

StirlingBenefits™

A 90 Degree Benefits Company

Employee Benefits Guide



Greenwich Hospitality Corporation Open Enrollment 2021

This guide is information only, you must enroll to be covered. The benefit descriptions in this plans overview are intended to be brief outlines of coverage. Please refer to the plan document for exclusions, limitations and detailed coverage information.

WHAT'S INSIDE THIS GUIDE?

Who is Eligible	3
How to Enroll & Make Changes	3
Medical Benefits Summary.....	4
Prescription Drug Plan	11
Rx Rewards	11
\$ Copay Drug List	12
Best Care Setting	15
Member Web Portal.....	16
Healthy Rewards.....	17
Dental Plan Summary.....	19
Vision Plan Summary	20
Contact Information.....	22
Important Notices.....	23



OPEN ENROLLMENT 2021

Welcome to 2021 Open Enrollment for the medical, prescription drug, vision and dental benefit plans. Open enrollment enables anyone who has waived coverage to enroll now and make any changes in your dependent status. The following is information regarding your benefits program and changes that will take effect on March 1, 2021.

ARE YOU ELIGIBLE?

You are eligible to enroll when you work an average 30 hours per week and complete the 60 day employment waiting period.

ENROLLING

To enroll in the benefits plan, you must complete the enrollment form. Please remember your benefit choice will not change until next March unless there is a Special Enrollment event that will allow a mid-year change.

Once you're enrolled, register at <https://secure.healthx.com/StirlingMember> to access your personal account to track claims, Teladoc registration, temporary ID cards and other plan materials.

MID YEAR CHANGES

Notify HR within **30 days** when you have one of these mid-year changes and want to make enrollment changes:

- Birth or adoption of a child
- Marriage or divorce
- Dependents loss of other coverage

MEDICAL PLAN SUMMARY

Plan Description: PPO \$2,500/\$5,000
Network: CIGNA

Phone number: 203-876-1660
Provider Search: www.cigna.com

	In-Network	Out-of-Network
Deductible		
Per Individual:	\$2,500	\$5,000
Per Family:	\$5,000	\$10,000
Member Payment Level (unless otherwise stated)	After Deductible is satisfied, plan payment varies by service type until the network out-of-pocket maximum is reached. The plan will then pay 100% for the remainder of the Plan year, unless otherwise noted	After Deductible is satisfied, the Plan pays 60% of the allowable amount, until the out of network out-of-pocket maximum is reached. The plan will then pay 100% for the remainder of the Plan year, unless otherwise noted.

The Individual Deductible and Maximum Out-of-Pocket applies if you have coverage only for yourself. The Family Deductible and Maximum Out-of-Pocket applies if you have coverage for yourself and one or more eligible dependents. No more than the individual Deductible, or Out-of-Pocket amount will be applied to any one individual in a family. If you have family coverage, the deductible and out of pocket maximum may be met by any combination of covered family members.

Out-of-Pocket Maximum (includes Coinsurance, Deductible and Medical and Rx copays)

Per Person:	\$7,500	\$10,000
Family Maximum:	\$15,000	\$20,000

The following expenses will not apply toward the Out-of-Pocket Amount and are never paid at 100%: Cost Management penalties, charges in excess of the allowed amount for out of network services and pharmacy dispense as written differentials.

PREVENTIVE/ROUTINE CARE	IN NETWORK	OUT-OF-NETWORK
Child Care Exam	100% paid by plan	60% after deductible
(Care includes Office Visits, Physical Examination, Assessments, Immunizations, Vision Screening and Lab & Diagnostic Testing per the Patient Protection and Affordable Care Act guidelines. Routine Services not covered at an Urgent Care facility.)		
Adult Care	100% paid by plan	60% after deductible
Adult care physical exam includes Office Visits, Immunization, Assessments and Lab & Diagnostic Testing per the Patient Protection and Affordable Care Act guidelines. Routine Services not covered at an Urgent Care facility.		
Gynecological Exam & Pap Smear: 1 every year	100% paid by plan	60% after deductible
Mammography Exams - Baseline: Age 35 to 40: 1 baseline	100% paid by plan	60% after deductible
Mammography Exams - Routine: Age 40 to 50: 1 every 2 years unless required due to risk factors. Age 50 and older: annual	100% paid by plan	60% after deductible
Bone Density Screening:	100% paid by plan	60% after deductible
Endoscopies (colonoscopy or sigmoidoscopy)	100% paid by plan	60% after deductible
Prostate Cancer Screening	100% paid by plan	60% after deductible
Routine vision exam 1 every year	100% paid by plan	60% after deductible
Vision Hardware	Not Covered	Not Covered
Hearing Exam	Not covered except as required for newborns under the ACA	Not Covered

