TRAVELERS

2012 Employee Benefits Program

Medical

Summary Plan Description (SPD)

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Important Information

You Should Rely Only On Official Plan Documents

This booklet is provided to you to help you understand how your benefits work under the Medical Plan ("plan"), which is a component benefit program under The Travelers Trusteed Employee Benefit Plan.

The eligibility, benefit and claims process descriptions in this booklet are part of the official plan document governing the arrangement (together with the text of The Travelers Trusteed Employee Benefit Plan referenced in the General Information section).

Only the official plan document presents a complete and accurate description of the benefits available, and your rights and responsibilities, under any plan. You can rely only on the plan document, and not on any summary or other communication. We encourage you to read the plan document, which you can receive by contacting the Travelers Employee Services Unit ("ESU") at via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378.

To the extent that this booklet serves as a summary of benefits, and there is any information missing in this booklet, or if there is any discrepancy between the summary information in this booklet and any legal plan document, the plan documents will control (see the section titled "Role Of Insurer/TPA Provider" later in this booklet for more information). While every effort has been made to give you correct and complete information about your benefits in this booklet, a summary cannot deal with every set of circumstances.

It Describes Current Plan Terms

This booklet describes the terms of the plan in effect as of January 1, 2012.

Not An Employment Contract

The plan is not a contract of employment or a guarantee of continued employment for any definite period of time.

Right To Interpret

Travelers, its Administrative Committee, and others have broad discretionary authority to make factual determinations and to interpret the plan. This is described in the section entitled "Claims And Appeal Procedures."

Administrative Committee

The "Administrative Committee" is a person or committee appointed to this position in accordance with the terms of the plan. Currently, the Administrative Committee consists of a single person — the Executive Vice President – Human Resources of Travelers.

Oral Or Other Unofficial Modifications Are Not Permitted

The legal document governing the plan cannot be modified by oral statements made by anyone, or by unofficial communications (such as e-mail or mailings) or any other contracts (such as employment contracts or stock or asset purchase agreements). The plan can only be amended by official amendments. Amendments can only be adopted by authorized persons, such as the Board of Directors, the Chief Executive Officer, or others to whom the Board or the Chief Executive Officer has delegated amendment authority.

Overview

Introduction

When it comes to medical plan benefits, everyone has different needs. That's why Travelers offers all eligible employees a choice of medical plan options. Coverage is available for you alone, or for you and your eligible family members. You also may waive coverage.

Eligibility

You are eligible to enroll in one of Travelers' medical plan options on your first day of work as a regular status, salaried employee. You also can elect to cover your eligible family members. To be eligible, you must be scheduled to work at least 20 hours a week and not be a temporary employee. Certain retirees of Travelers also are eligible for this coverage as discussed in this overview and the Retiree Medical booklet which follows this section.

Cost

You and Travelers share the cost of coverage. The amount you pay depends on the medical option you select, your coverage level (employee only, employee/spouse, etc.), the smoker status of you and your spouse or domestic partner, your salary, and the number of hours you work.

Employee Coverage Options

You can choose one of the following options:

- The Choice Plus Plan, if offered in your area;
- The Blue Cross Blue Shield (BCBS) Plan, if offered in your area;
- The Out-of-Area Plan, if the Choice Plus Plan and BCBS Plan are not offered in your area;
- The High Deductible Plan, available to any eligible employee (other than residents of Hawaii);
- The Health Plan 200, residents of Hawaii only; or
- Waive coverage.

For expatriates, additional information on the BCBS World Wide Plan is available upon request.

Retiree Coverage Options

Please refer to the Retiree Medical booklet for information.

Overview

About This Publication

Travelers has prepared this summary of the plan's eligibility and cost rules, as well as rules regarding when your coverage under the plan begins and ends. Travelers has also prepared, for your information, tables summarizing the benefits under each medical option.

United Healthcare (UHC) administers the Choice Plus, Out-of-Area, High Deductible and Health Plan 200. UHC has prepared summaries describing the benefits covered and excluded under each of these options. These summaries are referred to as the "UHC summaries" throughout this booklet. The UHC summaries also describe the claims procedures for the plan options that UHC administers.

Blue Cross Blue Shield of Minnesota administers the BCBS plan option. Blue Cross Blue Shield of Minnesota has prepared a summary describing the benefits covered and excluded under the BCBS plan option. This summary is referred to as the "BCBS summary" throughout this booklet. The BCBS summary also describes the claims procedures for the plan option that Blue Cross Blue Shield of Minnesota administers.

If you have a question about eligibility, cost or when coverage begins or ends, you should refer to this booklet. If you have a question about covered or excluded benefits, or about the claims process followed by each administrator, you should refer to the UHC summaries or the BCBS summary.

If information in the tables summarizing benefit coverage and exclusions in this summary conflicts with the information in the UHC summaries or the BCBS summary, the UHC summaries or BCBS summary will govern. Similarly, if eligibility, cost, or coverage beginning and ending dates in the UHC summary or BCBS summary conflict with the information in this summary, the information in this booklet will govern.

Your Responsibilities

Participating in the plan provides you with certain benefits and rights. However, participation also comes with certain duties and responsibilities, which are described below.

Affirmation During Annual Enrollment

Every year during annual enrollment, you must affirm the smoker status of you and your spouse or domestic partner. You must also affirm your family members meet the eligibility requirements of the plan.

Changes In Your Family

You must inform the ESU when you have new family members you want to add to the plan (as a result of marriage, birth, adoption, etc.). It is VERY important that you tell us within 31 days of the date of marriage, or within 90 days of the birth or adoption. If you do not notify us within this timeframe and provide us with all the information we need to enroll your family member, then your family member will NOT be covered, and cannot be added to the plan until the next annual enrollment period.

If you get divorced, legally separated, file a Termination of Domestic Partnership or your child ceases to be eligible for the plan (because they are over age, for example), you MUST notify the ESU of this event within 60 days in order for the individual to be eligible to continue coverage (COBRA) under the plan, if applicable. Travelers will consider a failure to notify Travelers when a family member becomes ineligible as an intentional misrepresentation. This may result in a retroactive loss of coverage for the family member that is not a rescission.

See the Qualified Status Changes summary for more information.

Change Of Address

Remember to notify us when you or any of your family members covered by the plan have a change in address. It is very important that we are able to reach you in the event we need to communicate with you about your plan coverage.

Medicare Enrollment

You must inform ESU when you or a covered family member becomes enrolled in Medicare. This will affect how benefits are paid under the terms of the plan and may impact which option is available to you and your family members. Not notifying us, or notifying us late, can result in a delay in your receipt of benefits under the plan. See the Retiree Medical booklet for information on the interaction of Medicare and retiree medical coverage.

Other Coverage

Be sure to let UHC or BCBS know about the addition or termination of any other health plan coverage you may have. The plan coordinates the benefits it provides with the benefits you receive from other health plans. Failure to notify UHC or BCBS about the addition or termination of other health plan coverage can delay your receipt of benefits under the plan.

Benefits Materials

You have a responsibility to read and keep all of the materials Travelers distributes to you. If you read something you do not understand, it is your responsibility to ask questions.

Review For Errors

You must promptly review enrollment notifications, paycheck information and any other administrative communication for any errors. If you find an error, you must contact the ESU within 30 days of the date the information is provided or made available to you or you will not be able to bring any claim for relief from the error.

Eligibility

Employees

You are eligible to participate in the plan if you are:

- A regular status, salaried employee of Travelers or a participating affiliate; and
- You are scheduled to work at least 20 hours per week, or 50% of a full-time equivalent schedule if your office's workweek is less than 40 hours per week.

The "participating affiliates" currently are:

- Travelers Indemnity Company;
- The Premier Insurance Company of Massachusetts (also known as Travelers of Massachusetts);
- First Floridian Auto and Home Insurance Company (also known as Travelers of Florida); and
- TCI Global Services, Inc.

The following groups of people are not eligible to participate in the plan:

- Any temporary employee;
- Any employee classified as an "intern";
- Any employee who is:
    - Paid from a payroll system other than the U.S. payroll system of Travelers;
    - A local national employee — that is, citizen of another country who is not working in the United States unless Travelers specifically extends eligibility to the employee (including any such individual who has dual citizenship and thus is also a citizen of the United States, unless he or she is an expatriate on assignment from the United States); or
    - A citizen of a country other than the United States who is working on temporary assignment in the United States, as determined under the employment policies of Travelers unless Travelers specifically extends eligibility to the employee.
- Individuals employed with, performing services through, or paid by a third-party (such as an employee leasing or staffing agency); and
- Individuals performing services pursuant to a contract or agreement (whether verbal or written) which provides that he or she is an independent contractor or a consultant.

Please refer to the Retiree Medical booklet for information on retiree medical eligibility rules.

Family Members

Your family members are also eligible for coverage under the plan if you meet the eligibility criteria above, and you elect coverage for your family members under the plan. Eligible family members include:

- Your spouse. For this purpose, your "spouse" means either your federal spouse or state spouse as recognized by law. Your spouse does not include your former spouse from whom you are divorced or legally separated, even if your divorce decree or legal separation agreement requires you to provide medical coverage for your former spouse. Under the Defense of Marriage Act (DOMA), the federal government defines a legal union as between one man and one woman (a federal spouse), but some states define marriage more broadly (a state spouse). For most purposes, Travelers has defined spouse broadly enough to include both a federal spouse and a state spouse.
  - Your federal spouse means a person of the opposite sex to whom you are legally married under federal law (including a common-law spouse in a state that recognizes common-law marriage) and from whom you are not legally separated.
  - Your state spouse.* For this purpose, your "state spouse" means:
    - A person of the same sex (as his or her sex is recognized by the applicable state) to whom you are legally married under the laws of the state where the marriage is performed and from whom you are not legally separated; or
    - A person of the same sex (as his or her sex is recognized by the applicable state) to whom you are joined in a civil union under the laws of the state where the union was performed.

    The laws of the state in effect at the time of the marriage or civil union are considered, even if those laws are changed to no longer recognize certain marriages or civil unions.

    * In order for your state spouse to be considered your dependent for tax purposes, you must complete the State Spouse Dependent Tax Certification form.
- Your domestic partner.** For this purpose, a person is your "domestic partner" if:
  - You and this person have a long-term, intimate, committed relationship with each other, which is demonstrated to be one of mutual caring, affection, and responsibility for each other's common welfare;
  - You and this person hold yourselves out as in a relationship similar to marriage;
  - You and this person intend to continue your relationship with each other indefinitely;
  - You and this person meet the following marital status requirements:
    - If you and this person are of the opposite sex, both you and this person are unmarried to each other or anyone else; or
    - If you and this person are of the same sex, both you and this person are unmarried to anyone else;
  - You and this person are each other's sole domestic partner;
  - Both you and this person are at least 18 years of age;

- Both you and this person are capable to enter into a contract;
- You and this person are not related by blood closer than permitted by marriage law in your state of residence;
- You and this person share a principal residence and have lived together for at least six (6) consecutive months (and this six (6)-month period immediately precedes the date you complete the Domestic Partner Affidavit and Agreement);
- You and this person are jointly responsible to each other for basic living expenses; and
- The following timing requirements are met (as applicable):
    - At least six (6) months has elapsed since (i) the later of your divorce or this person's divorce from a previous spouse or (ii) the later of the death of your previous spouse or this person's previous spouse; and
    - At least six (6) months has elapsed since the date you notified Travelers that your previous domestic partnership ended (or the date your previous domestic partner was removed from your active coverage under this plan, if later).

** In order for an individual to be considered your domestic partner for this purpose, you and your domestic partner must complete the required Domestic Partner Affidavit and Agreement.

- A "child" of you or your spouse or domestic partner, who has not reached age 26, or a disabled dependent.
    - A "child" for this purpose includes your natural child, adopted child, stepchild, child for whom you are the legal guardian (sponsored dependent), and a child named in a Qualified Medical Child Support Order.

Family members listed above will not be eligible unless you timely affirm their eligibility and/or complete any eligibility audit as required under the rules of the plan. See the "Affirmation" and "Eligibility Audit" sections of this summary.

You will be asked to provide documentation supporting legal custody or legal guardianship when adding a sponsored dependent. If you fail to timely provide such documentation your sponsored dependent will not be added to your coverage. You will not be able to add your sponsored dependent until the next annual enrollment period, unless you have a Qualified Status Change before then and adding your sponsored dependent is consistent with that Qualified Status Change. See the Qualified Status Changes summary for more information.

If you and your spouse or domestic partner are both regular status employees of Travelers, you may be covered as an employee or as a family member, but not as both. In addition, only one of you may cover your eligible children as family members.

To enroll your domestic partner in the plan, contact the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378 for a Domestic Partner Affidavit and Agreement.

Eligibility

Disabled Dependents

If your dependent child is incapable of self-sustaining employment due to a chronic debilitating mental or physical condition, his or her coverage and dependent status may continue beyond the age limit of 26. To be eligible, your child must meet ALL of the following requirements:

- The child has a chronic debilitating mental or physical condition.
- The mental or physical disability was incurred before age 26.
- The child is unmarried.
- The child resides with you on a full-time basis (or, if they do not reside with you, is confined in a medical treatment facility or group home as a result of their condition).
- The child receives more than half of his or her support during the year from you.
- The child is incapable of self-sustaining employment.

Coverage continues for as long as your child meets the above requirements unless coverage is terminated as described in the section entitled "When Coverage Ends" found later in this booklet.

Upon reaching the age limit, you must provide proof that your disabled child meets all of the above requirements.

In addition, documentation of your child's disabled status must be provided upon request. This information will be reviewed by The Physician's Network (TPN) to validate your child's eligibility. Periodically thereafter, you will be asked to submit updated documentation to support continued eligibility. The time period for such submission may vary depending on the nature of the disability. If you fail to timely submit a new statement of eligibility upon request, your dependent's coverage will be terminated as of the date described in the plan's request for the new statement of eligibility. If you later provide evidence supporting disabled status, coverage will be provided prospectively from the date the new evidence is received and approved by the plan. If there is a gap in coverage, you may elect COBRA continuation coverage for your dependent for the gap period. If you fail to submit evidence supporting disabled status, your dependent will not be eligible for any COBRA continuation coverage under the plan, unless your child is no longer disabled and you have notified ESU within 60 days of the loss of your dependent's eligibility. See the COBRA summary for more information.

Affirmation

Smoker Status

Every year during annual enrollment, you must affirm the smoker status of you and your spouse or domestic partner. If you fail to affirm smoker status, you will be covered as a smoker. See the "Wellness Incentive" section for more information.

Family Member

Whenever you seek to cover (or to continue to cover) an eligible family member under the plan, you will be asked to affirm that each family member meets the eligibility requirements as described in this summary.

If you fail to timely affirm your family member's eligibility during annual enrollment, the consequence depends on whether the affected family member was previously covered. If your family member was not previously covered, that

individual will not receive coverage, and Travelers will adjust your coverage level appropriately. For example, if you elect Employee/children coverage, but you do not affirm that your children are eligible children, Travelers will adjust your election to Employee only coverage. If your family member was previously covered, your family member will lose his or her coverage under the plan. The loss of coverage will generally be effective as of the date specified in the plan's notice to you during the eligibility affirmation process.

If you later respond to the eligibility affirmation request and want to affirm your family member's eligibility, you will need to timely complete the eligibility audit process described below before your family members may be covered.

If you fail to timely affirm your family member's eligibility when you seek to cover your family member during the year as a result of a Qualified Status Change, then your family member will not receive coverage and you will not be able to add your family member to the plan until the next annual enrollment period, unless you have another Qualified Status Change and adding your family member is consistent with that Qualified Status Change. See the Qualified Status Changes summary for more information.

Eligibility Audit

Employees who fail to timely affirm their family member's eligibility upon request by the plan (other than requests related to mid-year additions of family members, which are subject to the Qualified Status Change timing rules) will be referred to the eligibility audit.

In addition to these referrals from the eligibility affirmation process, Travelers conducts random audits of employees and their covered family members on a quarterly basis. If you are selected for, or referred to, the eligibility audit, you will be asked to certify each family member's eligibility under the plan and to provide certain other supporting information as requested.

If you do not respond to the eligibility audit, or if you are not able to prove your family member's eligibility, your family member(s) will lose their coverage under the plan. The loss of coverage will generally be effective as of the date specified in the plan's notices regarding the eligibility. Travelers will consider a failure to respond to the eligibility audit as an intentional misrepresentation. This may result in a retroactive loss of coverage for the family member that is not a rescission. If you fail to complete the eligibility audit, your family member will not be eligible for any continuation coverage under the plan.

If family member coverage is removed and you later provide evidence that demonstrates your family member's eligibility, coverage will be provided prospectively from the date the eligibility audit is completed. If there is a gap in coverage with respect to family members previously covered under the plan, you may elect COBRA continuation coverage for that period.

Travelers also retains the right to separately investigate cases brought to Travelers' attention that may involve participants who may not satisfy the plan's eligibility requirements.

Other Consequences

Providing incorrect information during the enrollment, affirmation, eligibility audit, or separate investigation processes or failing to respond to the affirmation, audit, or separate investigation could result in termination of your family member's eligibility, disciplinary action, up to and including your termination of employment, your liability for benefits incorrectly paid, and civil or criminal prosecution. If your family member's coverage is cancelled, premiums for the retroactive period of cancelled coverage (if any) will not be refunded.

When Coverage Begins

Employee Coverage

Your coverage under the plan begins on the following day as applicable:

- The day you become eligible for the coverage, if you apply on or before that date or within 31 days after the date you become eligible;
- The first day of a calendar year, if you enroll for the next calendar year during the annual enrollment period;
- The day you have a Qualified Status Change, if your enrollment is consistent with your Qualified Status Change and your election is received within 31 days of the Qualified Status Change (see the Qualified Status Changes summary for more information, including information about before-tax and after-tax premiums); or
- On your Special Enrollment Date, if your election is received within the applicable timeframe (see the "Special Enrollment Rights" section later in this summary).

If you are a new hire and you do not elect or waive coverage within 31 days, you will be automatically enrolled in the High Deductible Plan with Employee only coverage. You will not be able to change your option or coverage level, or waive coverage, until the next annual enrollment period, unless you have a Qualified Status Change. If you have not elected coverage and you are terminated within five (5) business days of your hire date, you will not be enrolled in any option for that period.

If your employment was terminated because you could not prove eligibility to work in the United States or you did not affirm Travelers Principles of Employment within the time required by Travelers, a special rule applies if you are subsequently rehired. If you prove eligibility to work in the United States or you affirm the Principles of Employment and you are rehired, coverage will be reinstated or added. Your coverage will be effective on the date eligibility is proven or you make your affirmation, or, if later, the date you are rehired. If you are rehired within 30 days of your termination date and you elected coverage before your termination date, the reinstated coverage will be based on your prior election. If you did not elect coverage before your termination date or you are rehired more than 30 days after your original date of hire, then you will be treated as a new employee for purposes of the plan upon rehire.

If you are not working on the day your coverage is scheduled to begin and your coverage is cancelled, premiums for the retroactive period of cancelled coverage (if any) will not be refunded.

Family Member Coverage

If you enroll for employee/spouse, employee/child(ren) or family coverage, your eligible family members will become covered on the following day as applicable:

- The day you become covered;
- The first day of a calendar year, if enrolled during the annual enrollment period;
- The day of a Qualified Status Change, if enrollment is consistent with the Qualified Status Change and your election is received within 31 days of the Qualified Status Change (see the Qualified Status Changes summary for more information, including information about before-tax and after-tax premiums); or
- On your Special Enrollment Date, if your election is received within the applicable timeframe (see the "Special Enrollment Rights" section later in this summary).

Qualified Medical Child Support Order

Under federal law, group health plans must provide benefits in accordance with the requirements of a Qualified Medical Child Support Order (QMCSO). A child on whose behalf such an order is issued is an “alternate recipient” and will be treated as a participant under the plan. The court order may not require the plan to provide any type of benefit not otherwise provided.

All QMCSOs must be approved and accepted by the plan before benefits will be provided to the alternate recipient. If you are subject to a QMCSO, you must notify Travelers when you are hired or within 31 days after the issuance of the court order, if later. Travelers will provide you with the required enrollment materials.

You may obtain a copy of the plan’s QMSCO procedures from Corporate Employee Benefits by contacting the ESU.

Cost

If You Are An Employee

You and Travelers share the cost of your medical coverage. When you enroll in the plan, Travelers informs you of your share of the premium. Your premium is based on the option and coverage level you select, smoker status, the number of hours you work and your annual base salary. Your annual base salary is regular base pay, but excludes bonuses, overtime and other incentive pay. For members of the CAT team, annual base salary includes amounts characterized as "catastrophe" pay paid as an annual differential. Generally, you pay for your share of the premium with before-tax dollars from your salary.

In general, full-time employees pay a smaller share of the premium than part-time employees. For this purpose, "full-time employee" means an employee scheduled to work 40 hours per week or the number of hours designated as full-time by that employee's office.

If you cover your state spouse, or domestic partner or his or her children, you pay for their share of the premium on an after-tax basis unless you have certified that your state spouse or domestic partner qualifies as your dependent for tax purposes on your State Spouse Dependent Tax Certification or Certification of Domestic Partner Tax Status form. In certain states, state spouse or domestic partner coverage is before-tax for state tax purposes. The ESU will notify you if this special treatment applies to you.

Premiums are usually deducted from the first two paychecks of each month and not pro-rated for coverage of less than half a month. If you start coverage after the 7th of the month, you will pay premiums for the second half of that month in the next available pay period. If you start coverage after the 22nd of the month, you will pay premiums beginning in the next month in the next available pay period.

Wellness Incentive

You may be eligible for a non-smoker discount under the medical plan. To be eligible, you must not have used tobacco products during the previous six (6) months and you must not intend to use tobacco products in the future. Tobacco products under the plan are defined as cigarettes (including electronic cigarettes and vapor cigarettes), cigars, pipes, chewing tobacco and snuff.

