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

Employee-Paid

HOSPITAL CARE COVERAGE

SUMMARY OF BENEFITS

Prepared for: Livingston County

Hospital Care coverage provides a benefit according to the schedule below when a Covered Person incurs a Hospital stay resulting from a Covered Injury or Covered Illness. *See State Variations (marked by *) below.*

Who Can Elect Coverage:

You: All active, full-time Employees of the Employer and are regularly working a minimum of 30 hours per week, who are United States citizens and permanent resident aliens, regularly working and residing in the United States and their U.S. citizen Spouse and Dependent Children who are residing in the United States.

Union Employees - No waiting period. Non-Union Employees - First of the month following date of hire.

Your Spouse:* Up to age 70, as long as you apply for and are approved for coverage yourself.

Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage:

The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand the terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Benefit Waiting Period:* 0 days following the effective date, unless otherwise stated. No benefits will be paid for a loss which occurs during the Benefit Waiting Period.

Hospitalization Benefits	Plan 1
Hospital Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.	$1,500 per day
Hospital Chronic Condition Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.	$50 per day
Hospital Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.	$100 per day
Hospital Intensive Care Unit (ICU) Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.	$200 per day
Hospital Observation Stay 24 hour Elimination Period. Limited to 72 hours.	$100 per 24-hour period

Additional Care Benefits	Plan 1
Wellness Treatment, Health Screening and Preventative Care Benefit* Limited to 1 day, payable once per year. Examples include (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests.	$50 per day

Portability Feature:* You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage ends. You must be covered under the policy and be under the age of 70 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

NOTE: This insurance is NOT a substitute for comprehensive or major medical insurance coverage.

Employee's Monthly Cost of Coverage:

Tier	Plan 1
Employee Only	$26.87
Employee & Spouse	$58.71
Employee & Child(ren)	$49.04
Employee & Family	$80.87

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.

NOTE: The following are some of the important policy provisions, terms and conditions that apply to benefits described in the policy. This is not a complete list. See your Certificate of Insurance for more information.

Benefit Amounts Payable: Benefits for all Covered Persons are payable at 100% of the Benefit Amounts shown, unless otherwise stated. Late applicants, if allowed under this plan, may be required to provide medical evidence of insurability.

Benefit-Specific Conditions, Exclusions & Limitations (Hospital Care):

- **Hospital Admission:** Must be admitted as an Inpatient due to a Covered Injury or Covered Illness. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness.
- **Hospital Chronic Condition Admission:** Must be admitted as an Inpatient due to a covered chronic condition and treatment for the covered chronic condition must be provided by a specialist in that field of medicine. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness (including chronic conditions).
- **Hospital Stay:** Must be admitted as an Inpatient and confined to the Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the ICU Stay Benefit, only 1 benefit(s) will be paid for the same Covered Injury or Covered Illness, whichever is greater. Hospital stays within 30 days for the same or a related Covered Injury or Covered Illness is considered one Hospital Stay.
- **Intensive Care Unit (ICU) Stay:** Must be admitted as an Inpatient and confined in an ICU of a Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the Hospital Stay Benefit, only 1 benefit(s) will be paid for the same Covered Injury or Covered Illness, whichever is greater. ICU stays within 30 days for the same or a related Covered Injury or Covered Illness is considered one ICU stay.
- **Hospital Observation Stay:** Must be receiving treatment for a Covered Injury or Covered Illness in a Hospital, including an observation room, or ambulatory surgical center, for more than 24 hour on a non-inpatient basis and a charge must be incurred. This benefit is not payable if a benefit is payable under the Hospital Stay Benefit or Hospital Intensive Care Unit Stay Benefit.

Common Exclusions and Limitations:

Exclusions:* In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Illness which is caused by or results from any of the following (unless otherwise provided for in the policy):

- (1) intentionally self-inflicted injury, suicide or any attempted threat while sane or insane;
- (2) commission or attempt to commit a felony or an assault;
- (3) declared or undeclared war or act of war;
- (4) a Covered Injury or Covered Illness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
- (5) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage (excludes WA residents);
- (6) operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred. (excludes WA residents)
- Those not necessary, as determined by Us in accordance with generally accepted standards of medical practice, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician.
- Elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection or other disease of the involved part; or b) due to congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect.
- Dental surgery, unless the surgery is the result of an accidental injury;
- In addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
  - Employed or retained by the Subscriber;
  - providing homeopathic, aroma-therapeutic or herbal therapeutic services;
  - living in the Covered Person's household;
  - a parent, sibling, spouse or child of the Covered Person.

Pre-Existing Condition Limitation (applies to hospital care insurance only):* We will not pay benefits for a Covered Injury or Covered Illness caused, contributed to by, or resulting from, a Pre-Existing Condition. The term "Pre-Existing Condition" means any Illness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 12 months before the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

Common Exclusions and Limitations — continued

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Injury or Covered Illness that occurs after the Covered Person is insured under the Policy for at least 12 continuous months after the Covered Person's most recent effective date of insurance and effective date of any added or increased amount of coverage.

This Pre-Existing Condition Limitation does not apply to the following Additional Benefits: Wellness Treatment Health, Screening and Preventative Care.