SERVICE	IN NETWORK	OUT-OF-NETWORK
Acupuncture (20 visits per year)	100% after \$75 co-payment, deductible waived	60% after deductible
Allergy Testing/Injections	100% after \$50 co-payment PCP 100% after \$75 co-payment Specialist	60% after deductible
Anesthesia	80% after deductible	60% after deductible
Cardiac Rehabilitation (36 visits per year)	80% after deductible	60% after deductible
Chiropractic Therapy (20 visits per year)	\$75 co-payment	60% after deductible
Contraceptive Management	80% after deductible Deductible and coinsurance are waived for preventive services required to be covered by the Affordable Care Act. Note: for these ACA preventive services, over the counter contraceptives must be prescribed by a physician.	60% after deductible Note: over the counter contraceptives are not covered.
Developmental Disorders/Delay	80% after deductible	60% after deductible
Dialysis	80% after deductible	60% after deductible
Diabetic Supplies	100% after \$75 co-payment, deductible waived	
Durable Medical Equipment	80% after deductible	60% after deductible
Endoscopies/Colonoscopies (non-routine) Freestanding Facility	100% after \$250 co-payment, deductible waived	60% after deductible
Hospital Out Patient	80% after deductible	
Extraction of Impacted Wisdom Teeth	80% after deductible	60% after deductible
Genetic Testing (covered only if (1) they are Medically Necessary and meet the conditions listed in the Medical Benefits section of the Plan, or (2) for services from Network Providers, they are an item or service required to be covered by the ACA (i.e. preventive health service included in the recommendations and guidelines listed above in this Schedule under preventive care.)	Covered under Medical Benefits: 80% after deductible Covered under ACA: 100%; deductible waived	60% after deductible
Hearing Aid	Not Covered	Not Covered

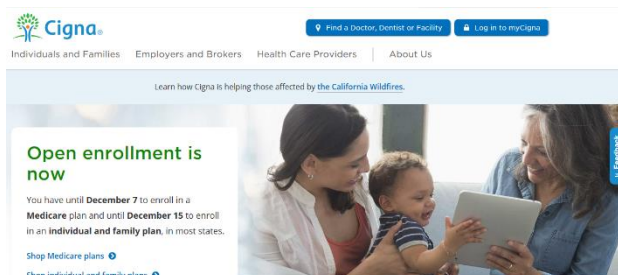
SERVICE	IN NETWORK	OUT-OF-NETWORK
Home Health Care <i>(90 visits per year)</i>	80% after deductible	60% after deductible
Hospice Care (Inpatient/home setting) <i>Bereavement Counseling 6 visits lifetime</i>	80% after deductible	60% after deductible
Home Infusion Therapy	80% after deductible	60% after deductible
Impotence Testing for and up to Diagnosis	PCP: 100% after \$50 co-payment, deductible waived Specialist: 100% after \$75 co-payment, deductible waived	60% after deductible
Impotence Treatment	Not Covered	Not Covered
Infertility Testing for and up to Diagnosis	PCP: 100% after \$50 co-payment, deductible waived Specialist: 100% after \$75 co-payment, deductible waived	60% after deductible
Infertility Treatment (\$15,000 lifetime maximum)	80% after deductible	
Infusion Therapy	80% after deductible	60% after deductible
IV Therapy/Injection Therapy	80% after deductible	60% after deductible
Laboratory		
Office <i>(Follows Primary Care or Specialist Office visit co-pay)</i>	PCP: 100% after \$50 co-payment Specialist: 100% after \$75 co-payment	60% after deductible
Free Standing (not physician, office or hospital)	100% after \$50 co-payment	
Outpatient Hospital	100% after \$200 co-payment <i>deductible waived all services</i>	
MRI/MRA/CT/CTA/PET Scans Free-standing diagnostic center	100% after \$100 co-payment, deductible waived	60% after deductible
MRI/MRA/CT/CTA/PET Scans outpatient hospital	100% after \$300 co-payment, deductible waived	60% after deductible
Medical Supplies	80% after deductible	60% after deductible
Maternity/Prenatal (Office Visits and Office Services)	100%, deductible waived	60% after deductible