Medical rates are based on smoker status as reflected in the Benefits System. If you are a smoker you will be charged smoker rates. If your spouse or domestic partner is a smoker, and you elect coverage for him or her under the medical plan, you will be charged smoker rates. If you add your spouse or domestic partner to your medical coverage and he or she is a smoker, you will be charged smoker rates effective on the date you add him or her to your medical coverage.

If you or your spouse or domestic partner change from smoker to non-smoker status, each of you must complete an affidavit before the change can be implemented.

Upon enrollment and every year during annual enrollment, you must affirm the smoker status of you and your spouse or domestic partner. If you fail to affirm smoker status, you will be covered as a smoker.

If you claim non-smoker status, Travelers reserves the right to verify whether you are a non-smoker. If you falsely claim non-smoker status, this could lead to disciplinary action, up to and including your termination of employment, and you may become liable for the difference between non-smoker and smoker premium charges retroactive to the time you first claimed non-smoker status.

Reasonable Alternative: Coverage Elected During Annual Enrollment

If you are a smoker, you may still receive the non-smoker discount if you complete the approved UHC or BCBS tobacco cessation program, provide program completion documentation from UHC or BCBS and provide a completed Reasonable Alternative Certification Form to the ESU. The UHC or BCBS tobacco cessation program must start by March 31st of the plan year and must be completed by December 1st of the plan year. All documentation must be submitted to the ESU within 31 days of completing the program (but in no case later than December 15th) and must be approved by the ESU. You will then be charged non-smoker medical rates for the remainder of the plan year. Keep in mind that your spouse or domestic partner must be a non-smoker as well, or must also complete or start an approved UHC or BCBS tobacco cessation program by March 31st, complete the program by December 1st and submit the required documentation by the deadline for you to receive non-smoker medical rates. The UHC and BCBS smoking cessation programs are deemed approved tobacco cessation programs.

You will also receive a refund of the difference in cost between the smoker and non-smoker premiums that you paid retroactive to January 1. This refund is taxable income to you. Refunds must be processed in the same plan year. For that reason, if you complete an approved tobacco cessation program in November or December, you must submit all documentation to the ESU by December 15th to be eligible for a premium refund. You may not receive a premium refund for documentation submitted after December 15th.

If it is unreasonably difficult or medically inadvisable for you to meet the above standards, contact the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378 for additional information.

Reasonable Alternative: Coverage Elected After A Qualified Status Change, New Hire Or Re-hire Event

If you are a smoker, you may receive the non-smoker discount if you complete the approved UHC or BCBS tobacco cessation program, provide program completion documentation from UHC or BCBS and provide a completed Reasonable Alternative Certification Form to the ESU. You and/or your spouse or domestic partner must enroll in the UHC or BCBS tobacco cessation program within 90 days of the Qualified Status Change event or benefit eligibility date, as applicable, and complete the program. All documentation (program completion documentation from UHC or BCBS and a completed Reasonable Alternative Certification Form) must be submitted to the ESU no later than 31 days after completing the program and must be approved by the ESU.

If your request is received by December 15th of the plan year, you will then be charged non-smoker medical rates for the remainder of the calendar year. In addition, you will receive a refund of the difference in cost between the smoker and non-smoker premiums that you paid retroactive to January 1 or your benefits effective date, whichever is later. This refund is taxable income to you. If your request is received after December 15th of the plan year, your non-smoker status will not be processed until the next calendar year. You will be considered to qualify for the reasonable alternative for the next plan year and will be charged non-smoker medical rates for the next calendar year.

If it is unreasonably difficult or medically inadvisable for you to meet the above standards, contact the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378 for additional information.

If You Are A Retiree

Please refer to the Retiree Medical booklet for information on cost.

Right To Modify/Terminate Coverage

Travelers does not guarantee that it will maintain coverage under the plan and/or any component plan. The benefits provided by the plan and/or any component plan are not "vested" benefits. Travelers does not promise the continuation of any benefit nor does it promise any specific level of benefits, or cost for such benefits, for either employees or retirees, at any time.

Travelers can amend or terminate the plan at any time and for any reason. An amendment may apply to active participants, to persons who are on leave, to retirees or other former employees, or to others who are no longer active participants in the plan. Further, an amendment may apply to all participants or only to some participants.

Choosing Your Medical Option

Currently, your medical options from Travelers include:

- The Choice Plus Plan, if offered in your area;
- The BCBS Plan, if offered in your area;
- The Out-of-Area Plan, if the Choice Plus or BCBS Plans are not offered in your area;
- The High Deductible Plan, available to any eligible employee (other than residents of Hawaii);
- The Health Plan 200, residents of Hawaii only; or
- Waive coverage.

You may choose the following coverage levels for any medical option:

- Employee only (coverage for you only);
- Employee/spouse (coverage for you and your spouse or domestic partner);
- Employee/child(ren) (coverage for you and one or more children); or
- Family (coverage for you, your spouse or domestic partner and one or more children).

If you are a new employee, you may choose medical coverage when you are first hired. If you do not elect or waive coverage within 31 days, you will be automatically enrolled in the High Deductible Plan with Employee only coverage. You will not be able to change your option or coverage level, or waive coverage, until the next annual enrollment period unless you experience a Qualified Status Change.

If you waive coverage in any year of employment and later decide that you want coverage, you may enroll during the next annual enrollment period. If you enroll during the next annual enrollment period, your coverage will take effect on the following January 1 (or earlier if you experience a Qualified Status Change).

Changing Medical Coverage

In general, once you choose a medical option, your coverage will be effective for the remainder of the calendar year. However, you may change from one plan option to another during the annual enrollment period held each fall (effective the following January 1) or if you experience a Qualified Status Change. You also may change coverage levels at that time.

Please note that when you choose the BCBS Plan or the Choice Plus Plan medical option, you are electing an entire network of providers and facilities. It is your responsibility to confirm that the provider you choose is a network provider and is accepting new patients. If a provider does not participate in the network, benefits will be considered to be provided at the out-of-network level. A change in a provider's or facility's network status does not constitute a Qualified Status Change event unless the network is no longer adequate. A network is considered adequate if there are at least 2 primary care providers within 15 miles.

You cannot make mid-year changes to your level of coverage or terminate your coverage unless you experience a Qualified Status Change — and the coverage change or termination of coverage is consistent with the status change. See the Qualified Status Changes summary for more details. You may also make a change during a Special Enrollment period

described below. Your request must be received in the ESU within 31 days (60 days for Medicaid or CHIP or 90 days for birth or adoption) after the event. The change is then effective as of the date of the event.

No Pre-Existing Condition Exclusions

Travelers' plan options do not include pre-existing condition limitations. This means that if you have a medical condition at the time you enroll in the plan you will receive full benefits for any eligible expenses due to the pre-existing medical condition. For instance, if you have a heart condition at the time you enroll in the plan, the plan will provide benefits for eligible expenses related to the heart condition (after your payment of applicable copays and deductibles) and for any other treatment you receive after your enrollment in the plan. The plan will not, however, cover any expenses for treatment you received prior to your enrollment.

Special Enrollment Rights

A federal law called the Health Insurance Portability and Accountability Act ("HIPAA") provides you with special enrollment rights. You and your family members have the right to enroll for loss of coverage, new family member and Medicaid or CHIP, as described below.

Refer to the Qualified Status Changes summary for more information. If your enrollment request is not received within the applicable timeframe, you will be required to wait until the next annual enrollment period or Qualified Status Change event to add your new family member.

"Received" means physically or electronically received by the ESU with a postmark, date stamp or other reliable evidence dated within the 31-day timeframe (60 days for Medicaid or CHIP or 90 days for birth or adoption). If the ESU does not receive your enrollment request within the required timeframe, you will need to prove that you sent it to the ESU within the required timeframe in order for the enrollment to be honored (e.g., by producing a dated fax receipt or certified mail receipt).

Loss Of Coverage

If you decline enrollment for yourself and your family members because of other health insurance coverage, you may enroll yourself and your family member in this plan after eligibility for your other coverage ends as a result of:

- Divorce or annulment;
- Legal separation;
- Termination of Domestic Partnership;
- Death;
- Termination of employment;
- Reduction in hours of work; or
- Elimination of employer contributions toward such coverage.

If you or your family member have elected continuation coverage under COBRA under the other plan, you may also enroll in this plan when COBRA coverage has been exhausted.

Your request to change your coverage must be received within 31 days after eligibility for other coverage ends or after COBRA coverage has been exhausted. If you enroll in the applicable timeframe, the coverage will be effective on the day of the event causing a loss of coverage.

New Family Members

In addition, if you have a newborn child, you may enroll your child in the plan. Your request to enroll a newborn child must be received by ESU within 90 days after the birth. If you request enrollment in the applicable timeframe, the coverage will be effective on the date of the newborn's birth.

If you have an adopted newborn child, you may enroll your child at the earliest of documented assumption of legal and financial responsibility for the child OR at leaving the hospital after birth if the child is released into your household under custody. Your request to enroll an adopted newborn must be received by ESU within 90 days of such date. If you request enrollment in the applicable timeframe, the coverage will be effective on such date.

You may enroll adopted children, other than adopted newborn children, when custody is granted or, if sooner, when you assume a legal obligation for the support of a child in anticipation of the adoption. Your request to enroll an adopted child must be received by ESU within 90 days of such date. If you request enrollment in the applicable timeframe, the coverage will be effective on such date.

If any of the "new family member" events described above occur after the annual enrollment period in which you first elect coverage but before the following plan year begins, you may elect to have coverage for the newborn or adopted child become effective on the first day of the following plan year instead of the earlier effective dates described above.

Any other person who becomes eligible for coverage after you have enrolled in the plan can be enrolled if requested within 31 days of the event. If you request to enroll in the applicable timeframe, the coverage will be effective on the day of the Qualified Status Change.

Medicaid Or CHIP

If you decline enrollment for yourself and/or your family members because of Medicaid or state Children's Health Insurance Program (CHIP) coverage, you may enroll yourself and/or your family members in the plan after eligibility and coverage for Medicaid or CHIP ends.

If you decline enrollment for yourself and/or your family members and you become eligible for premium assistance under the plan from Medicaid or CHIP, you may enroll yourself and/or your family members in the plan.

Your request to change your coverage for Medicaid or CHIP events must be received by ESU within 60 days after the Medicaid or CHIP event. If you request enrollment in the applicable timeframe, the coverage will be effective on the date of the Medicaid or CHIP event.

Medicare

Travelers plan options are primary to Medicare for active employees and family members of active employees eligible for Medicare. Travelers plan options are secondary to Medicare for employees on long-term disability, retirees, and their family members who are eligible for Medicare. For a summary of the Coordination of Benefits policies, please refer to the UHC or BCBS provided summary plan descriptions.

Choosing Your Medical Option

Note: Employees on long-term disability, retirees, and/or their family members eligible for Medicare are not eligible for the BCBS plan option. Coverage is available through a UHC option. You must inform ESU when you or a covered family member becomes enrolled in Medicare. Please contact the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378 for more information.

Key Medical Plan Terms

Eligible Expenses (UHC)

For network providers, eligible expenses are the contracted amounts agreed to between UHC and the providers for covered health services. For out-of-network providers, eligible expenses are expenses for covered health services which have been reviewed and approved by UHC. Such expenses are limited to competitive fees for health services based on available data resources in that geographic area for the Choice Plus, Out-of-Area, High Deductible and Health Plan 200 Plans.

If an out-of-network provider charge exceeds the eligible expenses amount, you will be responsible for paying the excess portion, as well as any deductibles, copays and coinsurance that would normally apply. Charges exceeding UHC eligible expense amounts do not apply toward the out-of-pocket maximum. A full description is available in the UHC summary plan description.

Allowed Amount (BCBS)

The negotiated amount the network BlueCard PPO provider has agreed to accept as full payment for covered health services. A full description is available in the BCBS summary plan description.

Coinsurance

Coinsurance refers to the percent of covered expenses you must pay until you reach the out-of-pocket maximum.

Copay

A copay is the amount you must pay before the plan begins to cover expenses. Once you pay the copay, the plan generally pays the rest of your covered medical expenses for the service.

Deductible

The deductible is the amount you pay each calendar year for covered medical expenses before plan benefits are available.

Lifetime Benefit Maximum

The lifetime benefit maximum is the maximum benefit available for each eligible participant during his or her lifetime.

Key Medical Plan Terms

Out-Of-Pocket Maximum

An out-of-pocket maximum limits the amount of money you must pay out-of-pocket each year for covered expenses.

Once your covered out-of-pocket expenses reach the out-of-pocket maximum, the plan pays 100% of your covered expenses for the rest of the year (excluding copays which you continue to be responsible for).

The following expenses do not count toward the out-of-pocket maximum:

- Office visit, emergency room, and urgent care copays;
- Penalties for failure to pre-certify or preauthorize certain services;
- Amounts exceeding eligible expenses or allowed amounts as determined by UHC and BCBS;
- Prescription drug copays and coinsurance and ancillary fees associated with the Express Scripts prescription drug plan; and
- Ineligible charges.

Summary of Benefits

The information on the following pages describes the prescription drug benefit that is automatically included in each medical option. It also summarizes in table form the major benefits for the Choice Plus, BCBS, Out-of-Area, High Deductible, and Health Plan 200 plan options. The tables are provided for your convenience in comparing medical plan options.

This summary does not describe all of the benefits, maximums, limitations and exclusions that may apply. If the terms of the UHC summaries or the BCBS summary are different from or inconsistent with the provisions of the tables in this summary, the terms of the UHC summaries or the BCBS summary will control. Refer to the UHC summaries or the BCBS summary for more details about specific benefits, maximums, limitations and exclusions. You may obtain a copy of the UHC summary plan descriptions or the BCBS summary plan description online through *my*HR or by requesting a copy from the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378.

Prescription Drug Coverage

When you enroll in any Travelers medical plan option, you will automatically receive prescription drug coverage through Express Scripts. Please refer to the Retiree Medical booklet for information on retiree prescription coverage.

Preventive Prescriptions

The following over-the-counter products may be eligible for coverage as preventive medication through Express Scripts at no cost to you, subject to a prescription and the following criteria noted in the table below.

Product	Dosage/Dosage Form	Criteria
Fluoride	Oral dosage forms typically used by children/infants (e.g., drops, chewable tablets) in strengths providing less than or equal to 0.5 mg/day	Preschool children older than six (6) months through five (5) years of age whose primary water source is deficient in fluoride
Aspirin (to prevent cardiovascular disease)	Oral dosage forms typically used by adults (e.g., tablets) in strengths providing less than or equal to 325 mg/day	Men age 45 to 49 Women age 55 to 79
Folic Acid	Oral dosage forms typically used by adults (e.g., tablets) in strengths providing 0.4 to 0.8 mg/day	Women age 18 to 45
Iron Supplements	Concentration and oral dosage forms (e.g., drops, syrups, suspensions) typically used by infants	Children age 6 to 12 months who are at increased risk for iron deficiency anemia

Note that the prescription drug benefits (coinsurance, etc.) described below do not apply for Health Plan 200. See the charts in this booklet labeled "2012 United Healthcare Health Plan 200" for details of the prescription drug coverage offered under Health Plan 200.

Retail Prescriptions

Each time you need up to a 30-day supply of prescription drugs, show your Express Scripts ID card at a participating network pharmacy. The copay and coinsurance amounts for retail drugs (other than infertility drugs) are as follows:

- $7 for generic drugs;
- 20% for formulary brand-name drugs and compound medications;
- 40% for non-formulary brand-name drugs;
- Minimum per brand-name prescription (formulary or non-formulary): $32; and
- Maximum per brand-name prescription (formulary and non-formulary): $130.

Prescription Drug Coverage

A separate $2,350 calendar year out-of-pocket maximum for prescription drugs applies to each plan member. This means that when a member pays $2,350 in eligible prescription drug copay and coinsurance, all retail, specialty medicine, and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% (excluding infertility medications). Ancillary charges associated with certain brand name medications do not apply to the out-of-pocket maximum.

90-Day Supply at Retail Program through CVS

You can fill a 90-day supply of prescription drugs at CVS retail locations nationwide. Under this option, you will pay:

- $21 for generic drugs (the equivalent of three (3) retail copays for generic drugs);
- 20% for formulary brand-name drugs and 40% for non-formulary brand-name drugs, subject to:
- Minimum per brand-name prescription (formulary or non-formulary): $96; and
- Maximum per brand-name prescription (formulary or non-formulary): $390.

Under this option, you will not have to pay the Preferred Home Delivery additional 10% coinsurance for failure to use the mail order pharmacy.

Specialty medications (e.g., medications for arthritis, cancer, hepatitis, multiple sclerosis and other chronic conditions) and controlled substance medications are excluded from this program. For additional information regarding which medications are excluded from this option contact Express Scripts at 877.494.7472.

Note: Retirees are not eligible for the 90-day Supply at Retail Program.

Infertility Medications

Infertility medications are covered subject to 50% coinsurance. There is no minimum or maximum per prescription and the coinsurance for infertility medications does not apply towards the $2,350 annual out-of-pocket maximum. Infertility medications are NOT covered under the High Deductible Plan.

If You Need A Prescription Filled Before Receiving Your ID Card

You must pay the entire cost for the medication and then submit a claim form to Express Scripts. You will be reimbursed for the cost of the prescription minus the applicable copay or coinsurance. Claim forms are available on *my*HR or from the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378.

If You Fill A Prescription At An Out-Of-Network Pharmacy

You must pay the entire cost for the medication and then submit a claim form to Express Scripts. Your reimbursement will be based upon whether or not you had access to a network pharmacy. If you had access to a network pharmacy, you will be reimbursed at the contracted rate for out-of-network prescriptions minus the applicable copay or coinsurance. If you did not have access to a network pharmacy, the network copay or coinsurance will apply. Claim forms are available on *my*HR or from the ESU.

Prescription Drug Coverage

Specialty Medication Program: CuraScript

Specialty medications are covered up to a 30-day supply through Express Scripts specialty medication pharmacy company CuraScript. A partial list of conditions that may result in these specialty medications includes arthritis, cancer, hepatitis, infertility, migraines, RSV and multiple sclerosis. Under the specialty program, members are allowed two (2) initial fills per medication at a local retail pharmacy. Thereafter, the medication will be filled via the CuraScript mail order pharmacy. Specialty medications are subject to the same coinsurance (minimums and maximums) as retail prescriptions with the exception of infertility medications which are covered at 50% (with no minimums or maximums, no out-of-pocket maximum and are not covered under the High Deductible Plan). The out-of-pocket maximum described under the section "Retail Prescriptions" also applies to specialty medications. All prescriptions, regardless of where obtained, are combined for the out-of-pocket maximum. If you have questions on this program, you can contact CuraScript directly at 800.278.0980.

Drug Quantity Management Program

The Drug Quantity Management ("DQM") program is designed to make your use of prescription drugs safer and more affordable. Through the DQM program, certain medication prescriptions are limited to the daily dose that the U.S. Food and Drug Administration ("FDA") considers to be safe and effective.

For these medications, a 30-day prescription (or 90-day prescription if mail-order) will be dispensed in accordance with the daily dose recommendations provided by the FDA. The DQM program is intended to help you receive a safe dosage of your medication and to help you avoid the expense of extra medication that could go to waste. If your physician feels it is medically necessary for you to receive additional medication beyond the quantity allowed under the DQM program, your physician should call Express Scripts prior authorization line at 800.417.8164. For a list of the specific medications that are part of the DQM program, please refer to the Drug Quantity Management FAQ document which can be found on *my*HR.

Step Therapy Program

The Step Therapy program is required for new prescriptions written on or after January 1, 2012 in the following drug categories:

- Proton pump inhibitors (e.g., for acid reflux)
- Tetracycline and topical medications (e.g., for acne)
- Nasal steroids (e.g., for allergies)
- Hypnotics (e.g., for insomnia); and
- Cox2 and non-steroidal anti-inflammatory drugs (e.g., for pain).

The program is intended to help patients get the prescription drugs they need, while also considering patient safety, cost and health. If you are prescribed a drug that requires Step Therapy, you must follow the Step Therapy process or the plan will not cover your prescription.

The first step in the Step Therapy process is a front-line generic drug determined by medical professionals to be safe, effective and affordable. If you can't take the recommended generic drug (for example, because of a historic allergy) or this drug does not work for you and your doctor decides the drug isn't appropriate for you, then your doctor can prescribe a drug in the second step to see if that drug works for you. These are brand name prescription drugs and are

recommended only if the first step drug doesn't work for the patient. If your doctor's request for an override is approved, you will pay the appropriate copay or coinsurance for the drug. If the override is not approved, you may have to pay full price for the drug. For additional information on the Step Therapy program, please refer to the Step Therapy FAQ document which can be found on *my*HR.

Mail Order Drug Pharmacy

You can obtain up to a 90-day maintenance drug supply through the Express Scripts mail-order pharmacy. The mail-order pharmacy offers the convenience of home delivery of up to a 90-day supply, lower prices and a phone that is staffed by pharmacists 24 hours per day, 7 days a week. The coinsurance amounts for mail-order drugs (excluding infertility drugs) are as follows:

- $14 for generic drugs;
- 20% for formulary brand-name drugs;
- 40% for non-formulary brand-name drugs;
- Minimum per brand-name prescription (formulary and non-formulary): $64; and
- Maximum per brand-name prescription (formulary and non-formulary): $260.

The out-of-pocket maximum described under the section "Retail Prescriptions" also applies to the mail order drug pharmacy prescriptions, which are combined with retail prescriptions and specialty medicine prescriptions for purposes of the out-of-pocket maximum.

