



AURA

**National Optical Astronomy
Observatory**

**Employee Benefits
Summary**

01/2009



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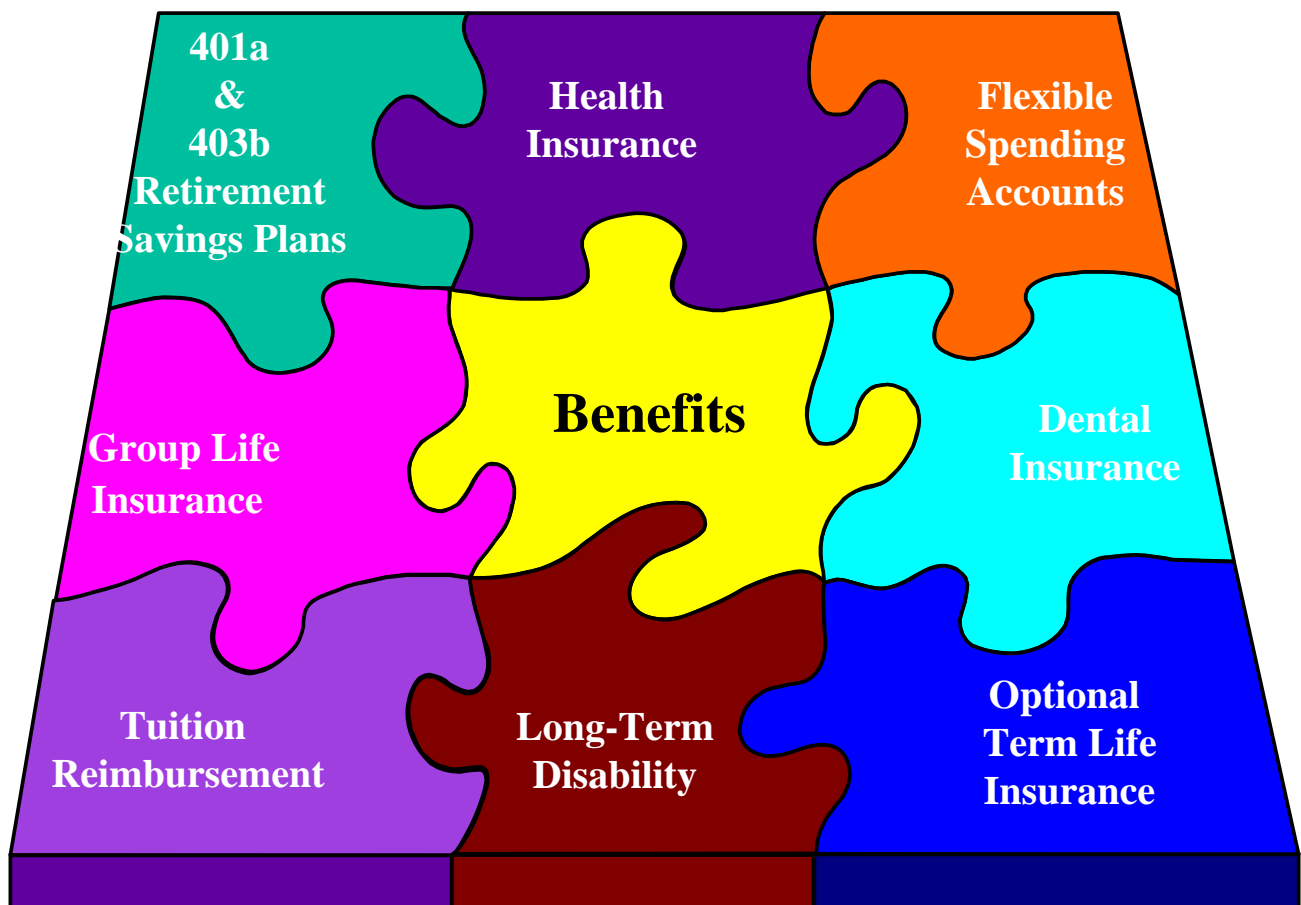
Your Benefits

We are pleased to provide you and your family with a comprehensive benefits package that addresses your personal health, medical and financial well being.

We encourage you to examine this booklet carefully in order to understand the benefits available to you and your family members.

The Best Decisions... are based on information. This booklet has been prepared to assist you in evaluating the coverage available through AURA/ National Optical Astronomy Observatory.

- This guide is an **overview of the benefit plans** and should not be construed as the individual Summary Plan Descriptions. It should not be relied upon to fully determine coverage. If differences exist between this Employee Benefits Summary and the Certificate of Coverage, the certificate governs.
- For each coverage elected, you will receive a Summary Plan Description and detailed coverage information from the insurance carrier or Human Resources. If you are uncertain about any provisions specified in this guide, please refer to the Certificate of Coverage which will govern.



Benefit Plan Eligibility

You and eligible for benefits if you fall into one of the following categories:

- Regular Full-time Employee
- Regular Part-time Employee – normally scheduled at least 20 hours per week

Your dependents include:

- Legal Spouse or Domestic Partner
- Your unmarried dependent children up to age 19 who are dependent on you for financial support;
- Your unmarried children between 19 and 25, if they depend primarily on you for financial support and are enrolled as full-time student in an accredited school
- Your physically or mentally disabled dependent child(ren) of any age but only if the physical or mental disability began while they were eligible for benefits.

When coverage begins:

Medical and Dental and Group Life Insurance

The first day of the month following or coincident with employment.

Optional Life and Voluntary AD&D Insurance

The first day of the month following or coincident with employment or the date you apply and are approved, if later.

Long Term Disability (Full-time employees only)

The first day of the month following one year of active continuous employment unless enrolled in a LTD plan within the three months immediately preceding employment.