SERVICE	IN NETWORK	OUT-OF-NETWORK
Massage Therapy (20 visits per year)	100% after \$75 co-payment, deductible waived	60% after deductible
Nutritional Counseling 2 visits per year for Diabetic Education	80% after deductible	60% after deductible
Office Services (not associated with office visit) These include laboratory services, x-rays, and diagnostic tests. See benefit for injections performed in the office.	PCP: 100% after \$50 co-payment, deductible waived Specialist: 100% after \$75 co-payment	60% after deductible
Orthotics Foot/ Other (excludes foot orthotics unless part of diabetes treatment)	80% after deductible	60% after Deductible
Pain Management	80% after deductible	60% after deductible
Physical, Speech & Occupational Therapy Combined 90 Rehabilitation visits per year Combined 60 Habilitative visits per year	Rehabilitation: 100% after \$75 co-payment, deductible waived Habilitative: 100% after \$75 co-payment, deductible waived	60% after deductible
Physician Visit (Inpatient stay)	80% after deductible	60% after deductible
Primary Care Office Visit	100% after \$50 co-payment, deductible waived	60% after deductible
Private Duty Nursing (Inpatient/Outpatient)	Not Covered	Not Covered
Prosthetic Appliance/Devices	80% after deductible	60% after deductible
Radiation/Chemotherapy	80% after deductible	60% after deductible
Second Surgical Opinion	100% after \$75-copayment, deductible waived	60% after deductible
Specialist Office Visit	100% after \$75-copayment, deductible waived	60% after deductible
Sterilization	80% after deductible Deductible and coinsurance are waived for services included in the recommendations and guidelines listed above in this Schedule under preventive care.	60% after deductible
Surgeon's Fees (Inpatient, Outpatient, Office surgery)	80% after deductible	60% after deductible
TMJ Treatment (excludes orthodontia)	80% after deductible	60% after deductible
Wig (After chemotherapy only- 2 wigs per lifetime)	80% after deductible	60% after deductible

SERVICE	IN NETWORK	OUT-OF-NETWORK
X-ray		60% after deductible
Office (<i>Follows Primary Care or Specialist Office visit co-pay</i>)	PCP: 100% after \$50 co-payment	
	Specialist: 100% after \$75 co-payment	
Free Standing (not physician, office or hospital)	100% after \$50 co-payment	
Outpatient Hospital	100% after \$200 co-payment	
	<i>deductible waived all services</i>	
Organ Transplant	80% after deductible	60% after deductible

HOSPITAL SERVICES	IN NETWORK	OUT-OF-NETWORK
Ambulance Service		
Medical Emergency	100% after \$500 co-payment, deductible waived	100% after \$500 copay, deductible waived
Non-Emergency	Not Covered	Not Covered
Emergency Room & Emergency Room Observation (waived if admitted)	100% after \$200 copay, deductible waived	100% after \$150 copay, deductible waived
Non-Emergency use of ER	Not Covered	Not Covered
Room & Board- Semi-Private, ICU & Other Special Units	80% after deductible	60% after deductible
Routine Well Newborn Care	80% after deductible	60% after deductible
Inpatient Surgery	80% after deductible	60% after deductible
Inpatient Visits	80% after deductible	60% after deductible
Outpatient Surgical Hospital	80% after deductible	60% after deductible
Outpatient Surgical Ambulatory Facility	80% after deductible	60% after deductible
Pre-admission Testing	80% after deductible	60% after deductible
Skilled Nursing Facility/ Extended Care (90 days per year)	80% after deductible	60% after deductible
Urgent Care/Walk-In Center	100% after \$75 co-payment, deductible waived	60% after deductible


MENTAL HEALTH & SUBSTANCE SERVICE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	80% after deductible	60% after deductible
Outpatient Treatment (Office Visit)	100% after \$50 co-payment, deductible waived	60% after deductible
Outpatient Treatment (Outpatient, Intensive and Partial)	80% after deductible	60% after deductible



FIND A CIGNA HEALTH CARE PROVIDER

1. Visit Cigna.com – click on “Find a Doctor” (upper right).
2. On the next page, click on “Plans through your employer or school”
3. Click “Pick” (small orange box)
4. Click “PPO, Choice Fund PPO” in the pop-up box.



Your prescription drug program will be managed through **Araya**. The Pharmacy Helpline can be reached at 1-866-352-5171, or you can visit them on the web at www.arayarx.com. 

