 McGee Trafficway
MD 510
Kansas City, MO 64108
888-545-6200

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan’s fiscal year ends on 12/31.

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

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual

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

Plan Modification, Amendment and Termination

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

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

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

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

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

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income

Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the



administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance with Your Questions

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

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05-15

Notice of a Grievance

The grievance provision in this certificate may be superseded by the law of your state if you are not a Missouri resident and if such other state's grievance provision is more favorable than that which is provided in this certificate. Please see your explanation of benefits for the applicable grievance procedure.

Cigna Vision Second Level Grievance Address

Please submit your Level 2 Grievance documents to the following address:

Cigna
NAU National Appeals Unit
P.O. Box 188044
Chattanooga, TN 37422

Notice of an Appeal or a Grievance

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

Cigna Vision Second Level Appeals Address

Please submit your Level 2 Grievance documents to the following address:

Cigna
NAU National Appeals Unit
P.O. Box 188044
Chattanooga, TN 37422

HC-SPP4

04-10

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When You Have A Complaint Or Grievance

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

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

Start with Customer Service

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

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

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

Grievance Procedure

Cigna has a two step grievance procedure for resolving disputes regarding availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person and a health carrier.

To initiate a grievance, you must submit a request for a grievance in writing, no more than one year from the date Cigna issued its last grievance or adverse determination of receipt of a denial notice, to the following address:

Cigna National Appeals Unit (NAU)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your grievance should be approved and include any information supporting your grievance. If you are unable or choose not to write, you may ask to register your grievance by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form. We will acknowledge the receipt of your grievance within five working days.

Grievance

Your grievance will be reviewed and the decision made by someone not involved in the initial decision. Grievances involving Medical Necessity or clinical appropriateness will be considered by a health care professional. We will acknowledge the receipt of your grievance within ten working days.

For level one grievances, we will respond in writing with a decision within 15 calendar days after we receive a pre-service grievance. We will respond within 20 working days after we receive a post-service grievance. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th working day after receipt of the grievance to request an extension of up to 10 business days and to specify any additional information needed to complete the review.

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

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

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

Level Two Grievance

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

grievance. We will acknowledge the receipt of your level two grievance within ten working days and schedule a Committee review.

Level Two grievances must be reviewed by a Committee consisting of individuals, with the following qualifications: other covered persons; representatives of Cigna that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. Others who have a "need to know" may attend the Committee Meetings. The Participant and/or his/her representative may participate via conference call. A Same or Similar Specialist opinion must be obtained for standard Level Two Medical Necessity grievances. This Same or Similar Specialist opinion is considered in the Committee decision. A Physician Reviewer must be responsible for all denial decisions by the Committee. Notice of the committee meeting will be made within 10 calendar days in advance of the scheduled date of the meeting.

We will respond in writing with a decision within 15 calendar days after we receive a pre-service grievance. We will respond within 20 working days after we receive a post-service grievance. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th working day after receipt of the grievance to request an extension of up to 10 business days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two grievance, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

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

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two grievance review regarding your Medical Necessity grievance regarding a difference of opinion between a treating health care professional and Cigna concerning the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a health care service, you or your representative has the option to submit the dispute to the Missouri Department of Insurance, Financial Institutions and Professional Registration for resolution (which is binding upon Cigna and the plan) by an independent external reviewer. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to request a grievance to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

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

To request a review, you must notify the Missouri Department of Insurance, Financial Institutions and Professional Registration following receipt of Cigna's denial. The Missouri Department of Insurance, Financial Institutions and Professional Registration may select an Independent Review Organization to review your issue.

The Independent Review Organization will render an opinion within 20 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, or if your grievance concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services but you have not yet been discharged from a facility, the review shall be completed within three days.

Filing a Grievance with the State of Missouri

You have the right to contact the Missouri Department of Insurance, Financial Institutions and Professional Registration for assistance at any time. The Missouri Department of Insurance, Financial Institutions and Professional Registration may be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration
301 West High Street
P.O. Box 690
Jefferson City, MO 65102
Toll-Free Number: 1-800-726-7390

Notice of Benefit Determination on Grievance

Every notice of a determination on grievance will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary grievance procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your grievance, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the grievance process. A final notice of adverse determination will include a discussion of the decision.

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action in Federal Court under section 502(a) of ERISA if you are not satisfied with the outcome of the Grievances Procedure.

Definitions

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
 - unmarried and no more than 25 years of age, to mean at 12:01 a.m. on the 25th birthday of the eligible dependent, a resident of Missouri; and not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, U.S.C. Section 1395, et seq.
 - more than 25 but less than 26 years old.
 - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you (including that child from the date of placement in your home, unless the child is removed from placement prior to legal adoption). It also includes a stepchild, a grandchild who lives with you, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

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

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Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;

- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

Employee

The term Employee means a retired employee.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

Injury

The term Injury means an unexpected or unintended bodily injury.

Medicaid

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

Medically Necessary/Medical Necessity

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

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

Medicare

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

Ophthalmologist

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

Optician

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

Optometrist

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

Sickness – For Medical Insurance

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

Vision Provider

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