Money Purchase Pension Plan 401(a)

The first day of the month following one year of active continuous employment and completion of 1000 hours, unless enrolled in a employer pension plan within the three months immediately preceding employment.

Group Supplemental Retirement Account 403(b)

The first day of the month following or coincident with employment or the date you enroll, if later.

Employees must initially enroll in elected benefits within 31 days of their eligibility/hire date.

Every year during open enrollment, you will have an opportunity to make new benefit elections for the coming year. All eligible employees who wish to make any benefit changes must complete and return an enrollment form by the due date. If your share of cost for any coverage for which you are paying on a pre-tax basis increases or decreases due to a change in the premium, the amount withheld from your paycheck will be automatically adjusted.

Special Enrollment : If you decline enrollment for yourself or your dependents (including your spouse) in any of the AURA health plans because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Benefits Overview

❖ **HEALTH:** Premiums paid 100% for employees; you pay bi-weekly premiums for a portion of your dependent's coverage.

Arizona and other US locations- including New Mexico
Cigna Healthcare

Expatriates Outside the US:
CIGNA International

❖ **DENTAL:** Premiums paid 100% for employees; you pay bi-weekly premiums for a portion of your dependent's coverage.

Arizona - Employers Dental Services (EDS), Scheduled Plan

All Locations - MetLife PDP, Preferred Provider Organization

Expatriates Outside the US: CIGNA (included in Medical Plan)

❖ **GROUP LIFE INSURANCE (All locations) :** Sun Life Financial

Basic Life Insurance and AD&D:

Full-Time Employees: 1x salary to \$250,000 with a minimum of \$40,000

Part-Time Employees: 1x salary to \$250,000 with a minimum of \$20,000

Optional Life Insurance and Voluntary AD&D - \$10,000 increments up to
\$500,000 or seven times salary.

❖ **LONG TERM DISABILITY (LTD):** Sun Life Financial

Domestic - 60% of basic monthly earnings to a maximum of \$6,000/month.

International - 66 2/3% of basic monthly earnings to a maximum of \$6,000/month.

❖ **401(a) & 403(b) RETIREMENT SAVINGS PLANS –**

The **401(a)** is a Defined Contribution Plan funded by AURA contributing on a biweekly basis an amount equal to 10% of your base salary.

The **403(b)** is a Tax Sheltered Account and is funded entirely through salary reduction and contributions are tax deferred.

❖ **FLEXIBLE SPENDING ACCOUNTS –** Pre-tax salary reduction accounts for use in paying certain out-of pocket medical and dependent care costs.

❖ **TUITION REIMBURSEMENT -**Applies to regular full-time employees. Contact the Human Resources Department for further information regarding participation, qualifying programs, and reimbursement limitations.

Flexible Spending Accounts

◆ A **FLEXIBLE SPENDING ACCOUNT (FSA)** is an IRS Section 125 Cafeteria Plan that allow employees the option of pre-tax payroll deductions for some insurance premiums; unreimbursed medical expenses and child/dependent care expenses.

WHO IS ELIGIBLE FOR THE FSA?

All full time and part time employees who work a minimum of 20 hours per week.

Health Care Account:

You may use the account to cover eligible healthcare expenses not reimbursed medical expenses you or your dependents incur during the plan year. This includes deductibles, co-pays, over-the-counter medication, prescription drugs, vision, etc.

The maximum annual contribution limit is \$5,000.

The Medical Expense account may not be used for expenses which are reimbursable by your insurance or other means.

Dependent Care Account:

The account will reimburse you for eligible dependent care expenses if it is necessary for you and your spouse, if married to work. Covered services include care for:

- *dependents under the age of thirteen;*
- *children thirteen or older who are mentally or physically incapable of self-care;*
- *dependent adults.*

The maximum annual contribution limit is \$5,000 or \$2,500 for single individuals and married individuals filing separately.

You must USE IT...or LOSE IT!

Be careful in your planning. You should contribute no more than you expect to pay in 2009. Under current IRS regulations, any remaining balances left in your account at the end of the year will be forfeited.

Medical Benefits

Our goal is offer you a comprehensive medical plan with options to meet the diverse needs of our workforce. Prescription drug coverage is automatically included in all plans offered.

ARIZONA & NEW MEXICO- OPEN ACCESS PLUS (OAP)

This plan gives you the convenience of **referral-free access to physicians**, and the option to select a personal Primary Care Physician (PCP) as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.

When you visit network providers, you get access to quality care at the lowest out-of-pocket costs. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are higher when you see “preferred providers”, but you're still covered for visits to other providers.

Prescription drug coverage **is a part of your plan**. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled wherever you go. Mail-order service means quick, **convenient** delivery of your medications right to your home.

The CIGNA HealthCare 24-Hour Health Information Line connects you **to registered nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.

CIGNA Healthy Rewards® includes special offers on health and wellness programs and services often not covered by traditional benefits plans. Just call 1.800.870.3470 or visit our web site

www.mycigna.com – Visit the **interactive Web site** to learn more about your plan and get health information, 24 hours a day.

SEE APPENDIX A FOR THE ARIZONA-CIGNA Open Access Plus (OAP) SUMMARY OF COVERAGE.

SEE APPENDIX B FOR THE NEW MEXICO- CIGNA Open Access Plus (OAP) SUMMARY OF COVERAGES

For Expatriates outside of the United States we offer a benefit plan with CIGNA International Expatriate Benefits:

Under the CIGNA International plan you have the freedom of choice to see any doctor, dentist or visit any hospital in the world. You will not be assigned a doctor nor will you need a referral to see a specialist. International assignees have access to 24-hour Customer Service representatives, toll-free telephone and fax service from anywhere in the world. All claims are processed in Wilmington, Delaware, which is devoted to processing international claims and routinely handles language/currency/cultural issues.