PRESCRIPTION DRUG PROGRAM

	RETAIL (30-day supply)	MAIL ORDER (90-day supply)
Preventive ACA	\$0 co-payment	\$0 co-payment
Generics	\$10 co-payment	\$25 co-payment
Formulary Brands	\$40 co-payment	\$100 co-payment
Non-Formulary Brands	50% up to \$750	50% up to \$1,875

MANDATORY GENERICS

BRAND MEDICATIONS ARE EXCLUDED FROM COVERAGE WHEN A MEDICATION WITH THE SAME ACTIVE INGREDIENT(S) IS AVAILABLE GENERICALLY

SPECIALTY DRUGS, INJECTABLES, & OTHER DESIGNATED DRUGS (30-day supply)

Domestic Channel	50% up to \$750 co-payment
International Program Voluntary (ElectRx)	Copayment waived with \$50 or 10% Cash Reward

INTERNATIONAL MAIL ORDER PROGRAM

Rx Rewards! You may not know that most of the Brand-Named Drugs sold in the US are manufactured and distributed from countries, such as Canada, U.K., Australia and New Zealand. Medications are supplied in original factory sealed manufacturers packaging and delivered to your home. *The cost is lower through this program so your health plan is waiving your copay PLUS offering an incentive to share the savings!*

- ✓ You pay Zero when you use this voluntary mail order program.
- ✓ **NEW!** Cash reward for each monthly prescription of \$50, or 10% to \$250, whichever is greater!
- ✓ We will notify you by mail, email or phone if your medication qualifies.
- ✓ Prescriptions shipped directly to your home with no shipping or handling costs
Medications must be tried for 30 days before eligible through ElectRx

A list of eligible medications is located on the next page and is subject to change.

VOLUNTARY INTERNATIONAL \$0 COPAY MEDICATION LIST



Ampyra	10mg	168
Apidra 100 Units/mL Vial	10mL	1000U
Apidra Solostar 100 Units/mL	3mL x 5	1500U
Avonex	30mcg/0.5ml	4
Basaglar KwikPen	3ml x 5	1500U
Bydureon	2mg	4/Kit-3 Kits
Byetta Pen	5mcg	250mcg/ml
Byetta Pen	10mcg	250mcg/ml
Cimzia	200mg/ml	2
Copaxone	40mg/ml	12
Copaxone	20mg/ml	30
Cosentyx Pen Inj	150mg/ml	2
Enbrel Sureclick	50mg/ml	4
Enbrel Syringe	50mg/ml	4
Enbrel vial	25mg	4
FIASP 100units/ml Vial	10ml	1000u
Fiasp Flex touch pen	3mlx5	1500U
Humalog 100 Units/mL Kwikpen	3mL x 5	1500U
Humalog 100 Units/mL Vial	10mL	1000U
Humalog 200 units/ml Kwikpen	3mL x 5	3000U
Humalog Cartridge	3mlx5	1500U
Humalog Jr Kwikpen	3mlx5	1500u
Humalog Mix 50-50 100 Units/mL Kwikpen	3mL x 5	1500U
Humalog Mix75-25 Kwikpen 100 Units/mL	3mL x 5	1500U
Humatrope	6mg	3
Humatrope	12mg	3
Humatrope	24mg	1
HUMIRA Autoinj	40mg	2
HUMIRA Prefilled Syringe	40mg	2
Humulin 30/70 100units/ml Vial	10ml	1000U
Humulin N Kwikpen 100 Units/mL	3mL x 5	1500U
Humulin N Vial 100units/ml Vial	10ml	1000U
Humulin Regular 100units/ml Vial	10ml	1000U
Ibrance	100mg	21
Ibrance	125mg	21
Ibrance	75mg	21
Imbruvica	140mg	90
Intelligence	100 mg	120
INTERFERON-1B FOR INJ KIT		15
Jakafi	5mg	56

Jakafi	10mg	56
Jakafi	15mg	56

\$0 COPAY ELECTRX DRUGS

Jakafi	20mg	56
Lantus 100 Units/mL Vial	10mL	1000U
Lantus SoloStar 100 Unit/mL	3mL x 5	1500U
Levemir Flextouch 100 Units/mL	3mL x 5	1500U
Mekinst	0.5mg	30
Mekinst	02mg	30
Norditropin Inj Pen	15 mg / 1.5 ml	1
Norditropin Inj Pen	10mg/1.5ml	1
Novolog 100 Units/mL Vial - Novorapid (Canadian Substitution)	10mL	1000U
Novolog 30/70 - Novomix 30/70 (Canadian substitution)(cartridges)	3mlx5	1500u
Novolog FlexPen 100 Units/mL - Novorapid FlexTouch (Canadian Sub.)	3mL x5	1500U
Novolog Cartridge 100 Units/mL - Novorapid Cartridge (Can. Sub.)	3mlx5	1500U
Nplate	250mcg	2
Nplate	500mcg	2
Nucala Vial	100MG	1
Opsumit	10 mg	30
Orencia	125mg/ml	4
Ozempic	0.25mg/0.5mg	6ml
Ozempic	1mg	9ml
Saxenda	3mlx5	6mg/ml
Simponi	50mg/0.5ml	1
Simponi	1ml of 100mg/ml	1
Sprycel	100mg	30
Sprycel	70mg	60
Stelara	45mg/0.5ml	1
Stelara	90mg/1ml	1
Sutent	50mg	28
Synarel	2 mg/ml	1
Tafinlar	75 MG	120
Tafinlar	50 MG	120
Toujeo Solostar 300 Units/mL	1.5mL x 5	2250U
Tracleer	125mg	56
Tresiba u100	3ml x 5	1500U
Tresiba u200	3ml x 3	1800U
Trulicity 0.75mg/0.5ml	0.5mlx4	
Trulicity 1.5mg/0.5ml	1.5mlx4	
Tykerb	250mg	70