Preferred Home Delivery Policy

As part of our ongoing efforts to keep prescription drug costs under control, Travelers has negotiated greater discounts on maintenance medications filled through mail order and at select retailers. When members use the mail order pharmacy for maintenance medications, it results in an average plan savings of 10% in comparison to medications purchased at retail. The Preferred Home Delivery policy is intended to eliminate the cost difference between retail and mail order pharmacy pricing for maintenance medications.

This policy applies to prescriptions used for ongoing conditions or needs such as arthritis, asthma, birth control, diabetes, high blood pressure and high cholesterol. Under this policy, you are allowed to receive a 30-day supply of maintenance medication up to two (2) times from any network retail pharmacy.

After two (2) fills of a 30-day supply, you will need to make a decision:

- to use the Express Scripts mail order pharmacy for up to a 90-day supply,
- to use the 90-day Supply at Retail Program through CVS (which is excluded from the additional 10% coinsurance noted below), or
- to continue to use a retail pharmacy for refills. Any additional retail refills of the same 30-day maintenance medication will be subject to an additional 10% coinsurance above the regular copay or coinsurance (i.e., generic, formulary brand or non-formulary brand).

Once you have filled a maintenance medication prescription at retail, you will receive a reminder letter from Express Scripts about the Preferred Home Delivery Program.

Prescription Drug Coverage

Generic Drugs vs. Brand-Name Drugs

A brand-name, protected by a time-limited patent, is the name under which a drug is advertised and sold. Once the patent has expired, a generic equivalent may be manufactured by any company complying with the stringent FDA regulations for safety. For many prescriptions, there is no difference between the generic equivalent and the brand-name drug – except for the cost.

Generics Preferred Policy

The Generics Preferred Policy encourages generic prescription drug utilization through economic incentives for using generic medications, and it applies to all prescription classes except Coumadin and Synthroid.

This policy applies when you receive a brand-name prescription for a medicine when a chemically equivalent generic alternative is available. If a brand-name drug is dispensed rather than an available chemically equivalent generic drug, an ancillary charge is applied in addition to the member's generic copay. The ancillary charge is the difference in cost between the brand and the generic drug. Ancillary charges are your responsibility, regardless of whether the "Dispense as Written" box is checked by the doctor (except as described below for Coumadin and Synthroid). The ancillary charge does not apply towards the maximum coinsurance per prescription ($130 retail, $260 mail order) or the $2,350 per person out-of-pocket maximum.

If you or your family member's physician feels it is medically necessary to continue to receive the brand-name version of the medication instead of the generic, the physician can call Express Scripts Prior Authorization Line at 800.417.8164 before you obtain your prescription. If medical necessity is approved by Express Scripts, you pay the non-formulary coinsurance for the prescription and do not pay the ancillary charge.

For Coumadin and Synthroid, if your physician writes the prescription "Dispense as Written" for brand-name medication, you pay the non-formulary coinsurance and do not pay an additional fee. If this is not on the prescription, ancillary charges will apply.

What Is A Formulary?

A formulary is a list of FDA-approved prescription drugs that are on Express Scripts preferred list. Formulary drugs include both generic and brand-name drugs that are determined to be as safe and effective as other drugs that can be prescribed for the same condition. Drugs, mostly brand-name, that are not on the formulary are considered non-formulary. The formulary is reviewed quarterly by Express Scripts physicians and clinical pharmacists as new and updated information is made available to Express Scripts. The formulary is updated quarterly for additions and annually for deletions for benefit purposes.

Examples Of Covered Drugs And Supplies Include:

- Covered legend drugs (drugs that federal law requires to be dispensed by prescription only);
- Legend prenatal vitamins;
- Insulin (up to 30 days supply for one (1) copay);
- Infertility drugs (prior authorization is required for injections) (not covered under the High Deductible Plan);

- Limited diabetic supplies (insulin, syringes with/without needles; needles; blood glucose test strips; ketone test strips and tablets; lancets);
- Ostomy supplies;
- Smoking cessation drugs (up to a 90-day annual supply); and
- Oral contraceptives.

Examples Of Drugs And Supplies Not Covered:

- Over-the-counter multiple vitamins and nutritional supplements;*
- Legend single entity and multiple vitamins (except legend prenatal vitamins);*
- Medications for cosmetic purposes (such as Minoxidil);
- Medications for which there are limited benefits per Express Scripts' interpretation of clinical data;
- Medications with no FDA indications or outside the FDA approved dosage;
- Over-the-counter medications (such as Claritin, Rogaine, etc.);*
- Immunization agents, biological sera, blood, or blood plasma;
- Therapeutic devices and appliances;
- Charges for the administration or injection of any drug; and
- Experimental drugs.

*Except for over-the-counter medications covered as preventive medications in the "Preventive Prescriptions" section.

Prior Authorization

Prior authorization is required for some drugs and supplies in order for them to be covered. Prior authorization is the process of obtaining permission or pre-approval for a patient to receive select medicines as a covered benefit. The prior authorization process promotes safety and cost-effective prescribing by restricting coverage to FDA approved indications and medically appropriate uses.

The prior authorization process usually begins when the patient brings the prescription to the pharmacy. As the pharmacist attempts to fill the prescription, they will be notified that prior authorization is required. The pharmacist or your physician will need to call Express Scripts and provide them with more information before filling your prescription.

Examples where prior authorization is required:

- Growth hormones;
- Infertility drugs (injections);
- Drugs for inflammatory conditions like Rheumatoid Arthritis and Crohn's Disease;

- Weight-loss medications;
- Non-narcotic general analgesics (i.e. Imitrex and DHE);
- Retin-A (covered through age 29); and
- Lidoderm.

For a full listing of medications or to determine whether a specific medication is subject to prior authorization, call the Express Scripts Customer Service Call Center at the toll free number 877.494.7472.

Medicare Part B Coordination of Benefits

With prescription drug cost on the rise, coordinating benefits with Medicare Part B can help keep the cost down for both participants and the plan. Express Scripts began coordinating benefits for Medicare Part B covered prescriptions and supplies including oral cancer medications, immunosuppressant medications, respiratory agents, and diabetic testing and maintenance supplies. The same plan design applies; however, the claim will be first submitted to Medicare Part B for consideration and then the balance will be processed by Express Scripts. Prescriptions and supplies sourced at a retail pharmacy will require the retail pharmacy be a participating Medicare Part B retail pharmacy. Most major chains including CVS, Kroger, Rite Aid and Target are participating Part B retail pharmacies.

Prescriptions and supplies filled through home delivery mail order will use NationsHealth mail order pharmacy, a participating Medicare Part B mail order pharmacy who has partnered with Express Scripts. For more information, please call Express Scripts customer service at 844.494.7472 or NationsHealth customer service at 800.298.1418.

2012 United Healthcare Choice Plus Plan Summary

2012 Choice Plus Plan	Network	Out-of-Network
Deductible	$500 per person/$1,000 per family maximum	$1,000 per person/$2,000 per family maximum
Out-of-Pocket Limit (Includes deductible and coinsurance; excludes copays, prescription copays and coinsurance)	$3,150 per person/$6,300 per family	$6,300 per person/$12,600 per family
Lifetime Maximum	Unlimited	Unlimited
Office & Facility Visits		
Retail Medical Clinic Visit	You pay $10 copay per visit	You pay 30% coinsurance after the deductible
Primary Care Office Visit (including allergy shots)	You pay $23 copay per visit	You pay 30% coinsurance after the deductible
Specialist Office Visit	You pay $35 copay per visit	You pay 30% coinsurance after the deductible
Maternity Office Visit (prenatal and postnatal)	You pay $35 copay for initial visit	You pay 30% coinsurance after the deductible
Urgent Care Facility Visit	You pay $35 copay per visit	You pay 30% coinsurance after the deductible
Emergency Room	You pay $130 copay per visit; no copay if admitted to a hospital	You pay $130 copay per visit; no copay if admitted to a hospital
Prescription Drugs Administered by Express Scripts (excluding fertility drugs)*		
Retail – up to 30-day supply		If you filled a prescription at an out-of-network pharmacy, you will be reimbursed at the contracted rate minus the applicable coinsurance. If you did not have access to a network pharmacy, the network coinsurance will apply.
- Generic	$7 copay	
- Formulary Brand	20% coinsurance subject to a $32 minimum, $130 maximum	
- Non-Formulary Brand	40% coinsurance: subject to a $32 minimum, $130 maximum	
Mail Order – up to 90-day supply		
- Generic	$14 copay	
- Formulary Brand	20% coinsurance subject to a $64 minimum, $260 maximum	
- Non-Formulary Brand	40% coinsurance: subject to a $64 minimum, $260 maximum	
90-day Supply at Retail program – CVS pharmacies only		
- Generic	$21 copay	
- Formulary Brand	20% coinsurance subject to a $96 minimum, $390 maximum	
- Non-Formulary Brand	40% coinsurance: subject to a $96 minimum, $390 maximum	
Preferred Home Delivery for Maintenance Prescriptions (other than 90-day Supply at Retail through CVS)	You pay an additional 10% coinsurance for maintenance prescriptions filled more than twice at retail pharmacies	
Generics Preferred Policy (All except Coumadin and Synthroid)	You pay generic copay plus the cost difference between the generic and the brand name when a generic is available but not chosen	
Prescription Out-of-Pocket Maximum (combined network & out-of-network)	$2,350 per member, per calendar year	$2,350 per member, per calendar year
Inpatient Hospital and Physician Services	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Outpatient Hospital and Surgical Services	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Hospital Pre-Notifications	Not required	Employee initiates; coverage reduced by $500 for failure to provide pre-notification

*Specialty medicine sourced by CuraScript mail order pharmacy is subject to the retail prescription plan design. The prescription drug annual out-of-pocket maximum per member includes both retail and mail order drug expenses (excludes infertility medications, which are covered at 50%) and is separate from the Choice Plus Plan's annual out-of-pocket expenses. Once a member pays $2,350 in prescription drug copays and coinsurance, all retail, specialty medicine and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% of eligible expenses.

2012 United Healthcare Choice Plus Plan Summary

2012 Choice Plus Plan	Network	Out-of-Network
Diagnostic X-ray/Lab Work and Therapeutic Services		
Outpatient radiology and X-ray	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Outpatient hospital and independent lab work	You pay 10% coinsurance	You pay 30% coinsurance after the deductible
Hospital lab and x-ray	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
CT and MRI	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Cancer and IV therapeutics	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Preventive Care		
Well Child Visits Routine Physical Exams and Immunizations Mammogram Colonoscopy Routine Vision Care (annual exam) Routine Hearing Care (annual exam)	No copay	No coverage
Outpatient Care		
Chiropractic Care Visits	You pay $23 copay per visit; limited to 20 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 20 visits (network & out-of-network) per calendar year
Physical and Occupational Therapy	You pay $23 copay per visit; limited to 60 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 60 visits (network & out-of-network) per calendar year
Speech Therapy	You pay $23 copay per visit; limited to 60 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 60 visits (network & out-of-network) per calendar year
Mental Health and Substance Abuse		
Inpatient	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Outpatient Visit	You pay a $23 copay per visit	You pay 30% coinsurance after the deductible
Hospital Pre-Notification	Not required	Employee initiates; coverage reduced by $500 for failure to provide pre-notification
Special Services		
Ambulance	You pay 10% coinsurance after the deductible	You pay 10% coinsurance after the deductible
Home Medical Services	You pay 10% coinsurance after the deductible; limited to 60 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible, limited to 60 visits (network & out-of-network) per calendar year
Skilled Nursing Facility	You pay 10% coinsurance after the deductible; limited to 60 days (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 60 days (network & out-of-network) per calendar year
Hospice Care	You pay 10% coinsurance after the deductible; maximum benefit duration of 6 months	You pay 30% after the deductible; maximum benefit duration of 6 months
Medical Equipment and Supplies	You pay 10% coinsurance after the deductible; limits may apply	You pay 30% coinsurance after the deductible; limits may apply
Bariatric Surgery	Network Center of Excellence: You pay 10% coinsurance (no deductible) Other Network: You pay 10% coinsurance after the deductible	Not covered
Transplant	You pay 10% coinsurance after the deductible; coverage based on a limited list of organs/diseases	You pay 30% coinsurance after you meet the deductible; coverage based on a limited list of organs/diseases
Voluntary Sterilization	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Reversal of Voluntary Sterilization	Not covered	Not covered

2012 United Healthcare Choice Plus Plan Summary

2012 Choice Plus Plan	Network	Out-of-Network
Dental Services	Copay or deductible/coinsurance for applicable location applies (inpatient hospital, outpatient hospital, or physician office) for treatment due to: a. accidental injury (treatment must occur within 12 months of the injury) b. treatment or removal of a malignant tumor c. surgery to the joint of the jaw	You pay 30% coinsurance after the deductible for treatment due to: a. accidental injury (treatment must occur within 12 months of the injury) b. treatment or removal of a malignant tumor c. surgery to the joint of the jaw
Infertility		
Provider Services	Copay or deductible/coinsurance for applicable location applies (inpatient hospital, outpatient hospital, or physician office). $20,000 lifetime maximum benefits	Not covered
Prescription Drugs	You pay 50% coinsurance through Express Scripts Network (does not apply towards out-of-pocket maximum)	You will be reimbursed at the contracted rate minus the 50% coinsurance (does not apply towards out-of-pocket maximum)

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the UHC summary for more information.

2012 Blue Cross Blue Shield (BCBS) Plan Summary

2012 BCBS Plan	Network	Out-of-Network
Deductible	$500 per person/$1.000 per family maximum	$1.000 per person/$2,000 per family maximum
Out-Of-Pocket Limit (Includes deductible and coinsurance; excludes copays, prescription copays and coinsurance)	$3,150 per person/$6,300 per family	$6,300 per person/$12,600 per family
Lifetime Maximum	Unlimited	Unlimited
Office & Facility Visits		
Retail Medical Clinic Visit	You pay $10 copay per visit	You pay 30% coinsurance after the deductible
Primary Care Office Visit (including allergy shots)	You pay $23 copay per visit	You pay 30% coinsurance after the deductible
Specialist Office Visit	You pay $35 copay per visit	You pay 30% coinsurance after the deductible
Maternity Office Visit (prenatal and postnatal)	You pay $35 copay for initial visit	You pay 30% coinsurance after the deductible
Urgent Care Facility Visit	You pay $35 copay per visit	You pay 30% coinsurance after the deductible
Emergency Room	You pay $130 copay per visit; no copay if admitted to a hospital	You pay $130 copay per visit; no copay if admitted to a hospital
Prescription Drugs Administered by Express Scripts (excluding fertility drugs)*		
Retail – up to 30-day supply		If you filled a prescription at an out-of-network pharmacy, you will be reimbursed at the contracted rate minus the applicable coinsurance. If you did not have access to a network pharmacy, the network coinsurance will apply.
- Generic	$7 copay	
- Formulary Brand	20% coinsurance subject to a $32 minimum, $130 maximum	
- Non-Formulary Brand	40% coinsurance: subject to a $32 minimum, $130 maximum	
Mail Order – up to 90-day supply		
- Generic	$14 copay	
- Formulary Brand	20% coinsurance subject to a $64 minimum, $260 maximum	
- Non-Formulary Brand	40% coinsurance: subject to a $64 minimum, $260 maximum	
90-day Supply at Retail program – CVS pharmacies only		
- Generic	$21 copay	
- Formulary Brand	20% coinsurance subject to a $96 minimum, $390 maximum	
- Non-Formulary Brand	40% coinsurance: subject to a $96 minimum, $390 maximum	
Preferred Home Delivery for Maintenance Prescriptions (other than 90-day Supply at Retail through CVS)	You pay an additional 10% coinsurance for maintenance prescriptions filled more than twice at a retail pharmacies	
Generics Preferred Policy (All except Coumadin and Synthroid)	You pay generic copay plus the cost difference between the generic and the brand name when a generic is available but not chosen	
Prescription Out-of-Pocket Maximum (combined network & out-of-network)	$2,350 per member, per calendar year	$2,350 per member, per calendar year
Inpatient Hospital and Physician Services	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Outpatient Hospital and Surgical Services	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Hospital Pre-Notification	Not required	Employee initiatives; coverage reduced by $500 for failure to provide pre-notification

*Specialty medicine sourced by CuraScript mail order pharmacy is subject to the retail prescription plan design. The prescription drug annual out-of-pocket maximum per member includes both retail and mail order drug expenses (excludes infertility medications, which are covered at 50%) and is separate from the BCBS Plan's annual out-of-pocket expenses. Once a member pays $2,350 in prescription drug copays and coinsurance, all retail, specialty medicine and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% of eligible expenses.

2012 Blue Cross Blue Shield (BCBS) Plan Summary

2012 BCBS Plan	Network	Out-of-Network
Diagnostic X-ray/ Lab Work and Therapeutic Services		
Outpatient radiology and x-ray	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Outpatient hospital and independent lab work	You pay 10% coinsurance	You pay 30% coinsurance after the deductible
Hospital lab and x-ray	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
CT and MRI	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Cancer and IV therapeutics	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Preventive Care		
Well Child Visits Routine Physical Exams and Immunizations Mammogram Colonoscopy Routine Vision Care (annual exam) Routine Hearing Care (annual exam)	No copay	No coverage
Outpatient Care		
Chiropractic Care Visits	You pay $23 copay per visit; limited to 20 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 20 visits (network & out-of-network) per calendar year
Physical and Occupational Therapy	You pay $23 copay per visit; limited to 60 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 60 visits (network & out-of-network) per calendar year
Speech Therapy	You pay $23 copay per visit; limited to 60 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 60 visits (network & out-of-network) per calendar year
Mental Health and Substance Abuse		
Inpatient	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible
Outpatient Visits	You pay $23 copay per visit	You pay 30% coinsurance after the deductible
Hospital Pre-Notification	Not required	Employee initiates; coverage reduced by $500 for failure to provide pre-notification
Special Services		
Ambulance	You pay 10% coinsurance after the deductible	You pay 10% coinsurance after the deductible
Home Medical Services	You pay 10% coinsurance after the deductible; limited to 60 visits (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible, limited to 60 visits (network & out-of-network) per calendar year
Skilled Nursing Facility	You pay 10% coinsurance after the deductible; limited to 60 days (network & out-of-network) per calendar year	You pay 30% coinsurance after the deductible; limited to 60 days (network & out-of-network) per calendar year
Hospice Care	You pay 10% coinsurance after the deductible; maximum benefit duration of 6 months	You pay 30% after the deductible; maximum benefit duration of 6 months
Medical Equipment and Supplies	You pay 10% coinsurance after the deductible; limits may apply	You pay 30% coinsurance after the deductible; limits may apply
Transplant	You pay 10% coinsurance after the deductible; coverage based on a limited list of organs/diseases	You pay 30% coinsurance after you meet the deductible; coverage based on a limited list of organs/diseases
Bariatric Surgery	Network Center of Excellence: You pay 10% coinsurance (no deductible) Other Network: You pay 10% coinsurance after the deductible	Not covered
Voluntary Sterilization	You pay 10% coinsurance after the deductible	You pay 30% coinsurance after the deductible

2012 Blue Cross Blue Shield (BCBS) Plan Summary

2012 BCBS Plan	Network	Out-of-Network
Reversal of Voluntary Sterilization	Not covered	Not covered
Dental Services	Copay or deductible/coinsurance for applicable location applies (inpatient hospital, outpatient hospital, or physician office) for treatment due to: a. accidental injury (treatment must occur within 12 months of the injury) b. treatment or removal of a malignant tumor c. surgery to the joint of the jaw	You pay 30% coinsurance after the deductible for treatment due to: a. accidental injury (treatment must occur within 12 months of the injury) b. treatment or removal of a malignant tumor c. surgery to the joint of the jaw
Infertility		
Provider Services	Copay or deductible/coinsurance for applicable location applies (inpatient hospital, outpatient hospital, or physician office). $20,000 lifetime maximum benefits (combined under all Travelers plans)	Not covered
Prescription Drugs	You pay 50% coinsurance through Express Scripts Network (does not apply towards out-of-pocket maximum)	You will be reimbursed at the contracted rate minus the 50% coinsurance (does not apply towards out-of-pocket maximum)

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the BCBS summary for more information.