SEE APPENDIX C FOR THE CIGNA- INTERNATIONAL SUMMARY OF COVERAGE

Your Cost for Medical Insurance

The figures below reflect the bi-weekly cost to you for covering yourself and any dependents*:

Dependent Medical are pre-tax deductions, which reduces your taxable income.

2009 Benefit Renewal Premium Rates Active Employee Plans

Effective January 1, 2009

Location	Dental Insurance Plans		Full-time Employees		Part-time Employees 50% FTE
Tucson	Employers Dental Services	New Rates paid by AURA/month	New Per Paycheck Deduction *		New Per Paycheck Deduction **
	Employee	\$11.74	\$0.00		\$2.71
	Employee +1	\$20.40	\$2.00		\$5.71
	Employee +2 (or more)	\$27.79	\$3.70		\$8.27
All areas	MetLife	Monthly Rate paid by AURA/month	Per Paycheck Deduction *		Paycheck Deduction **
	Employee	\$41.86	\$0.00		\$9.66
	Employee + Spouse	\$83.47	\$9.60		\$24.06
	Employee + Child(ren)	\$88.80	\$10.83		\$25.91
	Employee + Family	\$126.44	\$19.52		\$38.94
Medical Insurance Plans					
Arizona California	CIGNA AZ-CA	New Rates paid by AURA/month	New Per Pay Check Deduction *		New Per Paycheck Deduction **
	Employee	\$474.39	\$0.00		\$109.47
	Employee +1	\$949.04	\$109.53		\$273.78
	Employee +2 (or more)	\$1,413.45	\$216.71		\$434.53
New Mexico	CIGNA NM	New Rates paid by AURA/month	New Per Pay Check Deduction *		New Per Paycheck Deduction **
	Employee	\$800.13	\$0.00		\$184.65
	Employee +1	\$1,609.65	\$186.81		\$464.86
	Employee + Family	\$2,338.31	\$354.96		\$717.09
Combined Medical & Dental Insurance Plans					
Expatriates	Cigna International	New Rates paid by AURA/month	New Per Pay Check Deduction *		New Per Paycheck Deduction **
	Employee	\$491.71	\$0.00		\$113.47
	Employee +1	\$1,072.46	\$132.02		\$314.50
	Employee +2 (or more)	\$1,584.93	\$252.28		\$491.89

*Actual employee Deduction may be lower due to premium capping

**Employee Deduction may be lower due to hours scheduled and premium capping- contact HR for your rate

Dental Benefits

Good dental care is essential to the maintenance of your overall health and requires regular check-ups and preventive care. The dental plans provide important insurance protection for you and your family.

Summary of Dental Benefits			
Benefit	MetLife		Employers Dental Service
Plan Type	Indemnity/PPO		Prepaid
Annual Deductible	\$50 Individual \$150 Family		No Deductibles
Annual Maximum Benefit	\$1,500		No Dollar Limit
	<i>In-Network*</i>	<i>Out-of-Network**</i>	<i>Network Only</i>
Preventive Care			
Office Visit			\$5/visit
Periodic Oral Exam			N/C
Prophylaxis Cleaning	100% of PDP fee	100% of R&C fee	\$7/visit
Sealants (molars to age 19)	Deductible Waived	Deductible Waived	\$12/tooth
Fluoride Applications			\$7 N/C for child
X-rays			N/C
Basic Restorative			
Office Visit			\$5/visit
Amalgam Fillings			\$13-\$30 (amalgam)
Extractions	100% of PDP fee	80% of R&C fee	\$35 (single)
Periodontal			co-pay/procedure
Oral Surgery			co-pay/procedure
Major Restorative			
Office Visit			\$5/visit
Crowns			\$280 (plus lab fees)
Dentures			co-pay/procedure
Fixed Bridgework	60% of PDP fee	50% of R&C fee	co-pay/procedure
Crown/Bridge Repair			co-pay/procedure
Inlays			co-pay/procedure
Orthodontia			
Child (to age 19)	50% of PDP or R&C fee \$1000 Lifetime Maximum		25% discount off normal charges
Adult	no coverage		25% discount off normal charges
TMJ Services			
Exam, Services, etc.	no coverage		25% discount off normal charges
Specialist			
	Same as benefits above		25% discount off normal charges of an EDS Specialist

* Benefits provided by a participating PDP- provider at a negotiated fee schedule

** Reasonable and Customary charge for benefits provided under the plan for covered dental services that are not provided by a participation PDP provider

Your Cost for Dental Insurance

Dependent Dental Premiums are pre-tax deductions, which reduces your taxable income.

2009 Benefit Renewal Premium Rates Active Employee Plans

Effective January 1, 2009

Location	Dental Insurance Plans	Full-time Employees		Part-time Employees 50% FTE
Tucson	Employers Dental Services	New Rates paid by AURA/month	New Per Paycheck Deduction *	New Per Paycheck Deduction **
	Employee	\$11.74	\$0.00	\$2.71
	Employee +1	\$20.40	\$2.00	\$5.71
	Employee +2 (or more)	\$27.79	\$3.70	\$8.27
All areas	MetLife	Monthly Rate paid by AURA/month	Per Paycheck Deduction *	Paycheck Deduction **
	Employee	\$41.86	\$0.00	\$9.66
	Employee + Spouse	\$83.47	\$9.60	\$24.06
	Employee + Child(ren)	\$88.80	\$10.83	\$25.91
	Employee + Family	\$126.44	\$19.52	\$38.94

Basic Group Life Insurance



Sun Life Financial#:67430
Customer Service: 1-800-247-6785

Sun Life Financial

Our Life Insurance plan is underwritten by Sun Life Assurance Company of Canada.