Vimpat	50mg	60
Vimpat	50mg	180

\$0 COPAY ELECTRX DRUGS

VimpR	100mg	60
Vimpat	100mg	180
Vimpat	150mg	60
Vimpat	150mg	180
Vimpat	200mg	60
Vimpat	200mg	180
Votrient	200mg	120
Victoza	3mlx3	
Vimpat	100mg	60
Vimpat	100mg	180
Vimpat	150mg	60
Vimpat	150mg	180
Vimpat	200mg	60
Vimpat	200mg	180
Vimpat	50mg	60
Vimpat	50mg	180
Votrient	200mg	120
Xeljanz XR	11mg	30
Xeljanz	5mg	60
Xeljanz	10mg	60
Xifaxan	550mg	60
Xifaxan	550mg	180
Xiidra	5%	180

BEST CARE SETTINGS

When seeking care, you may have alternatives other than the emergency room, allowing you to save significant dollars out of your own pocket.

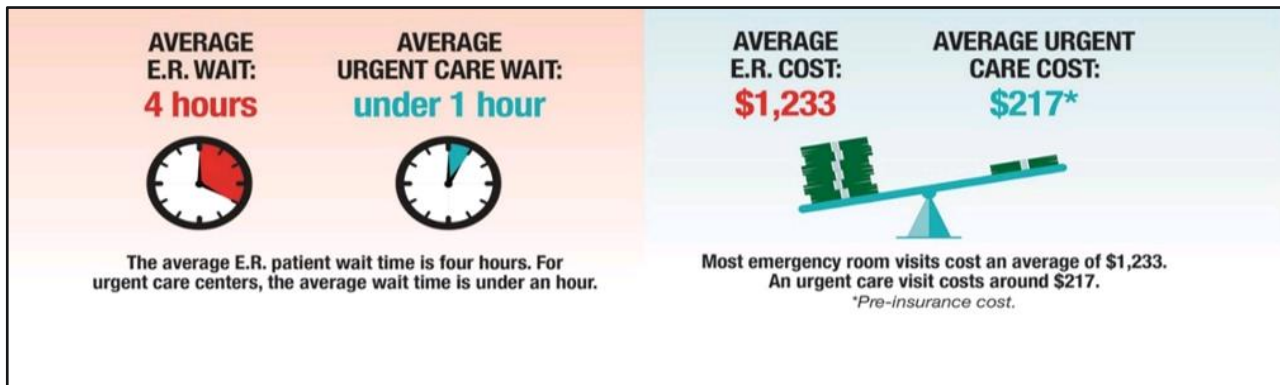
When to visit your Primary Care Physician

If it isn't urgent, it's usually best to go to your primary care doctor. Your doctor knows you and your health history. He or she can, access your medical records. Plus, your doctor can provide follow-up care and refer you to a specialist.

When to visit An Urgent Care Center

Sometimes, you may need care fast. If your primary care physician is unavailable, you may want to try an urgent care or retail health clinic in your network. Chances are you won't have to wait as long as you would at the ER. You may pay less, too. Urgent Care Centers can typically treat things like:

- Sprains and Strains
- Minor Broken Bones
- Minor Infections
- Small Cuts
- Sore Throats
- Rashes



When to visit the Emergency Room

- Large Open Wounds
- Sudden Change in Vision
- Chest Pain
- Sudden Weakness or Trouble Walking
- Major Burns
- Spinal Injuries
- Severe Head Injury
- Difficulty Breathing
- Major Broken Bones

MEMBER PORTAL – MANAGE YOUR MEDICAL / DENTAL & VISION BENEFITS

Stirling Benefits, Inc. is pleased to announce a new and improved self-service online tool. The service is HIPAA compliant concerning patient privacy and gives online access to benefit information and services. Take a minute to sign up and review the exciting online services now available through a desktop device. To sign up for a user account, select [Click Here](#) under First Time Users from the Login screen.

Stirling Member Login

StirlingBenefits
Setting the Standard for Health

Welcome to the Stirling Benefits Member Information Center, your complete online health plan resource!