2012 Out-Of-Area Plan Summary

2012 Out-of-Area Plan	Coverage
Deductible	$400 per person/$800 per family maximum
Out-Of-Pocket Limit (Includes deductible and coinsurance; excludes copays, prescription copays and coinsurance)	$3,150 per person/$6,300 per family
Lifetime Maximum	Unlimited
Office & Facility Visits	
Retail Medical Clinic Visit	You pay 20% coinsurance after the deductible
Primary Care Office Visit (including allergy shots)	You pay 20% coinsurance after the deductible
Specialist Office Visit	You pay 20% coinsurance after the deductible
Maternity Office Visit (prenatal and postnatal)	You pay 20% coinsurance after the deductible
Urgent Care Facility Visit	You pay 20% coinsurance after the deductible
Emergency Room	You pay 20% coinsurance after the deductible
Prescription Drugs Administered by Express Scripts (excluding fertility drugs)*	
Retail – up to 30-day supply	
- Generic	$7 copay
- Formulary Brand	20% coinsurance subject to a $32 minimum, $130 maximum
- Non-Formulary Brand	40% coinsurance: subject to a $32 minimum, $130 maximum
Mail Order – up to 90-day supply	
- Generic	$14 copay
- Formulary Brand	20% coinsurance subject to a $64 minimum, $260 maximum
- Non-Formulary Brand	40% coinsurance: subject to a $64 minimum, $260 maximum
90-day Supply at Retail program – CVS pharmacies only	
- Generic	$21 copay
- Formulary Brand	20% coinsurance subject to a $96 minimum, $390 maximum
- Non-Formulary Brand	40% coinsurance: subject to a $96 minimum, $390 maximum
Out-Of-Network Pharmacy	If you filled a prescription at an out-of-network pharmacy, you will be reimbursed at the contracted rate minus the applicable coinsurance. If you did not have access to a network pharmacy, the network coinsurance will apply.
Preferred Home Delivery for Maintenance Prescriptions (other than 90-day Supply at Retail through CVS)	You pay an additional 10% coinsurance for maintenance prescriptions filled more than twice at retail pharmacies
Generics Preferred Policy (All except Coumadin and Synthroid)	You pay generic copay plus the cost difference between the generic and the brand name when a generic is available but not chosen
Prescription Out-of-Pocket Maximum	$2,350 per member, per calendar year.
Inpatient Hospital and Physician Services	You pay 20% coinsurance after the deductible
Outpatient Hospital and Surgical Services	You pay 20% coinsurance after the deductible
Hospital Pre-Notification	Employee initiates; coverage reduced by $500 for failure to provide pre-notification
Diagnostic X-ray/ Lab Work and Therapeutic Services	
Outpatient radiology and x-ray	You pay 20% coinsurance after the deductible
Outpatient hospital and independent lab work	You pay 20% coinsurance after the deductible
Hospital lab and x-ray	You pay 20% coinsurance after the deductible
CT and MRI	You pay 20% coinsurance after the deductible
Cancer and IV therapeutics	You pay 20% coinsurance after the deductible
Preventive Care	
Well Child Visit Routine Physical Exams and Immunizations Mammogram Colonoscopy Routine Vision Care (annual exam) Routine Hearing Care (annual exam)	No copay

* Specialty medicine sourced by CuraScript mail order pharmacy is subject to the retail prescription plan design. The prescription drug annual out-of-pocket maximum per member includes both retail and mail order drug expenses (excludes infertility medications, which are covered at 50%) and is separate from the Out-of-Area Plan's annual out-of-pocket expenses. Once a member pays $2,350 in prescription drug copays and coinsurance, all retail, specialty medicine and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% of eligible expenses.

2012 Out-Of-Area Plan Summary

2012 Out-of-Area Plan	Coverage
Outpatient Care	
Chiropractic Care Visits	You pay 20% coinsurance after the deductible; limited to 20 visits per calendar year
Physical and Occupational Therapy	You pay 20% coinsurance after the deductible; limited to 60 visits per calendar year
Speech Therapy	You pay 20% coinsurance after the deductible; limited to 60 visits per calendar year
Mental Health and Substance Abuse	
Inpatient	You pay 20% coinsurance after the deductible
Outpatient Visit	You pay 20% coinsurance after the deductible
Hospital Pre-Notification	Employee initiates; coverage reduced by $500 for failure to provide pre-notification
Special Services	
Ambulance	You pay 20% coinsurance after the deductible
Home Medical Services	You pay 20% coinsurance after the deductible, limited to 60 visits per calendar year
Skilled Nursing Facility	You pay 20% coinsurance after the deductible; limited to 60 days per calendar year
Hospice Care	You pay 20% coinsurance after the deductible; maximum benefit duration of 6 months
Medical Equipment and Supplies	You pay 20% coinsurance after the deductible; limits may apply
Bariatric Surgery	You pay 20% coinsurance after the deductible
Transplant	You pay 20% coinsurance after the deductible; coverage based on a limited list of organs/diseases
Voluntary Sterilization	You pay 20% coinsurance after the deductible
Reversal of Voluntary Sterilization	Not covered
Dental Services	You pay 20% coinsurance after the deductible for treatment due to: a. accidental injury (treatment must occur within 12 months of the injury) b. treatment or removal of a malignant tumor c. surgery to the joint of the jaw
Infertility	
Provider Services	You pay 20% coinsurance after the deductible; $20,000 lifetime maximum benefits
Prescription Drugs	You will be reimbursed at the contracted rate minus the 50% coinsurance (does not apply towards out-of-pocket maximum)

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the Out-Of-Area Plan summary for more information.

2012 High Deductible Plan Summary

2012 High Deductible Plan	Coverage
Deductible	$1,200 per person/$2,400 per family maximum
Out-Of-Pocket Limit (Includes deductible and coinsurance; excludes prescription copays and coinsurance)	$4,000 per person/$8,000 per family
Lifetime Maximum	Unlimited
Office & Facility Visits	
Retail Medical Clinic Visit	You pay 20% coinsurance after the deductible
Primary Care Office Visit (including allergy shots)	You pay 20% coinsurance after the deductible
Specialist Office Visit	You pay 20% coinsurance after the deductible
Maternity Office Visit (prenatal and postnatal)	You pay 20% coinsurance after the deductible
Urgent Care Facility Visit	You pay 20% coinsurance after the deductible
Emergency Room	You pay 20% coinsurance after the deductible
Prescription Drugs Administered by Express Scripts (Infertility drugs are not covered under this plan.)*	
Retail – up to 30-day supply	
- Generic	$7 copay
- Formulary Brand	20% coinsurance subject to a $32 minimum, $130 maximum
- Non-Formulary Brand	40% coinsurance: subject to a $32 minimum, $130 maximum
Mail Order – up to 90-day supply	
- Generic	$14 copay
- Formulary Brand	20% coinsurance subject to a $64 minimum, $260 maximum
- Non-Formulary Brand	40% coinsurance: subject to a $64 minimum, $260 maximum
90-day Supply at Retail program – CVS pharmacies only	
- Generic	$21 copay
- Formulary Brand	20% coinsurance subject to a $96 minimum, $390 maximum
- Non-Formulary Brand	40% coinsurance: subject to a $96 minimum, $390 maximum
Out-Of-Network Pharmacy	If you filled a prescription at an out-of-network pharmacy, you will be reimbursed at the contracted rate minus the applicable coinsurance. If you did not have access to a network pharmacy, the network coinsurance will apply.
Preferred Home Delivery for Maintenance Prescriptions (other than CVS 90-day Supply at Retail through CVS)	You pay an additional 10% coinsurance for maintenance prescriptions filled more than twice at retail pharmacies
Generics Preferred Policy (All except Coumadin and Synthroid)	You pay generic copay plus the cost difference between the generic and the brand name when a generic is available but not chosen.
Prescription Out-of-Pocket Maximum	$2,350 per member, per calendar year.
Inpatient Hospital and Physician Services	You pay 20% coinsurance after the deductible
Outpatient Hospital and Surgical Services	You pay 20% coinsurance after the deductible
Hospital Pre-Notification	Employee initiates; coverage reduced by $500 for failure to provide pre-notification
Diagnostic X-ray/ Lab Work and Therapeutic Services	
Outpatient radiology and x-ray	You pay 20% coinsurance after the deductible
Outpatient hospital and independent lab work	You pay 20% coinsurance after the deductible
Hospital lab and x-ray	You pay 20% coinsurance after the deductible
CT and MRI	You pay 20% coinsurance after the deductible
Cancer and IV therapeutics	You pay 20% coinsurance after the deductible

* Specialty medicine sourced by CuraScript mail order pharmacy is subject to the retail prescription plan design. The prescription drug annual out-of-pocket maximum per member includes both retail and mail order drug expenses and is separate from the High Deductible Plan's annual out-of-pocket expenses. Once a member pays $2,350 in prescription drug copays and coinsurance, all retail, specialty medicine and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% of eligible expenses. Note: fertility drugs are not covered under this plan.

2012 High Deductible Plan Summary

2012 High Deductible Plan	Coverage
Preventive Care	
Well Child Visits	No copay or coinsurance
Routine Physical Exams and Immunizations	No copay or coinsurance
Mammogram	No copay or coinsurance
Colonoscopy	No copay or coinsurance
Routine Vision Care (annual exam)	No copay or coinsurance
Routine Hearing Care (annual exam)	No copay or coinsurance
Outpatient Care	
Chiropractic Care Visits	You pay 20% coinsurance after the deductible; limited to 20 visits per calendar year
Physical and Occupational Therapy	You pay 20% coinsurance after the deductible; limited to 60 visits per calendar year
Speech Therapy	You pay 20% coinsurance after the deductible; limited to 60 visits per calendar year
Mental Health and Substance Abuse	
Inpatient	You pay 20% coinsurance after the deductible
Outpatient Visit	You pay 20% coinsurance after the deductible
Hospital Pre-Notification	Employee initiates; coverage reduced by $5000 for failure to provide pre-notification
Special Services	
Ambulance	You pay 20% coinsurance after the deductible
Home Medical Services	You pay 20% coinsurance after the deductible, limited to 60 visits per calendar year
Skilled Nursing Facility	You pay 20% coinsurance after the deductible; limited to 60 days per calendar year
Hospice Care	You pay 20% coinsurance after the deductible; maximum benefit duration of 6 months
Medical Equipment and Supplies	You pay 20% coinsurance after you meet the deductible; limits may apply
Bariatric Surgery	You pay 20% coinsurance after the deductible
Transplant	You pay 20% coinsurance after the deductible; coverage based on a limited list of organs/diseases
Voluntary Sterilization	You pay 20% coinsurance after the deductible
Reversal of Voluntary Sterilization	Not covered
Dental Services	You pay 20% coinsurance after the deductible for treatment due to: a. accidental injury (treatment must occur within 12 months of the injury) b. treatment or removal of a malignant tumor c. surgery to the joint of the jaw
Infertility	
Provider Services	Not covered
Prescription Drugs	Not covered

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the High Deductible Plan summary for more information.

2012 United Healthcare Health Plan 200

2012 Health Plan 200	Network	Out-of-Network
Deductible	$200 per person/$600 per family maximum combined network & out-of-network	$200 per person/$600 per family maximum combined network & out-of-network
Out-Of-Pocket Limit (Includes deductible and coinsurance, excludes prescription copays and coinsurance)	$1,000 per person/$2,000 per family maximum combined network & out-of-network	$1,000 per person/$2,000 per family maximum combined network & out-of-network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance		
Retail Medical Clinic Visit	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Primary Care Office Visit (including allergy shots)	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Specialist Office Visit	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Maternity Office Visits (prenatal and postnatal)	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Urgent Care Facility Visit	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Emergency Room	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Prescription Drugs Administered by Express Scripts (excluding fertility drugs)*		
Retail – up to 30-day supply		If you filled a prescription at an out-of-network pharmacy, you will be reimbursed at the contracted rate minus the applicable coinsurance. If you did not have access to a network pharmacy, the network coinsurance will apply
- Generic	$5 copay	
- Formulary Brand	$25 copay	
- Non-Formulary Brand	50% coinsurance: subject to a $40 minimum, $100 maximum	
Mail Order – up to 90-day supply		
- Generic	$10 copay	
- Formulary Brand	$50 copay	
- Non-Formulary Brand	50% coinsurance: subject to a $80 minimum, $200 maximum	
90-day Supply at Retail program – CVS pharmacies only		
- Generic	$15 copay	
- Formulary Brand	$75 copay	
- Non-Formulary Brand	50% coinsurance: subject to a $120 minimum, $300 maximum	
Preferred Home Delivery for Maintenance Prescriptions (other than CVS 90-day supply)	You pay an additional 10% coinsurance for maintenance prescriptions filled more than twice at a retail store pharmacies	
Generics Preferred Policy (All except Coumadin and Synthroid)	You pay generic copay plus the cost difference between the generic and the brand name when a generic is available but not chosen	
Inpatient Hospital and Physician Services	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Outpatient Hospital and Surgical Services	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Diagnostic X-ray/ Lab Work and Therapeutic Services		
Outpatient radiology and x-ray	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Non-hospital lab work	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Hospital lab and x-ray	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
CT and MRI	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Cancer and IV therapeutics	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible

*Specialty medicine sourced by CuraScript mail order pharmacy is subject to the retail prescription plan design.

2012 United Healthcare Health Plan 200

2012 Health Plan 200	Network	Out-of-Network
Preventive Care		
Well Child Visits Routine Physical Exams and Immunizations Mammogram Colonoscopy Routine Vision Care (annual exam) Routine Hearing Care (annual exam)	No coinsurance	You pay 20% coinsurance, no deductible
Outpatient Care		
Chiropractic Care Visits	You pay 10% coinsurance after the deductible; limited to 20 visits (combined network & out-of-network) per calendar year	You pay 20% coinsurance after the deductible; limited to 20 visits (combined network & out-of-network) per calendar year
Physical and Occupational Therapy	You pay 10% coinsurance after the deductible; limited to 20 visits OT, 30 visits PT (combined network & out-of-network) per calendar year	You pay 20% coinsurance after the deductible; limited to 20 visits OT, 30 visits PT (combined network & out-of-network) per calendar year
Speech Therapy	You pay 10% coinsurance after the deductible; limited to 30 visits (combined network & out-of-network) per calendar year	You pay 20% coinsurance after the deductible; limited to 30 visits (combined network & out-of-network) per calendar year
Mental Health and Substance Abuse		
Inpatient	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Outpatient Visit	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Hospital Pre-Notification	Employee initiates; coverage reduced 10% up to $400 for failure to provide pre-notification	Employee initiates; coverage reduced 10% up to $400 for failure to provide pre-notification
Special Services		
Home Medical Services	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Skilled Nursing Facility	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Hospice Care	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible
Medical Equipment and Supplies	You pay 10% coinsurance after the deductible	You pay 20% coinsurance after the deductible

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the UHC summary booklet for more information.

Other Important Information

Coordination Of Benefits

If you participate in the plan and another group medical plan, you must follow certain "coordination of benefits" rules.

According to coordination of benefit rules, you send your claim to the primary plan first. After the primary plan has paid benefits, you send your claim, along with the primary plan's explanation of benefits, to the secondary plan.

If Travelers' medical plan is secondary, it may pay benefits after the other plan has paid — but only if there are allowable expenses that exceed the primary plan's payment. Payment works as follows:

- Travelers' plan claims administrator determines the amount the Travelers plan would have paid if it were primary.
- If there is a difference between the amount actually paid by the primary plan and the amount that the Travelers plan would have paid as primary plan, Travelers will pay the difference.
- Travelers' plans do not coordinate benefits for outpatient prescription drug claims — that is, Travelers' plans will pay primary on your outpatient prescription drug claims, regardless of whether you have other prescription drug coverage.

For more information on how coordination of benefits works and whether Travelers' medical plan is primary or secondary to your other group coverage, please refer to the UHC summaries or BCBS summary.

Third-Party Liability (Subrogation)

Third-party liability rules apply to situations where some or all of your family medical expenses are covered by workers' compensation or other employee liability laws or no-fault auto insurance, or for injuries occurring under other circumstances that create a legal obligation on behalf of someone else to pay your medical expenses. If this situation arises, the plan has the right to be reimbursed for any medical expenses it pays for you or your family members. See the UHC summaries or the BCBS summary for detailed subrogation rules.

Fraud/ Misrepresentation

If you knowingly and with intent to defraud the plan file a claim that contains any materially false information including eligibility information, conceal information in order to mislead, or commit a fraudulent act, you may be subject to disciplinary action, up to and including termination of employment, and possible criminal and civil penalties. Travelers will consider such acts or omissions as intentional misrepresentation. This may result in a retroactive loss of coverage that is not a rescission.

Information Sharing

Travelers has engaged outside service providers to assist in the administration of its benefit plans. Travelers may need to share certain information about you and your family members with these service providers as appropriate for them to provide their services. Also, in certain circumstances, Travelers may be required to provide information to governmental agencies.

Claims And Appeal Procedures

Seeking Review Of Decisions You Disagree With

If you apply for a benefit and your claim is denied in whole or in part, the plan has a claims review procedure that you must follow in order to seek review of your claim – this procedure is described in the applicable "Benefit Claims And Appeal Procedure" section. Following the claims procedure is very important because it may affect your legal rights under the plan. (See the "Legal Action" section.)

The claims procedure is intended to provide a fair review of whether the terms of the plan have been followed in your case. The claims procedure is not intended as a way to air suggestions or complaints about the benefits offered by Travelers, and such matters will not be considered under the claims procedures.

If you believe the plan terms provide for your eligibility to participate, but you are not offered participation in the plan, or if you are denied participation when you inquire, you should follow the steps set out in the "Request For Eligibility Determination" section. Similarly, the procedures in that section are appropriate if you believe that your participation in the plan should be on different terms than are offered to you.

Inquiry vs. Benefit Claim

An employee or beneficiary may call, send an e-mail or send a letter to the ESU asking a question or seeking assistance. Not all questions or requests for assistance are "claims for benefits" and it can be difficult to tell whether a claim for benefits was intended.

We encourage you to seek information and ask questions. Travelers will not treat a communication as a formal claim unless either:

- You use the plan's claim form; or
- Travelers notifies you in writing that it considers your communication to constitute a claim for benefits.

If you are unclear of the status of your inquiry or claim request, please ask.

Benefit Claims And Appeal Procedure – Other Than For Prescription Drugs

For full details about the benefit claims and appeals procedures for the plan, other than for prescription drug coverage through Express Scripts, you should refer to the UHC summaries or the BCBS summary.

In general, you can obtain claim forms online through *my*HR by clicking on HR Forms on the right-hand navigation bar. If you have questions, please contact the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378. Send the completed form to the address listed on the form according to the instructions given.

For the Choice Plus Plan and BCBS Plan options, no claim forms are necessary if care is received in the network.

The benefit claims and appeals process for medical coverage other than prescription drug coverage through Express Scripts is fully outsourced to the applicable claims administrator, UHC or BCBS. Travelers has no involvement whatsoever with decisions relating to benefit claims and appeals for medical coverage other than prescription drug coverage through Express Scripts.

Benefit Claims And Appeal Procedure – Prescription Drugs

If you fill your prescription at an Express Scripts network pharmacy and show your Express Scripts ID card, or if you use the Express Scripts mail order or CuraScript mail order pharmacies, your claim will be processed in the normal course of the plan's operation. That means that usually you will not need to take any other action to receive the full prescription drug benefit under the plan.

Claim For Benefits

However, there are cases when you will need to request benefits. In the rare event that you need to purchase prescription drugs where no network pharmacy is available, or you forget to use your ID card, you will need to pay the full cost of the prescription at the pharmacy, and then submit a claim form to Express Scripts for reimbursement. The Express Scripts claim form is available on *my*HR or by calling the ESU. If you did not use an Express Scripts network pharmacy, your reimbursement will reflect the contracted rate for out-of-network prescriptions minus the applicable coinsurance. If you did not have access to a network pharmacy, your reimbursement will be based on billed charges less the applicable coinsurance.

You must submit claims within one (1) year of the drug purchase to receive reimbursement. If you submit your claim after the one (1)-year deadline, your claim will be denied.

You file a claim for benefits under the prescription drug plan by filing a claim form when you request to fill a prescription at either the retail, mail-order, or CuraScript pharmacy, or request written reimbursement for a prescription you have had filled.

Initial Review Procedure

In the event your physician prescribes a drug that was not dispensed or was denied prior authorization (PA), you may contact Express Scripts about an appeal. Note: The plan will not consider appeals for lower coinsurance levels on covered drugs.

There are generally two (2) kinds of prescription drug claims under the plan — pre-service claims and post-service claims. Pre-service claims are requests for prescription drugs which require prior authorization (see the "Prescription Drug Coverage" section for more details). A pre-service claim where your attending provider determines that a delay in treatment could seriously jeopardize your life, health, or the ability to regain maximum function, or could cause you severe pain that cannot be adequately managed while you wait for a decision, is considered an urgent care claim. All requests for prescription drugs which do not require prior authorization are considered post-service claims.

If your pre-service claim is denied, Express Scripts will respond to you depending upon the type of claim you have filed. If you have filed an urgent care claim, Express Scripts will respond as soon as possible, taking into account medical circumstances, but no later than 72 hours after your claim is received. If you have filed a pre-service claim, Express Scripts will respond within a reasonable time, but no later than 15 days after the date your claim is received, unless special circumstances beyond Express Scripts' control require a longer period of time for making the decision. If a longer period of time is required, you will be notified within the initial 15-day period. Express Scripts may take one 15-day extension.

If your post-service claim is denied, your prescription will not be covered at the pharmacy. You can fill the prescription by paying for the cost of the medication out of your own funds. Then, you should contact Express Scripts as outlined below. Express Scripts will respond within a reasonable time, but no later than 30 days after the date your claim is received, unless special circumstances beyond Express Scripts' control require a longer period of time for making the decision. If a longer period of time is required, you will be notified within the initial 30-day period. Express Scripts may take one 15-day extension.

If your urgent care claim did not include the information necessary to process your claim, you will be notified as soon as possible, but no later than 24 hours after your claim is received, and given 48 hours to provide the requested information. If your pre-service claim (other than an urgent care claim) or post-service claim did not include the information necessary to process your claim, you will be notified and given at least 45 days to provide the missing information. The timeframe for deciding your claim will be suspended until you provide the missing information. If the missing information is not provided within the time specified, your claim will be decided without that information, which means it will likely be denied.

If your claim is wholly or partially denied, you will be furnished with a written notice of the denial which will cover:

- Specific reasons for the denial;
- Plan provisions on which the denial was based;
- Additional material or information needed to make the request for benefits acceptable and the reason it is necessary;
- A statement disclosing any internal rule, guideline, protocol, or similar criteria relied upon in denying your claim (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment (or a statement that such an explanation is available upon request); and
- The procedure for appealing the denied request for benefits.

Any reference to an "authorized representative" means a person you authorize, in writing, to act on your behalf, which authorization is filed with Express Scripts or the Administrative Committee. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

First-Level Appeal Procedure For Prescription Drug Claims

If all or any portion of your claim is denied and you want to pursue the matter further, you (or your authorized representative) must, within 180 days after you receive the denial, file a written appeal as described below. Your written appeal should describe all of the reasons why you believe the claim denial was in error, and should include all written comments, documents, records and other information that you have relating to your claim and that you want to have considered in support of your appeal. Your appeal will be decided based on all the available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

During the 180-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

Address your appeal to:

Express Scripts, Inc.
Pharmacy Appeals – SST
6625 W. 78th St. - BL0390
Bloomington, MN 55439
877.494.7472

If the advice of a medical expert was obtained in connection with the initial benefit decision, the name of each expert will be provided upon request, regardless of whether the advice was relied on in making the decision on your claim.