All Regular Full-time and Part Time employees scheduled to work at least 20 hours per week are eligible for coverage.

Life Insurance Benefit:

FULL-TIME

LIFE- 1x salary to \$250,000 with a minimum of **\$40,000**

AD&D- \$10,000 increments up to \$500,000 or seven times salary

PART-TIME

LIFE- 1x salary to \$250,000 with a minimum of **\$20,000**

AD&D- \$10,000 increments up to \$500,000 or seven times salary

Upon receipt of a satisfactory claim, Sun Life will pay the death benefit to the designated beneficiary in accordance with the Certificate of Coverage.

LIFE REDUCTION SCHEDULE

At age 75, benefits will reduce to 65% of the covered amount;

At age 80, benefits will reduce to 50% of the original amount.

Optional Term Life & Voluntary Accidental Death & Dismemberment Insurance

Optional Term Life and Voluntary Accidental Death & Dismemberment (AD&D)

In addition to Basic Life and AD&D, if you meet the eligibility requirements, Sun Life provides you with the opportunity to purchase Optional Life and Voluntary AD&D Life insurance up to seven times your annual earnings, rounded to the next higher \$10,000 with a cap of \$500,000.

The Guarantee Issue amount of Optional Life Insurance, which means the amount you can be issued without submitting Evidence of Insurability, is \$100,000. The spousal Guarantee Issue amount is \$30,000 and dependent children is \$10,000. *(You must apply within 31 days of your eligibility date in order to receive this guarantee)* All costs related to providing evidence of insurability are the employees responsibility.

The OPTIONAL life insurance plan is insured by Sun Life of Assurance Company of Canada.

~~The benefit is paid entirely by the employee.~~

Sun Life Financial#:67430
Customer Service: 1-800-247-6785

You may also purchase.....

Optional Dependent Life Insurance

Spouse:
3 ½ times employees salary up to \$150,000.

Dependent Children:
to 19 years - \$10,000

Dependent children are eligible for coverage to age 19, or if they are a full time student, to age 25.

This benefit is fully paid for by the employee

Voluntary AD&D Insurance

Spouse:
50% of the employee amount

Sun Life Optional Life Insurance				
Rates/Month/\$10,000 Coverage				
AGE	Employee		Spouse	Child(ren)
	Non	Smoker		
00-24	\$ 0.90	\$ 1.70	\$ 0.81	\$1.23 for \$10,000 Coverage for eligible child(ren)
25-29	\$ 0.90	\$ 1.70	\$ 0.98	
30-34	\$ 1.00	\$ 1.90	\$ 1.30	
35-39	\$ 1.30	\$ 2.40	\$ 1.47	
40-44	\$ 2.10	\$ 3.90	\$ 1.63	
45-49	\$ 3.50	\$ 6.70	\$ 2.44	
50-54	\$ 5.70	\$ 11.50	\$ 3.75	
55-59	\$ 10.10	\$ 18.80	\$ 7.00	
60-64	\$ 12.40	\$ 21.70	\$ 10.75	
65-69	\$ 22.10	\$ 35.90	\$ 20.68	
70-74	\$ 37.40	\$ 56.10	not available	
75-80	\$ 57.77	\$ 86.50	available	

Sun Life Voluntary AD&D Coverage

\$.20/\$10,000 Coverage

Long Term Disability

We understand that for most of us our income is the most important financial resource. To be without income for an extended period of time would most likely be devastating for you and your family. NOAO recognizes the importance of protecting your income against the possibility of long term disability.

Sun Life Insurance Policy#: 67430
Customer Service: 1-800-247-6785



EMPLOYER
CONTRIBUTES
100% FOR THE
EMPLOYEE

Eligibility is after a one year waiting period unless waived. Enrollment is automatic.

◆ *Long Term Disability Plan Costs*

The cost of your Long Term Disability Plan is entirely paid for by NOAO and will provide a benefit if you become disabled for more than 180 days due to accident or illness.

◆ *Benefit Amount*

In the event that you become disabled, for over 180 days, the NOAO LTD plan will provide you with the following benefits:

Domestic Employees: 60% of your basic monthly earnings to a maximum of \$6,000 per month.

International Employees: 66 2/3% of your basic monthly earnings to a maximum of \$6,000 per month.

◆ *Benefit Period*

Should you become disabled and unable to return to work this benefit would continue until you are no longer disabled or up to age 65. If your disability occurs at or after age 65, benefits would be paid for a reduced period of time.

◆ *Mental & Nervous Benefit Period*

is limited to 24 months unless you are confined in a hospital.

◆ *Pre-Existing Condition*

limitation is applicable to this coverage. Namely, if you have received treatment for any condition 3 months prior to the coverage effective date, you will need to be treatment-free for 12 months from your effective date before benefits will be paid for the pre-existing condition.

AURA Retirement Program Summary

AURA offers employees tax-deferred retirement options in two investment companies. Teachers Insurance Annuity Association/College Retirement Equity Fund (TIAA-CREF) and Fidelity Investments for both the non-contributory AURA plan and for the employee voluntary plan. These companies provide a selection between fixed and variable funds for both the Regular and Supplemental programs.