Login
Username
Password
[Login]

First Time Users?
[Click Here]

Log in to access a wide array of information:

- View your health plan benefits and services
- Join/Temporary ID Card
- View network restrictions/provider
- View your health care costs and deduction/total of pocket services
- Contact customer service/claims

How do I access this information?

#1 Sign up!

To sign up online, go to:
<https://secure.healthx.com/StirlingMember>

Once on the Login screen, select [Click Here](#) under First Time Users. Read the License Agreement and [Agree](#) to proceed. Follow the simple instructions to complete the form as it relates to you.

You will need to enter your Member ID, First Name, Last Name and Date of Birth exactly as it appears on your ID card in order to establish a user account.

Usernames must start with a letter and must be at least 3 characters in length. An email address is required. This is the address that will be used to notify you of new information which becomes available for online viewing. Passwords must contain 1 letter, 1 number, and must be at least 8 characters in length.

Click on [Next](#) to continue the Sign-up process.
#2 Create your username and password

Use a username and password that only you will know. Also indicate hint questions and answers, so that your password can be retrieved by you, should you forget it in the future. Click on [Next](#) to proceed.

#3 Click on [Finish](#) to complete the Sign-up process.

If the information display is NOT correct, select the [Previous](#) button and make corrections. Once you confirm the information displayed is correct, select the [Finish](#) button to enter the website.

On your first successful portal login you can take advantage of doing your part to save the environment by signing up for paperless EOBs!

Go Paperless!
Did you know...
You can save the environment and reduce healthcare costs at the same time!

Share the Benefits of Technology
EOBs or Explanations of Benefits let you know when a medical, vision or dental claim is processed on your behalf. By changing from paper EOBs, which are often thrown away – to Paperless EOB notices, you can access the same information electronically, reducing waste and helping our environment.

When you go paperless you get!

- Email notifications when an EOB statement is posted to your account!
- Ability to view, print and download EOBs online from your account anytime.

Paperless Statements are secure and convenient!

- Paperless EOB statements are provided at no cost and you can easily switch back to paper statements at any time.

Questions or your EOB? Call Customer Service at (800) 447-6689.

[GO PAPERLESS] [NO THANKS]

The choice is yours and can be changed at anytime.

There are Quick Links and a tool bar to navigate you through all your Coverage, Claim, and Eligibility inquiries.

Home Coverage & Benefits Claims Access Information Resources

Quick Links

- Print ID Card
- Ask a Question
- Frequently Asked Questions
- Plan Documents
- Find a Provider
- Pharmacy Information

Any questions please contact our Customer Service Department at (800-447-6689)



CIGNA HEALTHY REWARDS

Ready to work out? Cigna We'll make getting there the easy part.

The Cigna Healthy Rewards[®] program* offers you access to a number of discounts on health programs and services, including gym memberships.

Where can you find more information? Start by logging in to myCigna.com and then follow this guide:

- Click on **“Manage My Health”** on the upper right
- Select **“Discount Programs—Healthy Rewards”**
- Find the blue tab > **“Fitness & Mind/Body”**
- Scroll down > **“Fitness Discounts”** > **“Low-cost Fitness Center Memberships”** > **“Learn More”**