A decision on the appeal will be made by MCMC, a third party contracted by Express Scripts to decide appeals, within 72 hours (for an urgent care claim appeal), 15 days (for a pre-service claim appeal) or 30 days (for a post-service claim appeal) of the date your appeal is received. You will receive a written decision including the specific reason(s) and plan references on which the decision is based (for urgent care claim appeals, you will be notified by telephone with written notice to follow). Express Scripts or the third party cannot extend the review period for making a benefit determination on an appeal.

Second-Level Appeal Procedure For Prescription Drug Claims

If MCMC upholds the original decision to deny your claim, and you want to pursue the matter further, you or your authorized representative must appeal MCMC's decision to uphold the denial. You must file your written appeal with the Travelers Administrative Committee no later than 90 days after you receive written notification of the denial of your claim. Your written appeal must describe all the reasons why you believe the claim denial was in error, and should include all written comments, documents, records and other information that you have relating to your claim and that you want to have considered in support of your appeal. Your appeal will be decided based on all of the available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

Travelers makes a form available for your use in preparing and submitting your second-level appeal. Appeals can be most meaningfully reviewed when you understand the plan and clearly express why you believe your claim was incorrectly denied, taking the plan's terms into consideration. The appeal form is essential in this process. Travelers requires you to use the appeal form, which is available on *my*HR or by contacting the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378, when you submit your second-level appeal.

During the 90-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

The Administrative Committee will review your appeal, without deference to the initial adverse decision. If your appeal involves an adverse decision based on medical judgment, your claim will be reviewed by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse decision nor is the subordinate of anyone consulted in connection with the initial adverse decision.

Address your appeal to:

Administrative Committee
The Travelers Companies, Inc.
385 Washington Street, 9275-SB02L
St. Paul, MN 55102

A decision on your second-level appeal will be made within 72 hours (for an urgent care claim appeal),15 days (for a pre-service claim appeal) or 30 days (for a post-service claim appeal) of the date your appeal is received. You will receive a written decision including the specific reason(s) and plan references on which the decision is based (for urgent care claim appeals, you will be notified by telephone with written notice to follow). The Administrative Committee cannot extend the review period for making a benefit determination on an appeal.

External Appeal Procedure For Prescription Drug Claims

If you want to pursue the matter further, you may use an external appeal process or pursue legal action. (See the "Legal Action" section.) Your external written appeal must be filed no later than four (4) months after you receive written notification of the denial of your second-level appeal. Your second-level written notification of the denial will explain the external appeal process and include instructions on how to file a request for external review. If you want to pursue the matter further after external review, you may pursue legal action.

Legal Action

If you have gone through the entire internal claims process, you have the right to file a lawsuit challenging the denial. The claims procedures described above, except the external review, are required by federal law and are designed to ensure that disputes regarding the plan are decided by the appropriate plan fiduciaries. Therefore, courts almost always require that a claimant exhaust a plan's internal claims procedures before filing suit (both filing the initial claim and appealing a denied claim). If you fail to do so, the court will likely dismiss your lawsuit. You are not required to use external review, but have the choice to do so. In a lawsuit, the court generally will review a decision on appeal based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the appropriate plan fiduciaries during the claims process.

You may pursue legal action only after you have completed the internal claims process described above. In addition, if you have completed the internal claims process above and want to bring a lawsuit, you must do so within one (1) year of the final denial of your claim. This time period is tolled during any external appeal process. Failure to file a lawsuit within one (1) year will cause your rights to expire.

Scope Of Discretionary Authority

UHC and BCBS are the plan fiduciaries for benefit claims and appeals other than for prescription drug coverage through Express Scripts. The Administrative Committee is the plan fiduciary for final appeals for the prescription drug coverage Express Scripts provides. The appropriate plan fiduciary has the final and discretionary authority to determine claims and appeals, and has the final and discretionary authority to interpret all terms of the plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the appropriate plan fiduciary on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is very broad and is limited only by the duties imposed under ERISA. The determination is intended to be given deference by courts to the maximum extent allowed under ERISA.

Request For Eligibility Determination

If you believe that you or a family member are eligible to participate in the plan under its terms, or if you believe that your participation should be on different terms than what has been offered to you, you should contact the ESU via *Ask*ESU, 4-ESU@travelers.com or 800-441-4378. Your contact will be treated as an informal inquiry regarding your eligibility. If the ESU informs you that you are not eligible to participate in the plan, and you disagree with this response, you or your authorized representative may file a written eligibility determination request under this procedure at the following address. You must file your eligibility determination request within 30 days of the date the ESU responds to your informal inquiry.

Address your eligibility determination request to:

Travelers Administrative Committee
c/o Employee Services Unit
The Travelers Companies, Inc.
385 Washington Street, 9275-SB02L
St. Paul, MN 55102

Or by e-mail: 4-ESU@travelers.com

Travelers makes a form available for your use in preparing and submitting your eligibility determination request. The form assists you in this process. The form is available on *my*HR or by contacting the ESU.

The Administrative Committee will review your eligibility determination request and will respond to you in writing as soon as administratively practicable.

If your eligibility determination request is denied, the denial will include:

- The specific reasons for the denial; and
- Reference to the pertinent plan provisions upon which the denial is based.

The plan procedures do not allow an appeal of any decision made on eligibility by the Administrative Committee. However, you may file a formal claim for benefits pursuant to the claims review procedure outlined in the applicable "Benefit Claims And Appeal Procedure" section and your eligibility for that benefit will be reviewed at that time.

When Coverage Ends

Your medical coverage ends on the earliest of the following:

- The date the plan terminates or is amended so that you are no longer covered;
- The last day of the month immediately following receipt of your written request to terminate coverage (due to a Qualified Status Change for active employees, or for any reason for retirees);
- The end of the period for which you made the last required contribution (If coverage is terminated for failure to pay premiums, it may be reinstated on the first occurrence of termination if you pay all back premiums due within 30 days of the termination notice. If premiums are not paid by then or if coverage was previously terminated and reinstated due to failure to pay premiums, coverage will not be reinstated. If your coverage is terminated for failure to pay premiums and you are on a leave of absence, you are not eligible to enroll during the annual enrollment period.);
- The last day of the month you enter the armed forces of any country other than the United States or the service of any government agency;
- The last day of the month in which you cease to be actively employed in an eligible position covered under this plan, unless you retire, begin an approved leave of absence or begin a disability leave of absence under the company's disability leave policy (contact the ESU for information on continuing coverage in these situations) or your employment terminates within the first five (5) business days of your initial hire date (or your date of rehire);
- The last day of the current coverage year if you elect to waive coverage during the annual enrollment;
- If you elect to discontinue coverage during a leave of absence, the later of the date your leave begins or the date during your leave as of which you elect to discontinue coverage;
- If, at the conclusion of a leave of absence (including a disability leave of absence), you fail to resume active employment in an eligible position covered under this plan, the last day of the month in which your leave of absence ends; or
- The day your employment terminates if you have elected coverage and your employment terminates (voluntarily or involuntarily) within the first five (5) business days of your initial hire date (or your date of rehire).

Family medical coverage ends on the earliest of the following:

- The end of the month in which your spouse, domestic partner or child no longer qualifies as an eligible family member;
- The last day of the month immediately following receipt of your written request to terminate family member coverage (due to a Qualified Status Change for active employees, or for any reason for retirees);
- The last day of the month for which you made the last required contribution for family member coverage;
- The day your coverage ends (under any circumstances, including under the company's disability leave policy); or
- The date specified in the plan notice when a family member is found not eligible (or for whom you do not provide evidence of eligibility when requested) through the Eligibility Audit process.

When Coverage Ends

Continuing Coverage Under COBRA

A federal law called COBRA gives you, your federal spouse and your children the right to continue medical coverage for a limited time in certain situations. Travelers currently extends the same continuation coverage privilege to your state spouse or domestic partner, but any such continuation would not be required by law and would not be under COBRA. You and your covered family members qualify for this continuing coverage if you experience a covered qualifying event.

The coverage that you and your covered family members may continue is generally the same that you or your covered family members had under Travelers' medical plan before the event. You must pay the entire cost of this coverage, plus a 2% administrative fee. Rates may change each year.

Please see the COBRA summary for more details on continuing your medical coverage.

Role Of Insurer/TPA Provider

ERISA requires Travelers to disclose certain information about the role of each provider in the administration and financing of the Plan. This information is provided in the table below.

Name of Third Party Administrator	Plan Option	Whether Benefits are Guaranteed	Medical Plan Role
United Healthcare	Choice Plus, Out-of-Area, High Deductible, Health Plan 200	United Healthcare does not guarantee payment of any benefits. All Claims are payable by the Employee Benefit Trust.	Claims Administration, Claim Fiduciary
Blue Cross Blue Shield of Minnesota	BCBS Plan	Blue Cross Blue Shield does not guarantee payment of any benefits. All claims are payable by the Employee Benefit Trust.	Claims Administration, Claim Fiduciary
Express Scripts	All options	Express Scripts does not guarantee payment of any benefits. All benefit claims are payable by the Employee Benefit Trust.	Claims Administration, Claim Fiduciary first-level appeal*

*Express Scripts has contracted with MCMC, LLC for first-level claim appeal reviews for Travelers prescription drug plans.

The Travelers Employee Benefit Trust will be credited with any favorable claims experience, or charged for any unfavorable claims experience, during the year. Favorable claims experience will occur when the premiums paid during the year exceed the amount paid out in benefit claims and administrative expenses (including administrative service fees). Likewise, unfavorable claims experience will occur when the amount paid out in claims and administrative fees exceeds the annual premiums.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under ERISA, the Employee Retirement Income Security Act of 1974.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

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

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

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

Continue Group Health Plan Coverage

You may be able to continue coverage if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary and the documents governing the plan for the rule governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

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

Your Rights Under ERISA

Assistance With Your Questions

If you have any questions about your plan, you should contact UHC at 866.679.0947, Blue Cross Blue Shield of Minnesota at 888.279.4242 or Express Scripts at 877.494.7472. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy

Federal law protects the privacy of your health information under Travelers' group health plans and is generally referred to as the HIPAA privacy rules (an acronym for the Health Insurance Portability and Accountability Act). The HIPAA privacy rules restrict Travelers' ability to access or distribute protected health information from the covered plans, except as authorized by you or allowed by law.

Privacy Notice

The HIPAA Notice of Privacy Practices from Travelers' group health plans describes in detail how the HIPAA privacy rules affect you and Travelers. A copy of the Travelers Notice of Privacy Practices is available under the "Forms" section of *my*HR, or upon request from the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378.

Individual Rights

Specifically, the privacy notice describes five (5) individual rights you have:

- The right to request restrictions;
- The right to request confidential communications;
- The right to inspect and copy your protected health information;
- The right to amend your protected health information; and
- The right to receive an accounting of certain disclosures of your protected health information.

For more information about these rights, review the notices under the "Forms" section of *my*HR, or contact the ESU.

General Information

Plan Name

The Travelers Medical Plan is a component program under The Travelers Trusteed Employee Benefit Plan.

Type Of Plan

The plan is a welfare benefit plan.

Plan Sponsor And Administrator

Travelers is the "sponsor" and the "administrator" of the plan for purposes of ERISA. Travelers has contracted with Blue Cross Blue Shield of Minnesota, United Healthcare, and Express Scripts to provide claims administration under the plan. Travelers acts as administrator through its Administrative Committee, which is responsible for the general management and administration of the plan. Day-to-day administrative functions are performed by Blue Cross Blue Shield of Minnesota, United Healthcare, and Express Scripts.

You can obtain additional information about the Administrative Committee by contacting the ESU via *Ask*ESU, 4-ESU@travelers.com or 800.441.4378.

Named Fiduciaries

Blue Cross Blue Shield of Minnesota is a named fiduciary for claims purposes for the BCBS plan option. Its address is:

P.O. Box 64338
St. Paul, MN 55164

United Healthcare is a named fiduciary for claims purposes for all medical plan options administered by UHC. Its address is:

P.O. Box 30990
Salt Lake City, UT 84130

MCMC, LLC is a named fiduciary for first-level claim appeal purposes for all Express Scripts administered prescription drug plans. Its address is:

Express Scripts, Inc.
Pharmacy Appeals – SST
6625 W. 78th St – BL0390
Bloomington, MN 55439

Medium For Providing Benefits

Benefits under the plan are provided through the Travelers Employee Benefit Trust.

General Information

Source Of Contributions

There are both employer and employee contributions to the Employee Benefit Trust.

Plan Year

The plan year is the calendar year.

Plan Number

The Travelers Trusteed Employee Benefit Plan has been assigned the following identification number: 508.

Employer Identification Number

Travelers' federal employer identification number is 41-0518860.

Agent For Service Of Legal Process

Legal process may be served on Travelers at the following address:

Travelers Companies, Inc.
c/o Corporate Secretary
385 Washington Street, 9275-NB16A
St. Paul, MN 55102

TRAVELERS

2012 Employee Benefits Program

Retiree Medical

Summary Plan Description (SPD)

Important Information

About This Booklet

This booklet describes the eligibility requirements and other special rules that apply to the retiree coverage for legacy St. Paul Companies, legacy USF&G, legacy Travelers Property Casualty and Travelers participants. This booklet describes the retiree coverage available under two (2) separate plans: The Travelers Medical Plan, a component program under The Travelers Trusteed Employee Benefit Plan and The Travelers Retiree Medical Plan. The two (2) plans described in this booklet are collectively referred to as the "plan," but the "General Information" section of this booklet identifies which options are available under each plan.

United Healthcare (UHC) administers the Choice Plus, Out-of-Area, High Deductible, Health Plan 200, Comprehensive Plan-Medicare Eligible, Medicare Supplement, POS, Medical 400 and Medical 200 plan options. UHC has prepared summaries describing the benefits covered and excluded under each of these options. These summaries are referred to as the "UHC summaries" throughout this booklet. The UHC summaries also describe the claims procedures for the plan options that UHC administers.

Blue Cross Blue Shield of Minnesota administers the BCBS plan option. Blue Cross Blue Shield of Minnesota has prepared a summary describing the benefits covered and excluded under the BCBS plan option. This summary is referred to as the "BCBS summary" throughout this booklet. The BCBS summary also describes the claims procedures for the plan option that Blue Cross Blue Shield of Minnesota administers.

If you are a retiree enrolled in an option under The Travelers Medical Plan, then this document serves as an addendum to the summary plan description for The Travelers Medical Plan. It should be read in conjunction with the booklet describing active employee coverage under The Travelers Medical Plan and the UHC summaries or the BCBS summary. The booklet describing active employee coverage and the UHC summaries or the BCBS summary describe the benefits, terms and conditions of coverage under The Travelers Medical Plan, and your rights under The Travelers Medical Plan and ERISA.

If you are a retiree enrolled in an option under The Travelers Retiree Medical Plan, then this document is both the summary plan description and the official plan document. It should be read in conjunction with the UHC summaries which describe the benefits, terms and conditions of coverage. This booklet describes your rights under The Travelers Retiree Medical Plan and ERISA.

If you have a question about eligibility, cost or when coverage begins or ends, you should refer to this booklet. If you have a question about covered or excluded benefits, or about the claims process followed by each administrator, you should refer to the UHC summaries or the BCBS summary.

If information in the tables summarizing benefit coverage and exclusions in this booklet conflicts with the information in the UHC summaries or the BCBS summary, the UHC summaries or BCBS summary will govern. Similarly, if eligibility, cost, or coverage beginning and ending dates in the UHC summary or BCBS summary conflict with the information in this booklet, the information in this booklet will govern.

It Describes Current Plan Terms

This booklet describes the plan in effect on and after January 1, 2012.

Important Information

Right To Amend Or Terminate

Travelers does not guarantee that it will maintain retiree/spouse/children coverage for your entire life. The benefits provided by the plan as described in this Retiree Medical booklet and in the materials provided for active employees and/or any component plan are not "vested" benefits. Travelers does not promise the continuation of any benefit nor does it promise any specific level of benefits, or cost for such benefits, at or during retirement.

Travelers has the right to amend or terminate the plan at any time. An amendment may apply to active participants, to persons who are on leave, to retirees or other former employees, or to others who are no longer active participants in the plan. Further, an amendment may apply to all participants or only to some participants.

Travelers provides no guarantee that retiree coverage will continue at all, and no guarantee as to the future terms of that coverage. It is very important that you keep this in mind.

Right To Interpret

Travelers, its Administrative Committee and others have broad discretionary authority to make factual determinations and to interpret the plan. This right is described in the "Claims And Appeal Procedure" section of this summary.

Administrative Committee

The "Administrative Committee" is a person or committee appointed to this position in accordance with the terms of the plan. Currently, the Administrative Committee consists of a single person — the Executive Vice President – Human Resources of Travelers.

Oral Or Other Unofficial Modifications Are Not Permitted

The legal document governing the plan cannot be modified by oral statements made by anyone, or by unofficial communications (such as e-mail or mailings) or any other contracts (such as employment contracts or stock or asset purchase agreements). The plan can only be amended by official amendments. Amendments can only be adopted by authorized persons, such as the Board of Directors, the Chief Executive Officer, or others to whom the Board or the Chief Executive Officer has delegated amendment authority.

Eligibility

You must elect retiree coverage in order to obtain coverage.

Types Of Retiree Coverage

There are two (2) types of retiree medical coverage under the plan — special retiree coverage and access-only coverage.

If you have "special retiree coverage," then you pay a portion of the cost of coverage and Travelers pays the rest. If you have "access-only" coverage, then you pay the full cost of coverage, and Travelers does not contribute to the cost of your coverage.

To Be Considered A "Retiree"

In general, to be considered a "retiree" under this booklet, you must be regularly scheduled to work at least 20 hours per week immediately before your employment with Travelers ends, and your employment with Travelers must end after you satisfy one of the following age and service requirements:

- Age 65;
- Age 62 with at least one (1) year of service (for this plan, "year of service" has the same meaning as "year of vesting service" under the Travelers Pension Plan); or
- Age 55 with at least ten (10) years of service.

Special Rule For Rehired Employees

In general, if you do not satisfy the requirements to be considered a "retiree" as described above when your employment with Travelers ends, you will not be eligible for any retiree medical coverage under the plan. However, if you are subsequently rehired, you may still be considered a "retiree" for the purposes of qualifying as either a "Legacy St. Paul Companies Retiree" or a "Legacy TPC Retiree" (as described below), pursuant to the following rules:

- If you are rehired within 12 months after your initial termination date and you satisfy the age and service requirements to be a "retiree" described above upon the second termination of your employment, you will be eligible for applicable "special retiree coverage" upon your second termination date.
- If you were eligible for medical coverage offered by the Company on December 31, 2004, are rehired more than 12 months after your initial termination date, and satisfy the age and service requirements to be a "retiree" described above upon the second termination of your employment, you will be eligible for "access-only" coverage (but only through age 65), upon your second termination date. Any such access-only coverage shall be governed by the same terms and conditions of the access-only coverage made available to Travelers Retirees (as described in this booklet).

Special Rule For Corporate Divestitures

If your employment with Travelers ends due to a sale or other corporate transaction, and you continue in employment with the purchasing company, you are not eligible for any Travelers retiree coverage when your employment ends with Travelers. You also will not be eligible for any retiree coverage from Travelers when your employment ends with the purchasing company unless Travelers has specially agreed to provide such coverage (which is always subject to Travelers providing retiree coverage to anybody). You will be informed if retiree coverage is available, and whether the coverage is special retiree coverage or access-only coverage.

Legacy St. Paul Companies Retirees

Before December 31, 2004

If you were a legacy St. Paul Companies Retiree receiving retiree medical coverage on December 31, 2004, you currently remain eligible for that coverage. However, Travelers retains the right to eliminate or change your coverage in the future.

Eligibility Requirements For Special Retiree Coverage As A Legacy St. Paul Companies Retiree

To be eligible for special retiree coverage you must be a "retiree" as described above. Additionally, you must satisfy the following requirements:

1. You must have been an employee of legacy St. Paul Companies, Inc. before January 1, 2001;
2. You must have elected the traditional medical plan during Retirement Choice — 2001;
3. As of December 31, 2002, you must have been within five (5) years of satisfying one of the age and service requirements to be considered a "retiree" as describe above; and
4. Prior to or on December 31, 2004, you must have been a participant in The St. Paul Companies, Inc. Employee Benefit Plan.

Legacy USF&G Retirees

To be eligible for retiree coverage as a Legacy USF&G Retiree, you must be a "retiree" as described above. Additionally, you must satisfy the following requirements:

1. You must have retired from USF&G before January 1, 1999; and
2. If you retired from USF&G before January 1, 1992, at the time of your retirement you must have been either:
    a. At least age 65, or
    b. At least age 55 with 20 years of service under the applicable pension plan; or
3. If you retired from USF&G on or after January 1, 1992, at the time of your retirement, you must have been either:
    a. At least age 65, or
    b. At least age 55 with ten (10) years of service under the applicable pension plan.

Legacy TPC Retirees

To be eligible for retiree coverage as a Legacy TPC Retiree, you must be a "retiree" as described above. Additionally, you must satisfy the following requirements:

1. You must have been an employee of Travelers Property Casualty Corp. (or an affiliate thereof) on August 20, 2002;
2. You must have had ten (10) years of service under the applicable pension plan when your employment ended;
3. You must have been a participant in the Travelers Welfare Benefit Plan prior to or on December 31, 2004; and
4. You must be a member of one or more of the following groups:
    a. The Legacy TPC Pre-1993 Retiree group,
    b. The Legacy TPC Transitional Retiree group,
    c. The Legacy TPC Associates Retiree group,
    d. The Legacy TPC Citibank Retiree group, or
    e. The Legacy TPC Pay-All Retiree group.