	Money Purchase Pension Plan – MPP (401A) Regular Retirement Account	Supplemental Retirement Account – SRA (403B) Tax Sheltered Account
Eligibility:	One year waiting period (may be waived if participant in similar plan prior to hire).	First day of any pay period coincident with or following date of hire.
Vesting:	100% immediately upon participation.	
Contributions:	Employer only.	Employee only.
Amount:	10% of base salary. Contributions are made bi-weekly at the close of the pay period in which they are earned.	No minimum contribution imposed by TIAA-CREF or Fidelity. Maximum contingent upon IRS regulations.*
Tax-Status:	Employer contributions are 100% tax-deferred.	Employee contributions are 100% tax-deferred.
Withdrawal Provisions:	No in-service withdrawals. Upon termination, lump sum withdrawal subject to 10% early withdrawal penalty and federal and state taxes if not rolled-over to another qualified plan. Some restrictions apply on TIAA-CREF accounts.	No in-service withdrawals, except full or partial withdrawals for defined hardships, subject to 10% early withdrawal penalty and federal and state taxes.
Portability:	May rollover qualified pension contributions from previous employer. May continue with future employer if future employer has a similar plan and allows rollovers into their plan.	Full transfer to other 403(b), IRA, 401(k) permitted.
Loan Provisions:	None on MPP.	Loans are permitted for TIAA/CREF. They are limited by federal guidelines and the rules of the investment company. No loans on Fidelity accounts.
Transfers:	Transfer of existing funds from one investment company to another at any time (providing you have an open account); subject to any and all fees imposed by respective investment companies. Frequency of transfer of funds within active accounts TIAA-CREF unlimited. Fidelity generally unlimited.	
Change In Investment:	Change from one investment company to the other anytime during the year. Changes in allocation of future contributions among funds within Fidelity are unlimited. TIAA-CREF is once a month.	Employees may cancel, increase, or decrease their contributions at the beginning of any pay period, as well as transfer from one investment company to the other at any time throughout the year. Transfer of funds within TIAA-CREF and Fidelity same as MPP.
Investment Option:	TIAA-CREF or Fidelity Investments	
*Note:	Employees may contribute the IRS determined maximum, which for 2009 max is \$16,500 An additional \$5,500 catch-up contribution is allowed for those 50 and older.	

APPENDIX A-1

CIGNA HealthCare Open Access Plus plan SUMMARY OF BENEFITS- ARIZONA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible Individual Family Maximum	None None	\$300 \$600
Calendar Year Out-of-Pocket Maximum Individual / Family Maximum	\$1,000/\$2,000	Excludes Plan Deductible \$2,000/\$4,000
Coinsurance	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges.	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.
Precertification -Inpatient – PHS+ (required for all inpatient admissions) Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)	Coordinated by your physician Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance
Lifetime Maximum	Unlimited	Unlimited
Pre-existing Condition Limitation	No	No
Physician Services Primary Care Physician (PCP) Office Visit Specialty Physician Office Visit Consultant and Referral Physician Services Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment. Allergy Treatment/Injections - PCP or Specialty Physician Allergy Serum (dispensed by physician in office) Second Opinion Consultations (provided on voluntary basis) Surgery Performed in the Physician's Office- PCP or Specialty Physician	\$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. \$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. \$10 copayment per office visit or actual charge, whichever is less No charge \$10 copayment per office visit \$10 copayment per office visit	20% of charges** 20% of charges** 20% of charges** 20% of charges**
Preventive Care Routine Preventive Care for Children through age 2 (including routine immunizations) Immunizations Routine Preventive Care for Children and Adults from age 3 (including routine immunizations) Unlimited maximum per calendar year Immunizations	\$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge, no plan deductible \$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge, no plan deductible	Covered in-network only Covered in-network only Covered in-network only Covered in-network only
Mammograms, PSA, Pap Test Note: Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services based on place of service.	No charge if billed by independent diagnostic facility or outpatient hospital \$10 copayment for associated wellness exam	20% of charges**

APPENDIX A-2

BENEFIT HIGHLIGHTS

IN-NETWORK

OUT-OF-NETWORK

<p>Inpatient Hospital Services including: Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy MRIs, MRAs, CAT Scans, PET Scans, etc.</p>	<p>No charge</p>	<p>20% of charges* Precertification required</p>
<p>Inpatient Hospital Doctor's Visits/Consultations Inpatient Hospital Professional Services</p>	<p>No charge No charge</p>	<p>20% of charges** 20% of charges**</p>
<p>Outpatient Facility Services Operating Room, Recovery Room, Procedure Room and Treatment Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician and Outpatient Professional Services</p>	<p>No charge No charge</p>	<p>20% of charges** 20% of charges**</p>
<p>Laboratory and Radiology Services (includes preadmission testing) Physician's Office Outpatient Hospital Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit) Independent X-Ray and/or Lab Facility Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</p>	<p>\$10 copayment per office visit No charge No charge No charge No charge</p>	<p>20% of charges** 20% of charges** No charge; <i>except if not a true emergency, then 20% of charges**</i> 20% of charges** No charge</p>
<p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) Outpatient Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit) Physician's Office</p>	<p>No charge No charge No charge</p>	<p>20% of charges** No charge; <i>except if not a true emergency, then 20% of charges**</i> 20% of charges**</p>
<p>Short-Term Rehabilitative Therapy Cardiac Rehabilitation and Chiropractic Services – (includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) 60 days maximum per calendar year# for all therapies combined <i>Note: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</i></p>	<p>\$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p>	<p>20% of charges**</p>
<p>Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician) Urgent Care Facility or Outpatient Facility Ambulance</p>	<p>\$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. \$75 copayment per visit (copay waived if admitted) No charge \$35 copayment per visit (copay waived if admitted) No charge</p>	<p><i>Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 20% of charges**</i></p>
<p>Maternity Care Services Initial Office Visit to Confirm Pregnancy <i>Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee) Office Visits not included in the total maternity fee performed by OB or Specialty Physician Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i></p>	<p>\$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge \$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge</p>	<p>20% of charges** 20% of charges** 20% of charges** Precertification required</p>