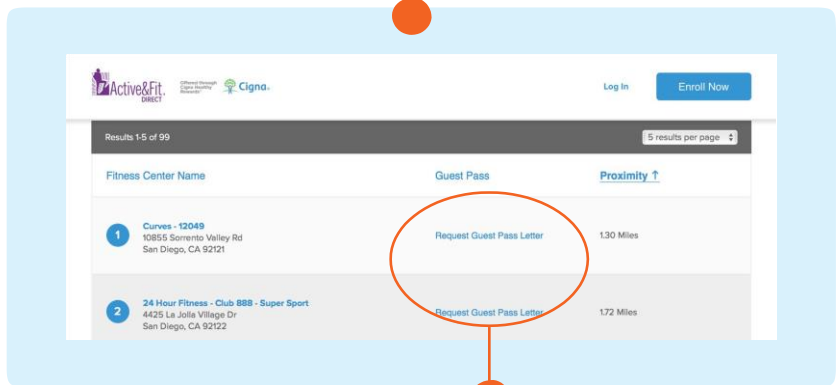
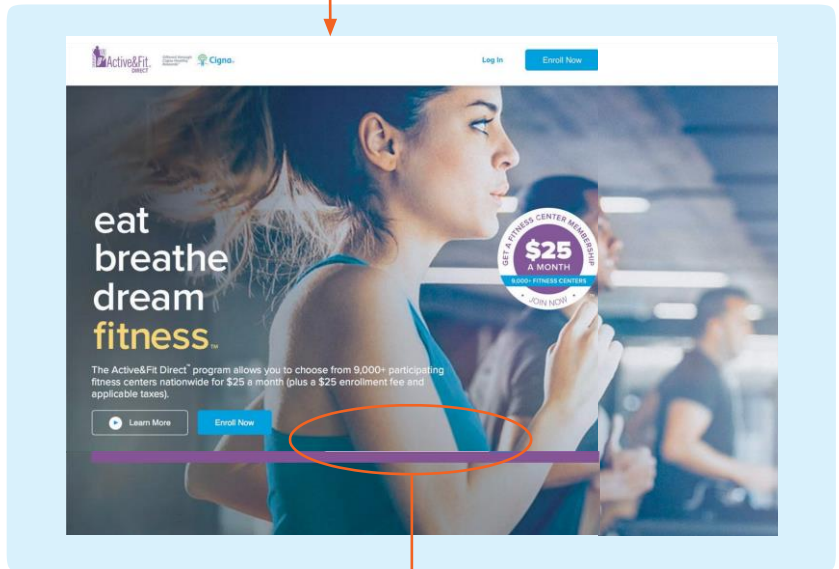
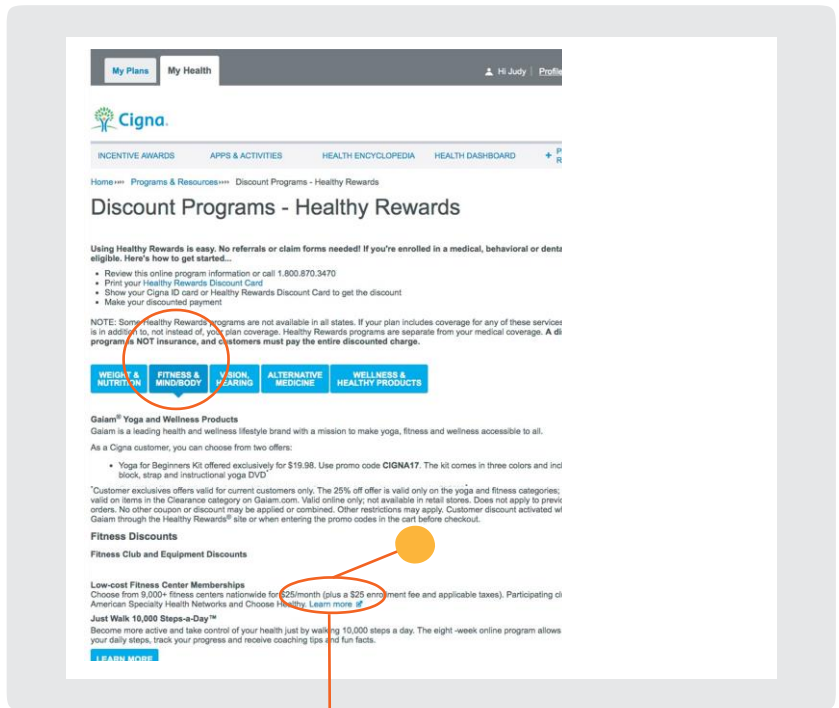


You're there!

The updated **Active & Fit Direct™** page takes the heavy lifting out of finding a local gym and accessing your discounted membership. And did we mention memberships are only **\$25 per month**.

From the home page, you can:

- Find a local gym by your zip code or city/state and get details on the facility.
- Not ready to enroll? Click **“Request Guest Pass Letter”** in your search results, create an account and then print your guest pass.
- If you're ready to get your Discounted membership, select **“Enroll Now”** You'll create an account if you didn't already, provide payment information and print your fitness card to take to your new gym.





DENTAL PLAN SUMMARY

No network of dentists –Visit any dentist of your choice!

Plan Year deductible, per person	\$50
per Family Unit.....	\$150

The deductible applies to these Classes of Service:

- Class B Services - Basic
- Class C Services - Major

Dental Percentage Payable

Class A Services - Preventive.....	100%
Class B Services - Basic	80%
Class C Services - Major	50%

Maximum Benefit Amount –

Per person per Plan Year	\$2,000 per person
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VISION PLAN SUMMARY

Service	Benefit	Frequency
Eye Examination	\$10 copay; then Plan pays up to \$45	Every 12 months
Frames	\$25 copay; then Plan pays up to \$75	Every 24 months
Lenses: Single Vision Bi Focal Tri Focal Lenticular	Covered 100% up to \$40/pair Covered 100% up to \$60/pair Covered 100% up to \$80/pair Covered 100% up to \$80/pair	Every 12 months
Progressive Lens Enhancements	Covered 100% up to \$80/pair	Every 12 months
Contact Lens Exam (fitting and evaluation)	\$25 copay; then Plan pays up to \$60	Every 12 months
Contact Lenses/pair	Covered at 100% up to \$130	Every 12 months
Maximum Annual Benefit	\$200/covered individual	