Eligibility Requirements For Special Retiree Coverage As A Legacy TPC Retiree

To be eligible for special retiree coverage you must be both a "retiree" and a "Legacy TPC Retiree" as described above. Additionally, you must be in a group described below.

Legacy TPC Pre-1993 Retiree Group

To be in the Legacy TPC Pre-1993 Retiree group you must satisfy the following requirements:

- You retired from legacy Travelers Property Casualty Corp. between January 1, 1990 and December 31, 1995;
- You were at least age 55 at the time you first retired; and
- You were later rehired by legacy Travelers Property Casualty as an employee.

Legacy TPC Transitional Retiree Group

To be in the Legacy TPC Transitional Retiree group you must satisfy the following requirements:

- You were an active employee of legacy Travelers Property Casualty Corp. on March 31, 1993; and
- You were at least age 50 with at least five (5) years of service as of December 30, 1993 (with "years of service" being defined in the pension plan applicable to you as of December 30, 1993).

Legacy TPC Associates Retiree Group

To be in the Legacy TPC Associates Retiree group you must satisfy the following requirements:

- You were an active participant in the Associates First Capital Corporation Pension Plan on December 31, 2001; or
- You became eligible to participate in The Citigroup Pension Plan on January 1, 2002; and
- You were

  a) at least age 50 with ten (10) years of service as of December 31, 2001, or

  b) at least age 62 with two (2) years of service as of November 30, 2000, or

  c) at least age 52 with seven (7) years of service as of November 30, 2000; and/or
- You have been informed that you are an Associates Retiree eligible for medical insurance coverage determined by Associates First Capital Corporation as of October 6, 2000.

Legacy TPC Citibank Retiree Group

To be in the Legacy TPC Citibank Retiree group you must satisfy the following requirement:

- You have been informed that you are a Citibank Retiree based on eligibility determined by Citigroup.

Eligibility Requirements For Access-Only Coverage As A Legacy TPC Retiree

To be eligible for access-only coverage you must be both a "retiree" and a "Legacy TPC Retiree" as described above. Additionally, you must be a Legacy TPC Pay-All Retiree as described below.

Legacy TPC Pay-All Retiree Group

To be in the Legacy TPC Pay-All Retiree group you must satisfy the following requirements:

- You must have terminated your employment before January 1, 2005; and
- You must not be described above (as eligible for special retiree coverage).

Travelers Retirees

To be eligible for access-only coverage you must be a "retiree" as described above. Additionally, you must satisfy the following requirements:

1. You were an employee of Travelers on December 31, 2004;
2. You were at least age 45 on December 31, 2004;
3. You were continuously actively employed with Travelers from December 31, 2004 until your retirement;
4. You retired from active employment with Travelers on or after January 1, 2005;

5. You were a participant in either The St. Paul Companies, Inc. Employee Benefit Plan or the Travelers Welfare Benefit Plan before December 31, 2004; and

6. You were less than age 65 when you retired.

Eligibility And Medicare

See the "Coverage And Options" section regarding "Coordination With Medicare."

Family Members

Your family members are also eligible for coverage under the plan if you meet the eligibility criteria above, and you elect coverage for your family members under the plan. Eligible family members include:

- Your spouse. For this purpose, your "spouse" means either your federal spouse or state spouse as recognized by law. Your spouse does not include your former spouse from whom you are divorced or legally separated, even if your divorce decree or legal separation agreement requires you to provide medical coverage for your former spouse. Under the Defense of Marriage Act (DOMA), the federal government defines a legal union as between one man and one woman (a federal spouse), but some states define marriage more broadly (a state spouse). For most purposes, Travelers has defined spouse broadly enough to include both a federal spouse and a state spouse.

  - Your federal spouse means a person of the opposite sex to whom you are legally married under federal law (including a common-law spouse in a state that recognizes common-law marriage) and from whom you are not legally separated.

  - Your state spouse. For this purpose, your "state spouse" means:

    - A person of the same sex (as his or her sex is recognized by the applicable state) to whom you are legally married under the laws of the state where the marriage is performed and from whom you are not legally separated; or

    - A person of the same sex (as his or her sex is recognized by the applicable state) to whom you are joined in a civil union under the laws of the state where the union was performed.

    The laws of the state in effect at the time of the marriage or civil union are considered, even if those laws are changed to no longer recognize certain marriages or civil unions.

- Your domestic partner.* For this purpose, a person is your "domestic partner" if:

  - You and this person have a long-term, intimate, committed relationship with each other, which is demonstrated to be one of mutual caring, affection, and responsibility for each other's common welfare;

  - You and this person hold yourselves out as in a relationship similar to marriage;

  - You and this person intend to continue your relationship with each other indefinitely;

  - You and this person meet the following marital status requirements:

    - If you and this person are of the opposite sex, both you and this person are unmarried to each other or anyone else; or

    - If you and this person are of the same sex, both you and this person are unmarried to anyone else;
  - You and this person are each other's sole domestic partner;
  - Both you and this person are at least 18 years of age;
  - Both you and this person are capable to enter into a contract;
  - You and this person are not related by blood closer than permitted by marriage law in your state of residence;
  - You and this person share a principal residence and have lived together for at least six (6) consecutive months (and this six (6)-month period immediately precedes the date you complete the Domestic Partner Affidavit and Agreement);
  - You and this person are jointly responsible to each other for basic living expenses; and
  - The following timing requirements are met (as applicable):
    - At least six (6) months has elapsed since (i) the later of your divorce or this person's divorce from a previous spouse or (ii) the later of the death of your previous spouse or this person's previous spouse; and
    - At least six (6) months has elapsed since the date you notified Travelers that your previous domestic partnership ended (or the date your previous domestic partner was removed from your active coverage under this plan, if later).

  * In order for an individual to be considered your domestic partner for this purpose, you and your domestic partner must complete the required Domestic Partner Affidavit and Agreement.

- A "child" of you or your spouse or domestic partner.
  - A "child" for this purpose includes your natural child, adopted child, stepchild, or child for whom you are the legal guardian (sponsored dependent), child of your state spouse or domestic partner, and a child named in a Qualified Medical Child Support Order who has not reached age 26, or a disabled dependent.

Family members listed above will not be eligible unless you timely affirm their eligibility and/or complete any eligibility audit as required under the rules of the plan. See the "Affirmation" and "Eligibility Audit" sections of this summary.

You may be asked to show documentation to support legal custody or legal guardianship for adopted, foster or stepchild(ren).

If you and your spouse or domestic partner are both retirees of Travelers, you may be covered as a retiree or as a family member, but not as both. In addition, only one (1) of you may cover your eligible children as family members.

To enroll your domestic partner in the plan, contact the ESU at 4-ESU@travelers.com or 800.441.4378 for a Domestic Partner Affidavit and Agreement.

Disabled Dependents

If your dependent child is incapable of self-sustaining employment due to a chronic debilitating mental or physical condition, his or her coverage and dependent status may continue beyond the age limit of 26. To be eligible, your child must meet ALL of the following requirements:

- The child has a chronic debilitating mental or physical condition.
- The mental or physical disability was incurred before age 26.
- The child is unmarried.
- The child resides with you on a full-time basis (or, if they do not reside with you, is confined in a medical treatment facility or group home as a result of their condition).
- The child receives more than half of his or her support during the year from you.
- The child is incapable of self-sustaining employment.

Coverage continues for as long as your child meets the above requirements unless coverage is terminated as described in the section entitled “When Coverage Ends” found later in this booklet.

Upon reaching the age limit, you must provide proof that your disabled child meets all of the above requirements.

In addition, documentation of your child’s disabled status must be provided upon request. This information will be reviewed by The Physician’s Network (TPN) to validate your child’s eligibility. Periodically thereafter, you will be asked to submit updated documentation to support continued eligibility. The time period for such submission may vary depending on the nature of the disability. If you fail to timely submit a new statement of eligibility upon request, your dependent’s coverage will be terminated as of the date described in the plan’s request for the new statement of eligibility. If you later provide evidence supporting disabled status, coverage will be provided prospectively from the date the new evidence is received and approved by the plan. If there is a gap in coverage, you may elect COBRA continuation coverage for your dependent for the gap period. If you fail to submit evidence supporting disabled status, your dependent will not be eligible for any COBRA continuation coverage under the plan, unless your child is no longer disabled and you have notified ESU within 60 days of the loss of your dependent’s eligibility. See the COBRA summary for more information.

Surviving Family Members After Your Death

If you are a retiree who has retiree medical coverage in place, or if you are an active employee who is eligible to retire with retiree medical coverage, your surviving spouse or domestic partner can elect coverage for himself/herself and eligible family members following your death. Eligible family members include your surviving spouse’s or domestic partner’s natural, adopted, foster, or stepchildren who meet the requirements to be a child outlined above.

If you were receiving or eligible for special retiree coverage, your surviving spouse or domestic partner and eligible family members similarly will be eligible for special retiree coverage.

If you were receiving or eligible for access-only coverage, your surviving spouse or domestic partner and eligible family members will be eligible for access-only coverage until you would no longer have been eligible for coverage.

If you do not have a surviving spouse or domestic partner, eligible family members lose eligibility upon your death.

Eligibility

Affirmation

Whenever you seek to cover (or to continue to cover) an eligible family member under the plan, you will be asked to affirm that each family member meets the eligibility requirements as described in this summary.

If you fail to timely affirm your family member's eligibility during annual benefits communication, the consequence depends on whether the affected family member was previously covered. If your family member was not previously covered, that individual will not receive coverage, and Travelers will adjust your coverage level appropriately. For example, if you elect Family coverage, but you do not affirm that your children are eligible children, Travelers will adjust your election to Single coverage. If your family member was previously covered, your family member will lose his or her coverage under the plan. The loss of coverage will generally be effective as of the date specified in the plan's notice to you during the eligibility affirmation process.

If you later respond to the eligibility affirmation request and want to affirm your family member's eligibility, you will need to timely complete the eligibility audit process described below before your family members may be covered.

If you fail to timely affirm your family member's eligibility when you seek to cover your family member during the year as a result of a special enrollment event, then your family member will not receive coverage and you will not be able to add your family member to the plan, unless you have another special enrollment event and adding your family member is consistent with that special enrollment event. See the "Special Enrollment Events" section for more information.

Eligibility Audit

Retirees who fail to timely affirm their family member's eligibility upon request by the plan (other than requests related to mid-year additions of family members, which are subject to the Qualified Status Change timing rules) will be referred to the eligibility audit.

In addition to these referrals from the eligibility affirmation process, Travelers conducts random audits of retirees and their covered family members on a quarterly basis. If you are selected for, or referred to, the eligibility audit, you will be asked to certify each family member's eligibility under the plan and to provide certain other supporting information as requested.

If you do not respond to the eligibility audit, or if you are not able to prove your family member's eligibility, your family member(s) will lose their coverage under the plan. The loss of coverage will generally be effective as of the date specified in the plan's notices regarding the eligibility. Travelers will consider a failure to respond to the eligibility audit as an intentional misrepresentation. This may result in a retroactive loss of coverage for the family member that is not a rescission. If you fail to complete the eligibility audit, your family member will not be eligible for any continuation coverage under the plan.

If you later provide evidence that demonstrates your family member's eligibility, coverage will be provided prospectively from the date the eligibility audit is completed. If there is a gap in coverage with respect to family members previously covered under the plan, you may elect COBRA continuation coverage for that period.

Travelers also retains the right to separately investigate cases brought to Travelers' attention that may involve participants who may not satisfy the plan's eligibility requirements.

Other Consequences

Providing incorrect information during the enrollment, affirmation, eligibility audit, or separate investigation processes or failing to respond to the affirmation, audit, or separate investigation could result in termination of your family member's eligibility, disciplinary action, your liability for benefits incorrectly paid, and civil or criminal prosecution. If your family member's coverage is cancelled, premiums for the retroactive period of cancelled coverage (if any) will not be refunded.

When Coverage Begins

Retiree Coverage

In order to receive retiree medical coverage, you must affirmatively elect retiree coverage within 60 days of the date your employment with Travelers ends (regardless of whether you were enrolled in active employee coverage). If you elect coverage, your retiree medical coverage begins on the latest of the following days:

- The day you retire if you either:
  - Had coverage as an active employee at retirement; or
  - Did not have active employee coverage at your retirement but you applied for retiree coverage within 60 days of your retirement.
- The day of any special enrollment event if your election is received within 60 days of the event. (Refer to the section titled “Special Enrollment Events.”)

Family Member Coverage

If you enroll for family coverage, your eligible family members will become covered when you do or the date provided in the “Special Enrollment Events” section.

Surviving Family Member Coverage

If you die while an active employee and are eligible for retiree medical coverage, coverage for your surviving spouse or domestic partner and eligible family members begins on the latest of the following days:

- The day you die, if your surviving spouse or domestic partner applies for coverage within 60 days of your death; or
- The first of the month following any special enrollment event, if your surviving spouse’s or domestic partner’s election is received within 60 days of the event. (Refer to the section titled “Special Enrollment Events.”)

Medical Plan Options

The following are your medical plan options for medical coverage (described either in the active employee summary or this summary). However, prescription coverage is described in the "Prescription Drug Coverage" section of this document, without regard to any prescription description in the active employee summary.

Legacy St. Paul Companies Retirees

Legacy St. Paul Retirees have the following medical plan options:

- If you and your eligible family member(s) are all under age 65 and not Medicare eligible, coverage will be under:
  - the Choice Plus Plan, if it is available in your area;
  - the BCBS Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the Choice Plus and BCBS Plans are not available in your area.
- If you and your eligible family member(s) are all age 65 or over or otherwise eligible for Medicare, your coverage will be under either:
  - the Comprehensive Plan — Medicare Eligible (which includes prescription drug coverage);
  - the Comprehensive Plan — Medicare—Eligible — Medical Only (which excludes prescription drug coverage).
- If you are age 65 or over or otherwise eligible for Medicare, but your eligible family member(s) are under age 65 and not Medicare eligible, your coverage will be under the Comprehensive Plan — Medicare Eligible (which includes prescription drug coverage). Coverage for your family member(s), until he or she is age 65 or Medicare eligible, will be under:
  - the Choice Plus Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the Choice Plus Plan is not available in your area;
- If you are under age 65 and not Medicare eligible, but your eligible family members are age 65 or over or otherwise eligible for Medicare, your eligible family members coverage will be under the Comprehensive Plan — Medicare Eligible (which includes prescription drug coverage). Coverage for you, until you are age 65 or Medicare eligible, will be under:
  - the Choice Plus Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the Choice Plus Plan is not available in your area.

Legacy USF&G Retirees

Legacy USF&G Retirees have the following medical plan options:

- If you and your eligible family member(s) are all under age 65 and not Medicare eligible, coverage will be under:
  - the Choice Plus Plan, if it is available in your area;
  - the BCBS Plan, if it is available in your area; or

- the Out-of-Area Plan, if the Choice Plus and BCBS Plans are not available in your area.

- If you and your eligible family member(s) are all age 65 or over or otherwise eligible for Medicare, your coverage will be under either:
  - the Medicare Supplement Plan (which includes prescription drug coverage); or
  - the Medicare Supplement Plan – Medical Only (which excludes prescription drug coverage).
- If you are age 65 or over or otherwise eligible for Medicare, but your eligible family member(s) are under age 65 and not Medicare eligible, your coverage will be under the Medicare Supplement Plan (which includes prescription drug coverage). Coverage for your family member(s), until he or she is age 65 or Medicare eligible, will be under:
  - the Choice Plus Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the Choice Plus Plan is not available in your area.
- If you are under age 65 and not Medicare eligible, but your eligible family members are age 65 or over or otherwise eligible for Medicare, your eligible family member's coverage will be under the Medicare Supplement Plan (which includes prescription drug coverage). Coverage for you, until you are age 65 or Medicare eligible, will be under:
  - the Choice Plus Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the Choice Plus Plan is not available in your area.

Legacy TPC Retirees

Legacy TPC Pre-1993, Transitional, Associates, and Citibank Retiree groups have the following medical plan options:

- If you and your eligible family member(s) are all under age 65 and not Medicare eligible, coverage will be under:
  - the POS Plan, if it is available in your area;
  - the BCBS Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the POS and BCBS Plans are not available in your area; or
  - the High Deductible Plan.
- If you and your eligible family member(s) are all age 65 or over or otherwise eligible for Medicare, coverage will be under either:
  - the Medical 200 Plan (which includes prescription drug coverage); or
  - the Medical 200 Plan — Medical Only (which excludes prescription drug coverage).
- If you are age 65 or over or otherwise eligible for Medicare, but your eligible family member(s) are under age 65 and not Medicare eligible, your coverage will be under the Medical 200 Plan (which includes prescription drug coverage). Coverage for your family member(s), until he or she is age 65 or Medicare eligible, will be under:
  - the POS Plan, if it is available in your area;

- the Out-of-Area Plan, if the POS Plan is not available in your area; or
- the High Deductible Plan.

- If you are under age 65 and not Medicare eligible, but your eligible family members are age 65 or over or otherwise eligible for Medicare, coverage for your family member(s) will be under the Medical 200 Plan (which includes prescription drug coverage). Coverage for you, until you are age 65 or Medicare eligible, will be under:
  - the POS Plan, if it is available in your area;
  - the Out-of-Area Plan, if the POS Plan is not available in your area; or
  - the High Deductible Plan.

Legacy TPC Pay-All Retiree Group

Legacy TPC Pay-All retirees have the following medical plan options:

- If you and your eligible family member(s) are all under age 65 and not Medicare eligible, coverage will be under:
  - the Choice Plus Plan, if it is available in your area;
  - the BCBS Plan, if it is available in your area; or
  - the Out-of-Area Plan, if the Choice Plus and BCBS Plans are not available in your area; or
  - the High Deductible Plan.
- If you and your eligible family member(s) are all age 65 or over or otherwise eligible for Medicare, coverage will be under either:
  - the Medical 400 (which includes prescription drug coverage); or
  - the Medical 400 – Medical Only Plan (which excludes prescription drug coverage).
- If you are age 65 or over or otherwise eligible for Medicare, but your eligible family member(s) are under age 65 and not Medicare eligible, your coverage will be under the Medical 400 Plan (which includes prescription drug coverage). Coverage for your family member(s), until he or she is age 65 or Medicare eligible, will be under:
  - the Choice Plus Plan, if it is available in your area;
  - the Out-of-Area Plan, if the Choice Plus Plan is not available in your area; or
  - the High Deductible Plan.
- If you are under age 65 and not Medicare eligible, but your eligible family member(s) are age 65 or over or otherwise eligible for Medicare, coverage for your family member(s) will be under the Medical 400 Plan (which includes prescription drug coverage). Coverage for you, until you are age 65 or Medicare eligible, will be under:
  - the Choice Plus Plan, if it is available in your area;
  - the Out-of-Area Plan, if the Choice Plus Plan is not available in your area; or
  - the High Deductible Plan.

Travelers Retirees

Travelers Retirees have the following medical plan options:

- If you and your eligible family member(s) are all under age 65 and not Medicare eligible, coverage will be under:
  - the Choice Plus Plan, if it is available in your area;
  - the BCBS Plan, if it is available in your area;
  - the Out-of-Area Plan, if the Choice Plus and BCBS Plans are not available in your area; or
  - the High Deductible Plan.
- Coverage ends for you when you reach age 65 or become Medicare eligible.
- Coverage for your eligible family member(s) ends upon the earlier of:
  - You reach age 65 or become Medicare eligible; or
  - Your eligible family member reaches age 65 or becomes Medicare eligible.

Notes About Options

The plan option that applies to your surviving spouse or domestic partner after your death will be determined as above based upon his or her age and residence.

The same plan option that applies to you or your surviving spouse or domestic partner also applies to eligible family members if family coverage is elected unless different ages result in different plans as discussed above.

Refer to the UHC summaries or the BCBS summary for a description of the benefits, terms and conditions of the plans.

Automatic Changes To Your Medical Plan Option

If you or your surviving spouse or domestic partner are covered under the Choice Plus, BCBS or POS Plan and move out of the service area of all of these plans, coverage will automatically switch to the Out-of-Area Plan. Similarly, if you or your surviving spouse or domestic partner are covered under the Out-of-Area Plan and move into the Choice Plus, BCBS and/or POS Plan service area, coverage will automatically switch to the Choice Plus, BCBS or POS Plan as applicable.

If you have special retiree coverage, or are a Legacy TPC Pay-All retiree, coverage will automatically switch to the applicable post-65 plan on the first day of the month in which you or your spouse or domestic partner turn age 65.

Changes To Your Medical Plan Option Requiring Action

If you have special retiree coverage or are a Legacy TPC Pay-All retiree and become Medicare eligible prior to age 65, you must notify the ESU within 60 days of Medicare eligibility in order to add or make changes to your coverage.

Coverage And Options

Coverage Levels

You can choose the following coverage levels if you have:

1. Special Retiree Coverage (Legacy St. Paul Companies and Legacy USF&G except for those mentioned in #2 below)
    - Single (coverage for you only); or
    - Family (coverage for you and one or more eligible family members).
2. Special Retiree Coverage (Legacy USF&G, under age 65 and retired after 8/1/1993)
    - Single (coverage for you only); or
    - Single + Spouse or Domestic Partner; or
    - Single + Child(ren); or
    - Family (coverage for you, your spouse or domestic partner and your eligible children).
3. Special Retiree and Access-Only Coverage (Legacy TPC) and Access-Only Coverage (Travelers Retiree Coverage)
    - Single (coverage for you only);
    - Single + One (coverage for you and one eligible family member).
    - Family (coverage for you and more than one eligible family member).