APPENDIX A-3

BENEFIT HIGHLIGHTS NETWORK

IN-NETWORK

OUT-OF-

<i>Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities</i> 60 days maximum per calendar year# combined for all facilities listed	No charge	20% of charges**
<i>Home Health Services</i> -Includes outpatient private duty nursing when approved as medically necessary, Unlimited days maximum per calendar year# 16 hour maximum per day#	No charge	20% of charges**
<i>Family Planning Services Office Visits (lab & radiology tests, counseling) Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Services Physician's Services – Inpatient or Outpatient Physician's Office</i>	\$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge No charge No charge \$10 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	20% of charges** 20% of charges* Precertification required 20% of charges** 20% of charges** 20% of charges**
<i>Infertility Services Note:</i> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not covered	Not covered
<i>TMJ – Surgical and Non-surgical</i>	Not Covered	Not Covered
<i>Mental Health and Substance Abuse Inpatient</i> – 30 days combined maximum per calendar year# <i>Mental Health Acute:</i> Based on a ratio of 1:1 <i>Partial:</i> Based on a ratio of 2:1 <i>Residential:</i> Based on a ratio of 2:1 <i>Substance Abuse Acute Detox:</i> Based on a ratio of 1:1 (requires 24 hour nursing) <i>Acute Inpatient Rehab:</i> Based on a ratio of 1:1 (requires 24 hour nursing) <i>Partial:</i> Based on a ratio of 2:1 <i>Residential:</i> Based on a ratio of 2:1 <i>Outpatient Individual</i> – 20 visits combined maximum per calendar year# <i>Group Therapy Mental Health</i> – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1 <i>Intensive Outpatient Mental Health & Substance Abuse</i> – 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Mental Health/Substance Abuse visits	No charge \$10 copayment per visit \$5 copayment per session No charge	20% of charges* Precertification required 20% of charges** 20% of charges** \$50 per program deductible, plus 20% of charges; no plan deductible
<i>Durable Medical Equipment</i> \$2,500 maximum per calendar year# <i>Diabetes Equipment</i> Unlimited maximum per calendar year	No charge No charge	20% of charges** 20% of charges**
<i>External Prosthetic Appliances</i> \$2,500 maximum per calendar year# <i>Diabetes Equipment & Custom Foot Orthotics</i> Unlimited maximum per calendar year	No charge No charge	20% of charges** 20% of charges**
<i>Vision Care</i> Eye Exam every 12 months	No charge after \$20 deductible	

APPENDIX A-3

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Prescription Drugs</i>		
<i>CIGNA Pharmacy Retail Drug Program</i> <i>Includes: insulin, insulin needles & syringes, diabetic test strips/lancets, oral contraceptives and contraceptive devices, and prenatal vitamins.</i>		
<i>Generic*** drugs on the Prescription Drug List for a 30-day supply</i>	\$10 copayment per rescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply</i>	\$25 copayment per rescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 30-day supply</i>	\$50 copayment per prescription/refill	Covered in-network only
<i>CIGNA Tel-Drug Mail Order Drug Program</i>		
<i>Generic*** drugs on the Prescription Drug List for a 90-day supply</i>	\$20 copayment per prescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply</i>	\$50 copayment per prescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 90-day supply</i>	\$100 copayment per prescription/refill	Covered in-network only
<i>***Designated as per generally-accepted industry sources and adopted by CG</i>		

Footnotes

* Services are subject to calendar year deductible.

** Out-of-network services are subject to the calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

In-network and out-of-network services apply to the same treatment or dollar maximum.

Regarding In-Network and Out-of-Network Services:

• Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.

Regarding In-Network Services:

• All services must be provided by one of the participating providers on our list in order to be covered.

Regarding Out-of-Network Services:

Your out-of-pocket costs will be higher than with a participating provider.

All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be pre-certified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not pre-certified. Non-approved admissions/days result in denial of benefits. The pre-certification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.

APPENDIX B-2

BENEFIT HIGHLIGHTS NETWORK	IN-NETWORK	OUT-OF-
<p>Outpatient Facility Services Operating Room, Recovery Room, Procedure Room and Treatment Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician and Outpatient Professional Services Note: Non-surgical treatment procedures are not subject to the facility copayment.</p>	\$50 copayment per facility visit No charge	25% of charges** 25% of charges**
<p>Laboratory and Radiology Services (includes preadmission testing) Physician's Office Outpatient Hospital Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit) Independent X-Ray and/or Lab Facility Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</p>	\$15 copayment per office visit No charge No charge No charge No charge	25% of charges** 25% of charges** No charge; <i>except if not a true emergency, then 25% of charges**</i> 25% of charges** No charge
<p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) Outpatient Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit) Physician's Office</p>	No charge No charge No charge	25% of charges** No charge; <i>except if not a true emergency, then 25% of charges**</i> 25% of charges**
<p>Short-Term Rehabilitative Therapy Cardiac Rehabilitation and Chiropractic Services – (includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) 20 days maximum per calendar year# for all therapies combined Note: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</p>	\$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	25% of charges**
<p>Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician) Urgent Care Facility or Outpatient Facility Ambulance</p>	\$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. \$50 copayment per visit (copay waived if admitted) No charge \$15 copayment per visit (copay waived if admitted) No charge	Care will be provided at in-network levels if it meets the “prudent layperson” definition of an emergency. Otherwise 25% of charges**
<p>Maternity Care Services Initial Office Visit to Confirm Pregnancy Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee) Office Visits not included in the total maternity fee performed by OB or Specialty Physician Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</p>	\$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge \$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. \$250 copayment per admission	25% of charges** 25% of charges** 25% of charges** Precertification required