Important Definitions:

Covered Illness: A physical or mental disease or disorder including pregnancy and complications of pregnancy that results in a covered loss. A Covered Illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.
Covered Injury: Any bodily harm that results in a covered loss.
Covered Person: An eligible person, as defined in the Schedule of Benefits, who is enrolled and for whom Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due, and coverage under this Policy remains in force.
Elimination Period: The continuous period of time that must be satisfied before a benefit shown in the Schedule of Benefits is payable. An Elimination Period may be satisfied during the Policy's Benefit Waiting Period.
Hospital:* An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of physicians; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis. The term Hospital does not include a clinic, facility, or unit of a Hospital for: (1) rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care; (2) the aged, drug addicts or alcoholics; or (3) a facility primarily or solely providing psychiatric services to mentally ill patients.

Policy Provisions:

When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received or if evidence of insurability is required, the first of the month after we have approved you (or your dependent) for coverage in writing unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home; disabled or receiving disability benefits or unable to perform activities of daily living.
When your coverage ends: Coverage for any Covered Person ends on the earliest of the date they are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your Spouse and Dependent Child(ren), if applicable, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the *Continuation of Insurance* provisions in your Certificate.)
30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

***State Variations**

For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative. Spouse definition includes civil union for employees residing in Vermont. **Portability** in VT is referred to as Continuation due to loss of eligibility. VT residents are not subject to the age limit to continue coverage. **Pre-Existing Condition Limitation,** differs in CA, FL, NC, SC and SD. **Exclusions** may vary for residents of MN, SC, SD, and WA. **Important Definitions** (Hospital) includes stays in substance abuse and mental nervous facilities in VT. **Wellness, Health Screen Test and Preventive Care Benefit** is not available to residents of VT. The Wellness rider will not include preventive care in NC.

Series 1.0/1.1

THIS POLICY PAYS LIMITED BENEFITS ONLY. IT DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.

This is not intended as a complete description of the insurance coverage offered. This is not a contract. Full terms and conditions of coverage are defined by and governed by Group Policy No.HC 960277. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence. Product availability, costs, benefits, riders and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form GHIP-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

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INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Phone: 1-800-732-1603

Life Insurance Company of North America

Employer: Livingston County

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is: _____

My Spouse's Information

Name _____ **Social Security #** _____
Birthdate _____ Gender _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Critical Illness Insurance – Policy # CI 960759

Choose both an Amount below and who you would like to include in your coverage.
See the enclosed Summary of Benefits for Monthly costs.

Who You Want to Cover	Coverage Amount			Guaranteed Coverage Amount*	
❑ Employee	❑ $5,000	❑ $10,000	❑ $20,000	$20,000	❑ Decline Coverage
❑ Spouse	❑ $2,500	❑ $5,000	❑ $10,000	$10,000	❑ Decline Coverage
❑ Children # of covered children ____	25% of employee amount			All Amounts	❑ Decline Coverage

Eligible dependent children are automatically enrolled.

Employee-Paid (Voluntary) Accidental Injury Insurance – Policy # AI 960785

Choose both a Plan below and who you would like to include in your coverage. See the enclosed Summary of Benefits for Monthly costs.

Who You Want to Cover	Dependents	Plan	Acceptance
❑ Employee Only ❑ Employee + Spouse ❑ Employee + Children ❑ Employee + Family	How many children are you covering? _____	❑ Plan 1	❑ Accept Coverage ❑ Decline Coverage

Employee-Paid (Voluntary) Hospital Care Insurance – Policy # HC 960277

Choose both a plan below and who you would like to include in your coverage.
See the enclosed Summary of Benefits for costs.

Who You Want to Cover	Plan	Acceptance
❑ Employee ❑ Employee + Spouse ❑ Employee + Children # of covered children ____ ❑ Employee + Family # of covered children ____	❑ Plan 1	❑ Accept Coverage ❑ Decline Coverage

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during this open enrollment.*
All coverage elected during this enrollment period will take effect on the latter of 01/01/2019 or the date the insurance company approves your application.

Form #TL-9334 © 2018 Cigna

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to critical illness insurance only):
We will not pay benefits for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition. The term "Pre-existing Condition" means any Sickness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 12 months before the Covered Person's most recent effective date of coverage, and the most recent effective date of any added or increased amount of coverage.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the Date of Diagnosis occurs after the Covered Person is insured under this Policy for at least 12 months after the Covered Person's most recent effective date of coverage, and effective date of any added or increased amount of coverage.

Pre-Existing Condition Limitation (applies to hospital care insurance only):
We will not pay benefits for a Covered Injury or Covered Illness caused, contributed to by, or resulting from, a Pre-existing Condition. The term "Pre-existing Condition" means any Illness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 12 months before the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Injury or Covered Illness that occurs after the Covered Person is insured under the Policy for at least 12 continuous months after the Covered Person's most recent effective date of insurance, and effective date of any added or increased amount of coverage.

For California Residents: By signing below, I certify that I and my dependents for whom I am applying for coverage are currently covered for comprehensive health benefits from an insurance policy, an HMO policy, or an employer health benefit plan. Anyone who is not currently covered for comprehensive health benefits is NOT eligible for Critical Illness and/or Hospital Care coverage.

Please Sign Here Signature _____ Date _____

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. If there is not enough room to specify all beneficiaries, attach, sign and date a separate page using the format below.

Accidental Death & Dismemberment Rider Policy# AI 960785					
Insured	**Beneficiary Name**	**Relationship**	**Social Security #**	**Date of Birth**	**Percentage** *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					
Child(ren)					

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____

Employee Signature _____ Date _____

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