Changing Your Coverage Level

After your coverage level is set at retirement, you can:

- Change from Single to Single + One or Family coverage (or change from Single + One to Family coverage) only if you experience a special enrollment event (Refer to the section titled “Special Enrollment Events”); or
- Change from Family or Single + One coverage to Single coverage at anytime upon written notice to the ESU. However, if you do so, you will only be allowed to change back to Single + One coverage or Family coverage if you experience a special enrollment event.

The same options and limitation apply to your surviving spouse or domestic partner if he or she receives coverage after your death.

Waiver Of Coverage

You or your surviving spouse or domestic partner can waive retiree coverage at any time. If you waive coverage, the waiver will also apply to all eligible family members, and you or your surviving spouse or domestic partner cannot again elect coverage unless you experience a special enrollment event. (Refer to the section titled “Special Enrollment Events.”)

Coordination With Medicare

If you are eligible for plan coverage that coordinates with Medicare, this section applies to you.

Medicare Part A And Part B

If you are a retiree, or the spouse or domestic partner of a retiree, who is eligible for Medicare, you may choose to either:

- waive coverage under this plan and rely on Medicare coverage instead; or,
- choose to continue coverage under the:
  - Comprehensive Plan — Medicare Eligible option if you are a Legacy St. Paul Companies Retiree;
  - Medicare Supplement Plan if you are a Legacy USF&G Retiree;
  - Medical 200 Plan if you are a Legacy TPC Retiree in the Pre-1993, Transitional, Associates or Citibank Retiree group; or
  - Medical 400 Plan if you are a Legacy TPC Retiree in the Pay-All Retiree group.

If you continue coverage under this plan, Medicare is primary and this plan is secondary, even if you do not participate in Medicare. You must first submit your claims to Medicare. Benefits from this plan are reduced by Medicare benefits, as follows:

- Medicare Part A and Part B benefits are subtracted from the total covered medical plan expenses; then
- The remaining amount is subject to the provisions of your medical plan option, including deductibles, copays and coinsurance.

If you are eligible but do not participate in Medicare Part B, the plan will estimate what Part B would have paid in subtracting from total covered medical plan expenses. Special rules may apply if you or your spouse are entitled to Medicare on the basis of disability.

If Medicare excludes (i.e., does not pay for) “never events,” the plan also will not pay for such events. “Never events” are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Examples of “never events” include surgery on the wrong body part, major medication errors and preventable post-operative deaths.

For more information, refer to the UHC summaries or the BCBS summary.

Medicare Part D

Travelers has chosen to continue to provide Medicare Part D eligible retiree plan participants with prescription drug benefits through Express Scripts. Medicare-eligible participants and their family members cannot be enrolled in a Medicare Part D plan option and remain eligible for the option which includes prescription drug benefits from Travelers. Medicare-eligible participants who actively enroll or are defaulted to a Medicare Part D plan option will be moved to the Medical Only option effective the end of the month in which their Medicare Part D plan option becomes effective.

Medical Only Options:

- Comprehensive Plan — Medicare Eligible—Medical Only if you are a Legacy St. Paul Companies Retiree;

- Medicare Supplement — Medical Only if you are a Legacy USF&G Retiree; or
- Medical 200/400 — Medical Only if you are a Legacy TPC Retiree.

Keep this in mind when making your Medicare Part D coverage election.

Special Enrollment Events For Retirees

There are two (2) circumstances where you can enroll for retiree coverage if you were eligible for coverage but previously waived it:

- When you become Medicare eligible (e.g., reach age 65) — assuming you were eligible for special retiree coverage or Legacy TPC Pay-All Retiree coverage at the time you retired from Travelers; or
- If you lose other coverage under qualifying circumstances (see below).

If you wish to enroll as a result of one of these special enrollment events, you must do so within 60 days of the event by filing a written election with the ESU. If you enroll in the specified timeframe, your coverage will be effective on the first day of the month following your loss of coverage.

Loss Of Coverage — Qualifying Circumstances That Permit Enrollment

If you are eligible for retiree coverage but have previously waived it, you can elect coverage under this plan if:

- You were covered under another group health plan (for example, a plan of another employer of yours, or your spouse's employer) throughout the period that your waiver under this plan was in effect, and
- The other coverage was terminated due to a loss of eligibility or the termination of employer contributions for such coverage.

  Loss of eligibility for coverage includes a loss of coverage as a result of:

  - Divorce or annulment;
  - Legal separation;
  - Termination of Domestic Partnership;
  - Death of your spouse or domestic partner;
  - Termination of your employment or your spouse's or domestic partner's employment, or reduction in hours below the medical plan eligibility threshold; or
  - Termination of the other plan.

  Loss of eligibility for coverage does not include a loss of coverage due to the failure to pay premiums or due to a voluntary termination of coverage.

If you or your family members have elected continuation coverage under COBRA under the other plan, you may also enroll in this plan when COBRA coverage has been exhausted.

When you enroll in this plan, you must provide evidence that you had other group health plan coverage in effect during your waiver period and that you have lost that coverage under qualifying circumstances.

Special Enrollment Events

Coverage For New Family Members

If you gain an eligible family member and you are covered under the plan, you will be able to enroll the new family member in the plan if you gain the eligible family member through:

- Marriage;
- Civil Union;
- Filing a Domestic Partner Affidavit and Agreement with Travelers in a form acceptable to Travelers;
- Birth, adoption or placement for adoption; or
- Issuance of a qualified medical child support order (QMCSO).

If you are covered under the plan but your spouse or domestic partner is not, if you gain an eligible family member through birth, adoption or placement for adoption, you can add coverage for your spouse or domestic partner as well as the child.

If there is birth, adoption or placement for adoption, any new, eligible family members will be covered from the date of such event, if your election is received by ESU within 60 days of the event.

If there is a marriage, civil union or Domestic Partner Affidavit and Agreement filed with Travelers in a form acceptable to Travelers, any new, eligible family members will be covered as of the first month following receipt of your timely election. Your request to add coverage must be received in the ESU within 60 days of the event.

If you have waived retiree coverage, your marriage, civil union or filing a Domestic Partner Affidavit and Agreement or the birth, adoption or placement for adoption of a child will NOT entitle you or your family members to elect coverage.

Special Enrollment Events For Surviving Family Members

If a surviving spouse or domestic partner is eligible for retiree coverage but waives it, he or she can enroll for retiree coverage later if he or she loses other coverage under qualifying circumstances. The same rules apply to your surviving spouse or domestic partner as apply to you. (See “Loss of Coverage — Qualifying Circumstances That Permit Enrollment” and “Coverage For New Family Members”.) If your surviving spouse remarries following your death, his or her new spouse and any new family members are not eligible for coverage under the plan.

ESU must receive the written enrollment election within 60 days of a special enrollment event. “Received” means physically received by the ESU with a postmark, date stamp, or other reliable evidence dated within the 60 day timeframe. If the ESU does not receive your change form(s) within the required timeframe, you will need to prove that you sent it to the ESU within the required timeframe in order for the change to be honored (e.g., by producing a dated fax receipt or certified mail receipt).

Special Retiree Coverage

You will be responsible for a portion of the cost of special retiree coverage and Travelers will pay the rest.

Legacy St. Paul Companies Retirees

If you are a Legacy St. Paul Companies Retiree, currently your share of the projected premium cost of your retiree medical coverage is based on your total age/service points at the time of your retirement:

Age at retirement + Years of service* = Age/service points

The following chart shows the percentage of the projected premium costs that you pay, based on age/service points earned as of your retirement date.

Age/Service Points	Retiree Contribution
80+	20%
75-79	40%
70-74	60%
69 or less	80%

The same percentages apply to a surviving spouse or domestic partner who receives regular retiree coverage after your death.

* "Years of service" under this plan means years of vesting service under the Travelers Pension Plan. Refer to the summary for that plan for further information on how years of vesting service are determined. Age/Service Points = age at retirement + years of service

Legacy USF&G Retirees

If you are a Legacy USF&G Retiree, currently your share of the projected premium cost of your retiree medical coverage is based on your retirement date.

Retirement Date Before August 1, 1993

If you retired before August 1, 1993, while under age 65, you pay 34.5% of projected premium costs. Once you are age 65 or over, you pay 30%.

Retirement Date On Or After August 1, 1993

If you retired on or after August 1, 1993, while under age 65, currently your share of the projected premium cost of your retiree medical coverage is based on your total age/service points:

Age at retirement + Years of service** = Age/service points

Cost

The following chart shows the percentage of the projected premium costs that you pay while under age 65, based on age/service points earned.

Age/Service Points	Retiree Contribution
80+	20%
75-79	40%
70-74	60%
69 or less	80%

** "Years of service" under this plan means years of vesting service under The Retirement Plan for U.S.A. Employees of USF&G. Refer to the summary for the pension plan for further information on how years of vesting service are determined. Age/Service Points = age at retirement + years of service

The following chart shows the percentage of the projected premium costs that you pay at age 65 and over, based on service earned.

Service Points	Retiree Contribution
20+	35%
19	37%
18	38%
17	40%
16	42%
15	43%
14	45%
13	46%
12	48%
11	50%
10	51%

The same percentages apply to a surviving spouse or domestic partner who receives special retiree coverage after your death.

Legacy TPC Retirees

If you are a legacy TPC Retiree, your share of the projected premium cost of your retiree medical coverage depends on which Travelers group you belong to:

Legacy TPC Pre-1993 Retiree Group

If you (or your surviving spouse) are in the Legacy TPC Pre-1993 Retiree group and:

- You are under age 65, you pay approximately 15-22% of the projected premium cost; or
- You are age 65 or over, Travelers pays the first $2,000 of the projected premium cost for you and your eligible family member(s). Then you will pay the remaining cost, up to 10% of your annual pension benefit, including non-qualified benefits. If there is cost remaining, Travelers will pay the difference.

Legacy TPC Transitional Retiree Group

If you (or your surviving spouse) are in the Legacy TPC Transitional Retiree group and:

- You are under age 65, if you have 30 or more years of service, Travelers will pay 50% of the projected premium cost for you and your eligible family member(s), up to a maximum total cost of $11,200. You pay the difference in the projected premium cost. If you have less than 30 years of service at the time of your retirement, Travelers will pay 50% of the cost reduced by 1½% for each year of service less than 30. For example, if you have 20 years of service, Travelers will pay the first 35% of the projected premium cost (1.5% x 10 = 15%, 50% - 15% = 35%); or

- You are age 65 or over, regardless of years of service, Travelers will pay the first 50% of the projected premium cost for you and your eligible family member(s), up to a maximum per person of $2,400. You pay the difference in the projected premium cost.

Legacy TPC Associates Retiree Group

If you (or your surviving spouse) are in the Legacy TPC Associates Retiree group and:

- You are under age 65, you will pay 10% of the projected premium cost; or

- You are age 65 or over, you will pay 30% of the cost of Single coverage or 20% of the cost of Family coverage.

Legacy TPC Citibank Retiree Group

If you (or your surviving spouse) are in the Legacy TPC Citibank Retiree group, your contribution is based on you and your eligible family member(s)' Medicare eligibility, your age and your years of service under the Citibank Pension Plan.

Access-Only Coverage

You will be responsible for the full cost of coverage and Travelers does not contribute to the cost of your coverage.

Legacy TPC Pay-All Retiree Group

If you are a Legacy TPC Retiree in the Pay-All Retiree group, you pay the full projected premium cost of access-only coverage. Similarly, your spouse or domestic partner would pay the full cost of access-only coverage if your spouse or domestic partner has coverage after your death.

Travelers Retirees

If you are a Travelers Retiree, you pay the full projected premium cost of access-only coverage. Similarly, your spouse or domestic partner would pay the full cost of access-only coverage if your spouse or domestic partner has coverage after your death.

Cost

How Cost Is Determined

The cost of the plan is determined by Travelers. The plan is self-funded, meaning that premiums are not paid to any insurance carrier.

The costs of the active employee portion of the plan and the retiree portion of the plan are determined separately based upon the experience within each group.

Projected premium costs are fixed monthly premiums and are not pro-rated for periods of coverage of less than one (1) month.

Right To Modify/Terminate Coverage And Cost Sharing Arrangements

Travelers does not guarantee that it will maintain coverage. The benefits provided by the plan and/or any component plan are not “vested” benefits. Travelers does not promise the continuation of any benefit nor does it promise any specific level of benefits, or cost for such benefits, at any time.

Travelers can amend or terminate the plan at any time and for any reason. An amendment may apply to active participants, to persons who are on leave, to retirees or others former employees, or to others who are no longer active participants in the plan. Further, an amendment may apply to all participants or only to some participants.

Prescription Drug Coverage

When you enroll in any Travelers medical plan option, you will automatically receive prescription drug coverage through Express Scripts. Retiree prescription coverage depends on your retiree group and whether your medical plan option includes prescription coverage.

Preventive Prescriptions

If you are a legacy St. Paul Companies Retiree, legacy USF&G Retiree or Travelers Retiree in a medical option described in the active employee summary, the following over-the-counter products may be eligible for coverage as preventive medication through Express Scripts at no cost to you, subject to a prescription and the following criteria noted in the table below.

Product	Dosage/Dosage Form	Criteria
Fluoride	Oral dosage forms typically used by children/infants (e.g., drops, chewable tablets) in strengths providing less than or equal to 0.5 mg/day	Preschool children older than six (6) months through five (5) years of age whose primary water source is deficient in fluoride
Aspirin (to prevent cardiovascular disease)	Oral dosage forms typically used by adults (e.g., tablets) in strengths providing less than or equal to 325 mg/day	Men age 45 to 49 Women age 55 to 79
Folic Acid	Oral dosage forms typically used by adults (e.g., tablets) in strengths providing 0.4 to 0.8 mg/day	Women age 18 to 45
Iron Supplements	Concentration and oral dosage forms (e.g., drops, syrups, suspensions) typically used by infants	Children age 6 to 12 months who are at increased risk for iron deficiency anemia

Retail Prescriptions

Each time you need up to a 30-day supply of prescription drugs, show your Express Scripts ID card at a participating network pharmacy. The copay and coinsurance amounts for retail drugs (other than infertility drugs) are as follows:

If you are a legacy St. Paul Companies Retiree, legacy USF&G Retiree or Travelers Retiree,

- $7 for generic drugs;
- 20% for formulary brand-name drugs and compound medications;
- 40% for non-formulary brand-name drugs;
- Minimum per brand-name prescription (formulary or non-formulary): $32; and
- Maximum per brand-name prescription (formulary and non-formulary): $130.

If you fill a prescription at an out-of-network pharmacy, you must pay the entire cost for the medication, then submit a claim form to Express Scripts. Your reimbursement will be based upon whether or not you had access to a network pharmacy. If you had access to a network pharmacy, you will be reimbursed at the contracted rate for out-of-network prescriptions minus the applicable coinsurance. If you did not have access to a network pharmacy, the network coinsurance will apply. Claim forms are available from the ESU.

A separate $2,350 calendar year out-of-pocket maximum for prescription drugs applies to each plan member. This means that when a member pays $2,350 in eligible prescription drug coinsurance, all retail, specialty medicine, and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% (excluding infertility medications). Ancillary charges associated with certain brand name medications do not apply to the out-of-pocket maximum.

If you are a legacy TPC Pre-1993, Transitional, Associates or Citibank Retiree,

- $7 for generic drugs;
- $12 for formulary brand-name drugs and compound medications; and
- $25 for non-formulary brand-name drugs.

Prescriptions from an out-of-network pharmacy are covered at 50%.

There is no out-of-pocket maximum for prescription drugs.

If you are a legacy TPC Pay-All Retiree,

- 25% after deductible for generic drugs;
- 30% after deductible for formulary brand-name drugs and compound medications; and
- 50% after deductible for non-formulary brand-name drugs.

Prescriptions from an out-of-network pharmacy are covered at 50%.

A $300 calendar year deductible for prescription drugs applies to each plan member. A separate $1,800 calendar year out-of-pocket maximum for prescription drugs applies to each plan member. This means that when a member pays $1,800 in eligible prescription drug coinsurance, all retail, specialty medicine, and mail order prescription drugs filled during the remainder of the calendar year will be covered at 100% (excluding infertility medications). Ancillary charges associated with certain brand name medications do not apply to the out-of-pocket maximum.

Infertility Medications

Infertility medications are covered subject to 50% coinsurance. There is no minimum or maximum per prescription and the coinsurance for infertility medications does not apply towards any annual out-of-pocket maximum. Infertility medications are NOT covered under the High Deductible Plan.

Prescription Drug Coverage

If You Need A Prescription Filled Before Receiving Your ID Card

You must pay the entire cost for the medication and then submit a claim form to Express Scripts. You will be reimbursed for the cost of the prescription minus the applicable copay or coinsurance. Claim forms are available from the ESU at 4-ESU@travelers.com or 800.441.4378.

Specialty Medication Program: CuraScript

Specialty medications are covered up to a 30-day supply through Express Scripts specialty medication pharmacy company CuraScript. A partial list of conditions that may result in these specialty medications includes arthritis, cancer, hepatitis, infertility, migraines, RSV and multiple sclerosis. Under the specialty program, members are allowed two (2) initial fills per medication at a local retail pharmacy. Thereafter, the medication will be filled via the CuraScript mail order pharmacy. Specialty medications are subject to the same coinsurance (minimums and maximums) as retail prescriptions with the exception of infertility medications which are covered at 50% (with no minimums or maximums, and no out-of-pocket maximum and are not covered under the High Deductible Plan). The out-of-pocket maximum described under the section "Retail Prescriptions" also applies to specialty medications. All prescriptions, regardless of where obtained, are combined for the out-of-pocket maximum. If you have questions on this program, you can contact CuraScript directly at 800.278.0980.

Drug Quantity Management Program

The Drug Quantity Management ("DQM") program is designed to make your use of prescription drugs safer and more affordable. Through the DQM program, certain medication prescriptions are limited to the daily dose that the U.S. Food and Drug Administration ("FDA") considers to be safe and effective.

For these medications, a 30-day prescription (or 90-day prescription if mail-order) will be dispensed in accordance with the daily dose recommendations provided by the FDA. The DQM program is intended to help you receive a safe dosage of your medication and to help you avoid the expense of extra medication that could go to waste. If your physician feels it is medically necessary for you to receive additional medication beyond the quantity allowed under the DQM program, your physician should call Express Scripts prior authorization line at 800.417.8164. For a list of the specific medications that are part of the DQM program, please refer to the Drug Quantity Management FAQ document which is available from the ESU.

Step Therapy Program

The Step Therapy program is required for new prescriptions written on or after January 1, 2012 in the following drug categories:

- Proton pump inhibitors (e.g., for acid reflux); and
- Cox2 and non-steroidal anti-inflammatory drugs (e.g., for pain).

The program is intended to help patients get the prescription drugs they need, while also considering patient safety, cost and health. If you are prescribed a drug that requires Step Therapy, you must follow the Step Therapy process or the plan will not cover your prescription.

The first step in the Step Therapy process is a front-line generic drug determined by medical professionals to be safe, effective and affordable. If you can't take the recommended generic drug (for example, because of a historic allergy) or this drug does not work for you and your doctor decides the drug isn't appropriate for you, then your doctor can

prescribe a drug in the second step to see if that drug works for you. These are brand name prescription drugs and are recommended only if the first step drug doesn't work for the patient. If your doctor's request for an override is approved, you will pay the appropriate copay or coinsurance for the drug. If the override is not approved, you may have to pay full price for the drug.

Mail Order Drug Pharmacy

You can obtain up to a 90-day maintenance drug supply through the Express Scripts mail-order pharmacy. The mail-order pharmacy offers the convenience of home delivery of up to a 90-day supply, lower prices and a phone that is staffed by pharmacists 24 hours per day, 7 days a week. The coinsurance amounts for mail-order drugs (excluding infertility drugs) are as follows:

If you are a legacy St. Paul Companies Retiree, legacy USF&G Retiree or Travelers Retiree,

- $14 for generic drugs;
- 20% for formulary brand-name drugs;
- 40% for non-formulary brand-name drugs;
- Minimum per brand-name prescription (formulary and non-formulary): $64; and
- Maximum per brand-name prescription (formulary and non-formulary): $260.

The out-of-pocket maximum described under the section "Retail Prescriptions" for legacy St. Paul Companies Retirees and legacy USF&G Retirees also applies to the mail order drug pharmacy prescriptions, which are combined with retail prescriptions and specialty medicine prescriptions for purposes of the out-of-pocket maximum.

If you are a legacy TPC Pre-1993, Transitional, Associates or Citibank Retiree,

- $14 for generic drugs;
- $24 for formulary brand-name drugs and compound medications; and
- $50 for non-formulary brand-name drugs.

There is no out-of-pocket maximum for prescription drugs.

If you are a legacy TPC Pay-All Retiree,

- 25% after deductible for generic drugs;
- 30% after deductible for formulary brand-name drugs and compound medications; and
- 50% after deductible for non-formulary brand-name drugs.

The deductible and out-of-pocket maximum described under the section "Retail Prescriptions" for legacy TPC Pay-All Retirees also apply to the mail order drug pharmacy prescriptions, which are combined with retail prescriptions and specialty medicine prescriptions for purposes of the deductible and out-of-pocket maximum.

Prescription Drug Coverage

Preferred Home Delivery Policy

As part of our ongoing efforts to keep prescription drug costs under control, Travelers has negotiated greater discounts on maintenance medications filled through mail order. When members use the mail order pharmacy for maintenance medications, it results in an average plan savings of 10% in comparison to medications purchased at retail.

This policy applies to prescriptions used for ongoing conditions or needs such as arthritis, asthma, birth control, diabetes, high blood pressure and high cholesterol. Under this policy, you are allowed to receive a 30-day supply of a maintenance medication up to two (2) times from any network retail pharmacy.

After two (2) fills of a 30-day supply, you will need to make a decision to either use the Express Scripts mail order pharmacy for up to a 90-day supply or continue to use a retail pharmacy for refills. Any additional retail refills of the same 30-day maintenance medication will be subject to additional coinsurance depending on your retiree group.