APPENDIX B-3

BENEFIT HIGHLIGHTS NETWORK

IN-NETWORK

OUT-OF-

<p>Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities 60 days maximum per calendar year# combined for all facilities listed</p>	<p>No charge</p>	<p>25% of charges**</p>
<p>Home Health Services -Includes outpatient private duty nursing when approved as medically necessary, Unlimited days maximum per calendar year# 16 hour maximum per day#</p>	<p>No charge</p>	<p>25% of charges**</p>
<p>Family Planning Services Office Visits (lab & radiology tests, counseling) Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Services Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>\$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. \$250 copayment per admission \$50 copayment per facility visit No charge \$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p>	<p>25% of charges** 25% of charges* Precertification required 25% of charges** 25% of charges** 25% of charges**</p>
<p>Infertility Services Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	<p>Not covered</p>	<p>Not covered</p>
<p>TMJ – Surgical and Non-surgical</p>	<p>Not Covered</p>	<p>Not Covered</p>
<p>Mental Health and Substance Abuse Inpatient – 30 days combined maximum per calendar year# Mental Health Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1 Substance Abuse Acute Detox: Based on a ratio of 1:1 (requires 24 hour nursing) Acute Inpatient Rehab: Based on a ratio of 1:1 (requires 24 hour nursing) Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1 Outpatient Individual – 20 visits combined maximum per calendar year# Group Therapy Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1 Intensive Outpatient Mental Health & Substance Abuse – 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Mental Health/Substance Abuse visits</p>	<p>\$10 copayment per visit \$5 copayment per session \$50 per program copayment No charge</p>	<p>\$50 deductible per admission plus 25% of charges* Precertification required 25% of charges** 25% of charges** \$50 per program deductible, plus 25% of charges; no plan deductible</p>
<p>Durable Medical Equipment \$2,500 maximum per calendar year# Diabetes Equipment Unlimited maximum per calendar year</p>	<p>No charge No charge</p>	<p>25% of charges** 25% of charges**</p>
<p>External Prosthetic Appliances \$2,500 maximum per calendar year# Diabetes Equipment & Custom Foot Orthotics Unlimited maximum per calendar year</p>	<p>No charge No charge</p>	<p>25% of charges** 25% of charges**</p>
<p>Vision Care Eye Exam every 12 months</p>	<p style="text-align: center;">20 No charge after \$20 deductible</p>	

APPENDIX B-3

BENEFIT HIGHLIGHTS NETWORK	IN-NETWORK	OUT-OF-
Durable Medical Equipment \$2,500 maximum per calendar year# Diabetes Equipment Unlimited maximum per calendar year	No charge No charge	20% of charges** 20% of charges**
External Prosthetic Appliances \$2,500 maximum per calendar year# Diabetes Equipment & Custom Foot Orthotics Unlimited maximum per calendar year	No charge No charge	20% of charges** 20% of charges**
Vision Care Eye Exam every 12 months	No charge after \$20 deductible	
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs		
CIGNA Pharmacy Retail Drug Program <i>Includes: insulin, insulin needles & syringes, diabetic test strips/lancets, oral contraceptives and contraceptive devices, and prenatal vitamins.</i>		
<i>Generic*** drugs on the Prescription Drug List for a 30-day supply</i>	\$10 copayment per prescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply</i>	\$20 copayment per prescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 30-day supply</i>	\$35 copayment per prescription/refill	Covered in-network only
CIGNA Tel-Drug Mail Order Drug Program		
<i>Generic*** drugs on the Prescription Drug List for a 90-day supply</i>	\$20 copayment per prescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply</i>	\$40 copayment per prescription/refill	Covered in-network only
<i>Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 90-day supply</i>	\$70 copayment per prescription/refill	Covered in-network only
<i>***Designated as per generally-accepted industry sources and adopted by CG</i>		

Footnotes

* Services are subject to calendar year deductible.

** Out-of-network services are subject to the calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

In-network and out-of-network services apply to the same treatment or dollar maximum.

Regarding In-Network and Out-of-Network Services:

•Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.

Regarding In-Network Services:

•All services must be provided by one of the participating providers on our list in order to be covered.

Regarding Out-of-Network Services:

Your out-of-pocket costs will be higher than with a participating provider.

All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be pre-certified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not pre-certified. Non-approved admissions/days result in denial of benefits. The pre-certification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.

APPENDIX C-1 CIGNA- INTERNATIONAL for Expatriate Employees



National Optical Astronomy Observatory Medical Benefits at a Glance For Employees and Dependents Benefit Effective January 1, 2009

PLAN FEATURE	BENEFITS
Calendar Year Deductible	\$100 /Individual \$200 /Family
Plan Coinsurance	80% of covered expenses after deductible
Lifetime Maximum	Unlimited (\$5,000,000 Infusion Therapy Maximum)
Annual Out-of-Pocket Limitation (including deductible)	\$1,100 /Individual \$2,200 /Family
Inpatient Charges & Outpatient Charges	Payable at Plan Coinsurance as any other treatment
Room & Board Charges <ul style="list-style-type: none"> - Semi Private Room and Board - - Private Room - - Special Care Units (ICU/CCU) 	Payable at Plan Coinsurance as any other treatment Hospital's average semi-private charge per day of confinement. Covered outside US only if semi-private not available, limited to semi-private room rate Limited to the ICU/CCU daily room rate
Doctor Visits	Payable at Plan Coinsurance as any other treatment
Pregnancy Expense Benefits	Payable at Plan Coinsurance as any other treatment
Routine Nursery	Payable at Plan Coinsurance as any other treatment including room and board, physician charges and circumcision for males prior to discharge
Mental Health	<i>Inpatient:</i> Payable at Plan Coinsurance as any other treatment with a Lifetime maximum of 27 days. <i>Outpatient:</i> Plan pays 50% up to 23 visits per calendar year Lifetime Maximum of 35 visits <i>Outpatient group therapy pays 50% after Plan deductible</i>
Substance Abuse Benefits	<i>Inpatient:</i> Payable at Plan Coinsurance as any other treatment
Skilled Nursing Services	Payable at Plan Coinsurance as any other treatment up to a 60-day limit in a calendar year.
Prescription Drugs	Payable at Plan Coinsurance as any other treatment Expenses for and smoking cessation products are excluded.