Covered Vision Benefits:

- Lenses prescribed by an ophthalmologist or optometrist in connection with a failure in visual acuity.
- Frames purchased in conjunction with lenses prescribed by an ophthalmologist or optometrist.
- Contact lenses prescribed by an ophthalmologist or optometrist

What is Not Covered:

- Services and/or materials not specifically included in the schedule of benefits;
- Services received outside of the United States;
- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (less than a +.38 diopter power);
- Two pair of glasses in lieu of bifocals;

What is Not Covered:

- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Plano contact lenses to change eye color cosmetically;
- Artistically painted contact lenses;
- Contact lens insurance policies or service contracts;
- Additional office visits associated with contact lens pathology;
- Contact lens modification, polishing or cleaning;
- Costs for covered services and/or materials above the benefit allowance;
- Services or materials of a cosmetic nature;
- Services and/or materials not indicated in this certificate as covered services;
- Pathological treatment;
- Laser or any other form of refractive surgery;
- Pre and post operative services;
- Local, state and/or federal taxes, except where we are required by law to pay;
- Corrective vision treatment of an experimental nature.
- Prescription Sunglasses

This plan provides limited benefits for vision coverage and this summary is intended to provide a general overview only. Refer to the Plan document for full details.

Important Contact Information:

MEDICAL PLAN CUSTOMER SERVICE – STIRLING BENEFITS, INC.
203.876.1660 | www.stirlingbenefits.com

MEMBER WEB PORTAL
<https://secure.healthx.com/StirlingMember>

PRESCRIPTION DRUG PROGRAM
1.866.352.5171 | www.arayarx.com

CLEVERRX PRESCRIPTION DRUG SAVINGS
<https://partner.cleverrx.com/myhcg>
Group ID: **3004**
Member ID: **101241**

MEDICAL PROVIDER SEARCH
www.cigna.com

CIGNA HEALTHY REWARDS
www.mycigna.com

Important Notices

According to federal law, we are required to provide the following information. For a fully copy, please visit the Stirling Benefits, Inc. website at <https://secure.healthx.com/StirlingMember>

Summary of Benefits Coverage (SBC)

Effective for plan renewals after January 1, 2012, the Patient Protection and Affordable Care Act requires employers that offer health coverage to provide a uniform Summary of Benefits and Coverage (SBC) to people who apply for and enroll in the health plan. This document contains the following:

- Overview of plan benefits, cost sharing and limitations
- Required set of examples of how the plan works
- A Standard glossary of medical and insurance terms must also be available SBC will be updated each plan renewal to reflect plan

Special Enrollment Rights

You may be eligible to enroll yourself and your dependents in a medical plan without waiting for an open enrollment period if:

- You or your eligible dependents decline the Medical Plan because you have other group medical coverage, then you lose the other coverage because you are no longer eligible, or because the employer failed to pay the required premium. In such cases, you must enroll in the Medical Plan within 30 days after losing the other coverage. You will have to provide proof that you had other coverage.
- You or your eligible dependents decline the Medical Plan because you have COBRA coverage under another group medical plan, then you exhaust your COBRA coverage. In such cases, you must complete your entire COBRA coverage period, and you must enroll in the Medical Plan within 30 days after completing your COBRA coverage period. You will have to provide proof that you completed your COBRA coverage period.
- You decline the Medical Plan and then a new dependent is added to your family due to marriage, birth, adoption or placement for adoption. In such cases, you must enroll in the Medical Plan within 30 days after the marriage, birth, adoption or placement for adoption. You will have to provide

proof of the event.

- You and your eligible dependents become eligible for premium assistance through a state Medicaid or Children's Health Insurance program (CHIP) and when you lose coverage under one of these programs. In such a case, you must request enrollment not later than 60 days after the loss of Medicaid or CHIP coverage or not later than 60 days of the determination of eligibility for Medicaid or CHIP premium assistance.

Women's Health and Cancer Rights Act of 1998

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy was performed;
- Any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical conditions related to the mastectomy, including lymph edema.

Prescription Drug Creditable Coverage Notice

This notice has information about your current prescription drug coverage prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Starting January 1, 2006, prescription drug coverage was available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage

People with Medicare can enroll in a Medicare prescription drug plan in November 2012. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

Prescription Drug Creditable Coverage Notice continued...

Each year you will have the opportunity to enroll in a Medicare prescription drug plan **between October 15th through December 7th**.

If you drop your coverage and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.