This is a brief overview of the benefits plan and is not intended to explain each benefit in detail. The specifics of the Plan are contained in the Summary Plan Description, which will be provided to you. In the event of a conflict between this overview or the Summary Plan Description and the Plan Document, the Terms of the Plan Document will govern.

APPENDIX C-2



National Optical Astronomy Observatory Medical Benefits at a Glance For Employees and Dependents

MEDICAL (CONTINUED)

PLAN FEATURE	BENEFITS
Home Health Care	Payable at Plan Coinsurance as any other treatment up to a 120-visit limit in a calendar year.
Hospice Care Services	Payable at Plan Coinsurance as any other treatment
Chiropractic Services	Payable at Plan Coinsurance as any other treatment up to a 20 days per calendar year maximum.
TMJ Treatment	Payable at Plan Coinsurance as any other treatment up to a \$1,000 lifetime maximum.
Papanicolaou (Pap) Screening Test	Payable at 100% not subject to deductible, up to one test per calendar year for all eligible females.
Prostate Cancer Screening	Payable at 100% not subject to deductible, one test per calendar year for males ages 50 and over.
Mammograms	Payable at 100% not subject to deductible, per the following schedule: <ul style="list-style-type: none"> • <i>Ages 35 – 39</i>: one baseline exam • <i>Ages 40 – 49</i>: one exam every one or two years for asymptomatic women, but no sooner than two years after a woman's baseline. • <i>Age 50 & Over</i>: one exam annually • <i>Any Age</i>: Whenever prescribed by a physician
Lead Poisoning Screening Test	Payable at 100% not subject to deductible, for children at or around 12 months old and children under age 6 who are considered to be at high risk.
Colorectal Cancer Screening	Payable at 100% not subject to deductible, for persons age 50 and older or for any person deemed at high risk of colon cancer because of family history, ethnic or lifestyle background.
Immunizations	Payable at Plan Coinsurance as any other treatment for children from birth through age 18 for immunization against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, Haemophilus influenza B, and hepatitis A.
Travel Immunizations	Payable at Plan Coinsurance as any other treatment
Adult Routine Physical Exams	Payable at 100%, not subject to the Deductible, for charges made for or in connection with the overall health and well being for members 18 years old and over up to a 24 month maximum of \$250. Adult routine immunizations are excluded.

This is a brief overview of the benefits plan and is not intended to explain each benefit in detail. The specifics of the Plan are contained in the Summary Plan Description, which will be provided to you. In the event of a conflict between this overview or the Summary Plan Description and the Plan Document, the Terms of the Plan Document will govern.

APPENDIX C-3



National Optical Astronomy Observatory Medical Benefits at a Glance For Employees and Dependents

MEDICAL (CONTINUED)

PLAN FEATURE	BENEFITS
Child Preventive Care Services	Payable at 100%, not subject to the deductible for children up to age 2 up to \$250 per calendar year from Birth to age 1 For children ages 3 through 17 \$125 per calendar year maximum. The following services are included: health history, physical examination, development assessments, anticipatory guidance, appropriate immunizations, and laboratory tests.
Emergency and Urgent Care Services	Payable at Plan Coinsurance as any other treatment
Laboratory and Radiology Services	Payable at Plan Coinsurance as any other treatment
Nutritional Evaluation	Covers charges made for nutritional evaluation and counseling when diet is part of the medical management of a documented organic disease.
Short Term Therapy	69 days (combined limit for Cardiac Rehab; Physical Therapy; Speech Therapy; Occupational Therapy Pulmonary Rehab and Cognitive Therapy)
Charges covered for Pre-ex conditions for late entrants	\$2,500 limit
Benefit Extension	10 days after termination if confined prior to termination
Pre-admission Certification/ Case Management <i>in the U.S. only</i>	Patient must call CIGNA International at 1-800-441-2668
Pre-admission Certification outside the U.S.	Not necessary

This is a brief overview of the benefits plan and is not intended to explain each benefit in detail. The specifics of the Plan are contained in the Summary Plan Description, which will be provided to you. In the event of a conflict between this overview or the Summary Plan Description and the Plan Document, the Terms of the Plan Document will govern.

APPENDIX C-4



National Optical Astronomy Observatory Dental Benefits at a Glance For Employees and Dependents Benefit Effective January 1, 2009

DENTAL

PLAN FEATURE		BENEFITS
Calendar Year Maximum		\$1,500
Deductible		
	Individual	\$50
	Family	\$150
Coinsurance Percentage		
Class I -	Preventive Services	100%
	Diagnostic – General	
	Preventive	
Class II -	Basic Services	80%
	Restorative (Basic)	
	Endodontics	
	Periodontics	
	Prosthodontics-Removable (Maintenance)	
	Prosthodontics-Fixed Bridge (Maintenance)	
	Oral Surgery	
Class III -	Major Services	50%
	Restorative (Major)	
	Prosthodontics-Removable (Installation)	
	Prosthodontics-Fixed Bridge (Installation)	
Class IV -	Orthodontia – (Limited to dependent children under age 19)	50%
	Lifetime Maximum	\$1,000
	Lifetime Deductible	\$0

This is a brief overview of the benefits plan and is not intended to explain each benefit in detail. The specifics of the Plan are contained in the Summary Plan Description, which will be provided to you. In the event of a conflict between this overview or the Summary Plan Description and the Plan Document, the Terms of the Plan Document will govern.