Once you have filled a maintenance medication prescription at retail, you will receive a reminder letter from Express Scripts about the Preferred Home Delivery Program.

If you are a legacy St. Paul Companies Retiree or legacy USF&G Retiree, you will be subject to an additional 10% coinsurance above the regular copay or coinsurance (i.e., generic, formulary brand or non-formulary brand).

If you are a legacy TPC Pre-1993, Transitional, Associates or Citibank Retiree, you will be subject to double copays for each refill.

If you are a legacy TPC Pay-All Retiree, you will be subject to 100% coinsurance (i.e., the full cost at the pharmacy).

Generic Drugs vs. Brand-Name Drugs

A brand-name, protected by a time-limited patent, is the name under which a drug is advertised and sold. Once the patent has expired, a generic equivalent may be manufactured by any company complying with the stringent FDA regulations for safety. For many prescriptions, there is no difference between the generic equivalent and the brand-name drug – except for the cost.

Generics Preferred Policy

The Generics Preferred Policy encourages generic prescription drug utilization through economic incentives for using generic medications, and it applies to all prescription classes except Coumadin and Synthroid.

This policy applies when you receive a brand-name prescription for a medicine when a chemically equivalent generic alternative is available. If a brand-name drug is dispensed rather than an available chemically equivalent generic drug, an ancillary charge is applied in addition to the member's generic copay. The ancillary charge is the difference in cost between the brand and the generic drug. Ancillary charges are your responsibility, regardless of whether the "Dispense as Written" box is checked by the doctor (except as described below for Coumadin and Synthroid). The ancillary charge does not apply towards the maximum coinsurance per prescription ($130 retail, $260 mail order) for legacy St. Paul Companies and legacy USF&G Retirees or any out-of-pocket maximum.

If you or your family member's physician feels it is medically necessary to continue to receive the brand-name version of the medication instead of the generic, the physician can call Express Scripts Prior Authorization Line at 800.417.8164 before you obtain your prescription. If medical necessity is approved by Express Scripts, you pay the non-formulary coinsurance for the prescription and do not pay the ancillary charge.

Prescription Drug Coverage

For Coumadin and Synthroid, if your physician writes the prescription "Dispense as Written" for brand-name medication, you pay the non-formulary coinsurance and do not pay an additional fee. If this is not on the prescription, ancillary charges will apply.

What Is A Formulary?

A formulary is a list of FDA-approved prescription drugs that are on Express Scripts preferred list. Formulary drugs include both generic and brand-name drugs that are determined to be as safe and effective as other drugs that can be prescribed for the same condition. Drugs, mostly brand-name, that are not on the formulary are considered non-formulary. The formulary is reviewed quarterly by Express Scripts physicians and clinical pharmacists as new and updated information is made available to Express Scripts. The formulary is updated quarterly for additions and annually for deletions for benefit purposes.

Examples Of Covered Drugs And Supplies Include:

- Covered legend drugs (drugs that federal law requires to be dispensed by prescription only);
- Legend prenatal vitamins;
- Insulin (up to 30 days supply for one (1) copay);
- Infertility drugs (prior authorization is required for injections) (not covered under the High Deductible Plan);
- Limited diabetic supplies (insulin, syringes with/without needles; needles; blood glucose test strips; ketone test strips and tablets; lancets);
- Ostomy supplies;
- Smoking cessation drugs (up to a 90-day annual supply); and
- Oral contraceptives.

Examples Of Drugs And Supplies Not Covered:

- Over-the-counter multiple vitamins and nutritional supplements;*
- Legend single entity and multiple vitamins (except legend prenatal vitamins);*
- Medications for cosmetic purposes (such as Minoxidil);
- Medications for which there are limited benefits per Express Scripts' interpretation of clinical data;
- Medications with no FDA indications or outside the FDA approved dosage;
- Over-the-counter medications (such as Claritin, Rogaine, etc.);*
- Immunization agents, biological sera, blood, or blood plasma;
- Therapeutic devices and appliances;

- Charges for the administration or injection of any drug; and
- Experimental drugs.

*If preventive prescriptions are applicable to you, as described in the "Preventive Prescriptions" section, these exclusions do not apply to over-the-counter medications covered as preventive medications.

Prior Authorization

Prior authorization is required for some drugs and supplies in order for them to be covered. Prior authorization is the process of obtaining permission or pre-approval for a patient to receive select medicines as a covered benefit. The prior authorization process promotes safety and cost-effective prescribing by restricting coverage to FDA approved indications and medically appropriate uses.

The prior authorization process usually begins when the patient brings the prescription to the pharmacy. As the pharmacist attempts to fill the prescription, they will be notified that prior authorization is required. The pharmacist or your physician will need to call Express Scripts and provide them with more information before filling your prescription.

Examples where prior authorization is required:

- Growth hormones;
- Infertility drugs (injections);
- Drugs for inflammatory conditions like Rheumatoid Arthritis and Crohn's Disease;
- Weight-loss medications;
- Non-narcotic general analgesics (i.e. Imitrex and DHE);
- Retin-A (covered through age 29); and
- Lidoderm.

For a full listing of medications or to determine whether a specific medication is subject to prior authorization, call the Express Scripts Customer Service Call Center at the toll free number 877.494.7472.

Medicare Part B Coordination of Benefits

With prescription drug cost on the rise, coordinating benefits with Medicare Part B can help keep the cost down for both participants and the plan. Express Scripts began coordinating benefits for Medicare Part B covered prescriptions and supplies including oral cancer medications, immunosuppressant medications, respiratory agents, and diabetic testing and maintenance supplies. The same plan design applies; however, the claim will be first submitted to Medicare Part B for consideration and then the balance will be processed by Express Scripts. Prescriptions and supplies sourced at a retail pharmacy will require the retail pharmacy be a participating Medicare Part B retail pharmacy. Most major chains including CVS, Kroger, Rite Aid and Target are participating Part B retail pharmacies.

Prescriptions and supplies filled through home delivery mail order will use NationsHealth mail order pharmacy, a participating Medicare Part B mail order pharmacy who has partnered with Express Scripts. For more information, please call Express Scripts customer service at 844.494.7472 or NationsHealth customer service at 800.298.1418.

Legacy St. Paul Companies Retiree Comprehensive Plan – Medicare Eligible

2012 Comprehensive Plan – Medicare Eligible	Benefit
Deductible	$300 per person/$600 per family
Out-Of-Pocket Limit (Includes deductible and coinsurance, excludes copays, prescription copays and coinsurance)	$1,200 per person/$2,400 per family
Lifetime Maximum	Unlimited
Office & Facility Visits	
Primary Care Office Visit (including allergy shots)	Covered at 80% after deductible
Urgent Care Facility Visit	Covered at 80% after deductible
Emergency Room	Covered at 80% after deductible
Prescription Drugs Administered by Express Scripts	
Retail – Up to 30-day supply	
- Generic	$7 copay
- Formulary Brand	You pay 20% coinsurance: $32 minimum, $130 maximum
- Non-Formulary Brand	You pay 40% coinsurance: $32 minimum, $130 maximum
Mail Order: Up to 90-day supply	
- Generic	$14 copay
- Formulary Brand	You pay 20% coinsurance: $64 minimum, $260 maximum
- Non-Formulary Brand	You pay 40% coinsurance: $64 minimum, $260 maximum
Prescription Out-of-Pocket Maximum	$2,350 per member, per calendar year
Preferred Home Delivery for Maintenance Prescriptions	You pay an additional 10% coinsurance for maintenance medications filled more than twice at retail store.
Generics Preferred Policy	You pay generic copay plus the cost difference between the brand and generic when a generic is available but not chosen
Inpatient Hospital and Physician Services	Covered at 80% after deductible
Outpatient Hospital and Surgical Services	Covered at 80% after deductible
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 80% after deductible
Preventive Care	
Routine Physical Exams and Immunizations	Covered at 100% of eligible expenses; no deductible
Routine GYN, PSA Exams	Covered at 100% of eligible expenses; no deductible
Routine Vision Care (annual exam)	Covered at 100% of eligible expenses; no deductible; limited to 1 exam per 12 months
Routine Hearing Care (annual exam)	Covered at 100% of eligible expenses; no deductible; limited to 1 exam per 12 months
Outpatient Care	
Chiropractic Care Visits	Covered at 80% after deductible; limited to 20 visits per calendar year
Physical and Occupational Therapy	Covered at 80% after deductible; limited to 60 visits per calendar year
Speech Therapy	Covered at 80% after deductible; limited to 60 visits per calendar year
Mental Health/Substance Abuse	
Inpatient	Covered at 80% after deductible
Outpatient	Covered at 80% after deductible
Special Services	
Durable Medical Equipment and Eligible Supplies	Covered at 80% after deductible

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the UHC summary for more information.

Legacy St. Paul Companies Retiree Comprehensive Plan – Medicare Eligible – Medical Only

2012 Comprehensive Plan – Medicare Eligible – Medical Only	Benefit
Deductible	$300 per person/$600 per family
Out-Of-Pocket Limit (excluding deductible)	$1,200 per person/$2,400 per family
Lifetime Maximum	Unlimited
Office & Facility Visits	
Primary Care Office Visit (including allergy shots)	Covered at 80% after deductible
Urgent Care Facility Visit	Covered at 80% after deductible
Emergency Room	Covered at 80% after deductible
Prescriptions	No coverage
Inpatient Hospital and Physician Services	Covered at 80% after deductible
Outpatient Hospital and Surgical Services	Covered at 80% after deductible
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 80% after deductible
Preventive Care	
Routine Physical Exams and Immunizations	Covered at 100% of eligible expenses; no deductible
Routine GYN, PSA Exams	Covered at 100% of eligible expenses; no deductible
Routine Vision Care (annual exam)	Covered at 100% of eligible expenses; no deductible; limited to 1 exam per 12 months
Routine Hearing Care (annual exam)	Covered at 100% of eligible expenses; no deductible; limited to 1 exam per 12 months
Outpatient Care	
Chiropractic Care Visits	Covered at 80% after deductible; limited to 20 visits per calendar year
Physical and Occupational Therapy	Covered at 80% after deductible; limited to 60 visits per calendar year
Speech Therapy	Covered at 80% after deductible; limited to 60 visits per calendar year
Mental Health/Substance Abuse	
Inpatient	Covered at 80% after deductible
Outpatient	Covered at 80% after deductible
Special Services	
Durable Medical Equipment and Eligible Supplies	Covered at 80% after deductible

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Retirees covering non-Medicare eligible family members are not eligible for this plan. Refer to the UHC summary for more information.

Legacy USF&G Retiree Medicare Supplement Plan

2012 Medicare Supplement Plan	Benefit
Deductible	None
Out-of-Pocket Limit	None
Lifetime Maximum	$500,000
Office & Facility Visits	
Primary Care Office Visit (including allergy shots)	Covered at 100% of eligible expenses
Urgent Care Facility Visit	Covered at 100% of eligible expenses
Emergency Room	Covered at 100% of eligible expenses
Prescription Drugs Administered by Express Scripts	
Retail – Up to 30-day supply	
- Generic	$7 copay
- Formulary Brand	You pay 20% coinsurance: $32 minimum, $130 maximum
- Non-Formulary Brand	You pay 40% coinsurance: $32 minimum, $130 maximum
Mail Order: Up to 90-day supply	
- Generic	$14 copay
- Formulary Brand	You pay 20% coinsurance: $64 minimum, $260 maximum
- Non-Formulary Brand	You pay 40% coinsurance: $64 minimum, $260 maximum
Prescription Out-of-Pocket Maximum	$2,350 per member, per calendar year
Preferred Home Delivery for Maintenance Prescriptions	You pay an additional 10% coinsurance for maintenance medications filled more than twice at retail store
Generics Preferred Policy	You pay generic copay plus the cost difference between the brand and generic when a generic is available but not chosen
Inpatient Hospital and Physician Services	Covered at 100% of eligible expenses
Inpatient Skilled Nursing Facility	Covered at 100% of eligible expenses for first 100 days; then limited to 80%; 200 day maximum
Outpatient Hospital and Surgical Services	Covered at 100% of eligible expenses
Outpatient Private Duty Nursing	Covered at 80% of eligible expenses to annual maximum of $10,000
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 100% of eligible expenses
Preventive Care	
Routine Physical Exams	Not Covered
Routine GYN, PSA Exams	Covered at 100% of eligible expenses
Immunizations	Covered at 100% of eligible expenses
Outpatient Care	
Chiropractic Care Visits	Covered at 100% of eligible expenses
Physical and Occupational Therapy	Covered at 100% of eligible expenses
Speech Therapy	Covered at 100% of eligible expenses
Mental Health/Substance Abuse	
Inpatient	Covered at 80% of eligible expenses
Outpatient	Covered at 80% of eligible expenses
Special Service	
Durable Medical Equipment and Eligible Supplies	Covered at 100% of eligible expenses

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the UHC summary for more information.

Legacy USF&G Retiree Medicare Supplement Plan – Medical Only

2012 Medicare Supplement Plan – Medical Only	Benefit
Deductible	None
Out-of-Pocket Limit	None
Lifetime Maximum	$500,000
Office & Facility Visits	
Primary Care Office Visit (including allergy shots)	Covered at 100% of eligible expenses
Urgent Care Facility Visit	Covered at 100% of eligible expenses
Emergency Room	Covered at 100% of eligible expenses
Prescriptions	No coverage
Inpatient Hospital and Physician Services	Covered at 100% of eligible expenses
Inpatient Skilled Nursing Facility	Covered at 100% of eligible expenses for first 100 days; then limited to 80%; 200 day maximum
Outpatient Hospital and Surgical Services	Covered at 100% of eligible expenses
Outpatient Private Duty Nursing	Covered at 80% of eligible expenses to annual maximum of $10,000
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 100% of eligible expenses
Preventive Care	
Routine Physical Exams	Not Covered
Routine GYN, PSA Exams	Covered at 100% of eligible expenses
Immunizations	Covered at 100% of eligible expenses
Outpatient Care	
Chiropractic Care Visits	Covered at 100% of eligible expenses
Physical and Occupational Therapy	Covered at 100% of eligible expenses
Speech Therapy	Covered at 100% of eligible expenses
Mental Health/Substance Abuse	
Inpatient	Covered at 80% of eligible expenses
Outpatient	Covered at 80% of eligible expenses
Special Services	
Durable Medical Equipment and Eligible Supplies	Covered at 100% of eligible expenses

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Retirees covering non-Medicare eligible family members are not eligible for this plan. Refer to the UHC summary for more information.

Legacy TPC Pre-1993, Transitional, Associates And Citibank Retiree POS Plan

2012 POS Plan	Network	Out-of-Network
Deductible	N/A	$500 per person/$1,500 per family
Out-of-Pocket Limit (including deductible)	N/A	$3,500 per person/ $7,000 per family
Lifetime Maximum	Unlimited	Unlimited
Office & Facility Visits		
Primary Care Office Visit (including allergy shots)	$10 copay	Covered at 70% after deductible
Urgent Care Facility Visit	$10 copay	$10 copay
Emergency Room	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Prescription Drugs Administered by Express Scripts		
Retail – up to 30-day supply		
- Generic	$7 copay	Covered at 50%
- Formulary Brand	$12 copay	Covered at 50%
- Non-Formulary Brand	$25 copay	Covered at 50%
Mail Order – up to 90-day supply		
- Generic	$14 copay	Not available
- Formulary Brand	$24 copay	Not available
- Non-Formulary Brand	$50 copay	Not available
Preferred Home Delivery for Maintenance Prescriptions	For maintenance medications filled more than twice at retail store, you pay double for each refill at a retail store.	
Inpatient Hospital and Physician Services	Covered at 100%	Covered at 70% after deductible**
Outpatient Hospital and Surgical Services	Covered at 100%; copayment applies if office visit is charged	Covered at 70% after deductible
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 100%	Covered at 70% after deductible
Preventive Care		
Routine Physical Exams	Covered at 100% after $10 copay	Covered at 70%; no deductible; $250 annual maximum for preventive exams.*
Routine GYN Exams	Covered at 100% after $10 copay	Covered at 70%; no deductible; $250 annual maximum for preventive exams.*
Well Child Visit and Immunizations	Covered at 100% after $10 copay	Covered at 70%; no deductible
Routine Vision Care	Covered at 100% after copay; limited to 1 exam per 24 months	Not covered
Routine Hearing Care	Covered at 100% after copay; limited to 1 exam per 24 months	Not covered
Outpatient Care		
Chiropractic Care Visits	$10 copay per visit; limited to 20 visits (network & out-of-network) per calendar year	Covered at 70% after deductible; limited to 20 visits (network & out-of-network) per calendar year
Physical and Occupational Therapy	$10 copay per visit; limited to 20 visits (network & out-of-network) per calendar year	Covered at 70% after deductible; limited to 20 visits (network & out-of-network) per calendar year
Speech Therapy	$10 copay per visit; limited to 20 visits (network & out-of-network) per calendar year	Covered at 70% after deductible; limited to 20 visits (network & out-of-network) per calendar year.
Mental Health/Substance Abuse (pre-certification required)		
Inpatient	Covered at 100%	Covered at 70% after deductible**
Outpatient	$10 copay per visit	Covered at 70% after deductible
Special Services		
Durable Medical Equipment and Eligible Medical Supplies	Covered at 100%	Covered at 70% after deductible

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Legacy TPC Pre-1993, Transitional, Associates And Citibank Retiree POS Plan

* Not subject to the calendar year deductible, does not apply to the Out-of-Pocket Limit, and maximum does not apply to well child care and certain cancer screening tests.

** There is a $500 inpatient confinement deductible which is a penalty for going out-of-network and does not apply to the Out-of-Pocket Limit or the calendar year deductible. An additional $500 non-notification deductible applies if pre-certification not completed.

Legacy TPC Pre-1993, Transitional, Associates And Citibank Retiree Medical 200 Plan

2012 Medical 200 Plan	Benefit	
Deductible	$200 per person/$600 per family	
Out-of-Pocket Limit	$1,000 per person/$2,000 per family	
Lifetime Maximum	$3,000,000	
Office & Facility Visits Primary Care Office Visit (including allergy shots)	Covered at 80% after deductible	
Urgent Care Facility Visit	Covered at 80% after deductible	
Emergency Room	Covered at 80% after deductible	
Prescription Drugs Administered by Express Scripts	Network	Out-of-Network
Retail – up to 34-day supply		
- Generic	$7 copay	Covered at 50%
- Formulary Brand	$12 copay	Covered at 50%
- Non-Formulary Brand	$25 copay	Covered at 50%
Mail Order – up to 90-day supply		
- Generic	$14 copay	Not available
- Formulary Brand	$24 copay	Not available
- Non-Formulary Brand	$50 copay	Not available
Preferred Home Delivery for Maintenance Prescriptions	For maintenance medications filled more than twice at retail store, you pay double for each refill at a retail store.	
Inpatient Hospital and Physician Services	Covered at 80% after deductible	
Outpatient Hospital and Surgical Services	Covered at 80% after deductible	
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 80% after deductible	
Preventive Care		
Routine Physical Exams	Covered at 80%; no deductible	
Routine GYN Exams	Covered at 80%; no deductible	
Well Child and Immunizations	Covered at 80%; no deductible	
Routine Vision Care	Covered at 80%; no deductible; limited to 1 exam per 24 months	
Outpatient Care		
Chiropractic Care Visits	Covered at 80% after deductible; limited to 20 visits per calendar year	
Physical and Occupational Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year	
Speech Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year	
Mental Health/Substance Abuse		
Inpatient	Covered at 80% after deductible	
Outpatient	Covered at 80% after deductible	
Special Services		
Durable Medical Equipment and Eligible Supplies	Covered at 80% after deductible	

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the UHC summary for more information.

Legacy TPC Pre-1993, Transitional, Associates And Citibank Retiree Medical 200 – Medical Only

2012 Medical 200 – Medical Only	Benefit
Deductible	$200 per person/$600 per family
Out-of-Pocket Limit	$1,000 per person/$2,000 per family
Lifetime Maximum	$3,000,000
Office & Facility Visits	
Primary Care Office Visit (including allergy shots)	Covered at 80% after deductible
Urgent Care Facility Visit	Covered at 80% after deductible
Emergency Room	Covered at 80% after deductible
Prescriptions	No coverage
Inpatient Hospital and Physician Services	Covered at 80% after deductible
Outpatient Hospital and Surgical Services	Covered at 80% after deductible
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 80% after deductible
Preventive Care	
Routine Physical Exams	Covered at 80%; no deductible
Routine GYN Exams	Covered at 80%; no deductible
Well Child and Immunizations	Covered at 80%; no deductible
Routine Vision Care	Covered at 80%; no deductible; limited to 1 exam per 24 months
Outpatient Care	
Chiropractic Care Visits	Covered at 80% after deductible; limited to 20 visits per calendar year
Physical and Occupational Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year
Speech Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year
Mental Health/Substance Abuse	
Inpatient	Covered at 80% after deductible
Outpatient	Covered at 80% after deductible
Special Services	
Durable Medical Equipment and Eligible Supplies	Covered at 80% after deductible

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Retirees covering non-Medicare eligible family members are not eligible for this plan. Refer to the UHC summary for more information.

Legacy TPC Pay-All Retiree Medical 400 Plan

2012 Medical 400 Plan	Benefit	
Deductible	$400 per person/$800 per family	
Out-of-Pocket Limit	$2,000 per person/$4,000 per family	
Lifetime Maximum	$3,000,000	
Office & Facility Visits		
Primary Care Office Visit (including allergy shots)	Covered at 80% after deductible	
Urgent Care Facility Visit	Covered at 80% after deductible	
Emergency Room	Covered at 80% after deductible	
Prescriptions Subject to a $300 deductible and an $1,800 out-of-pocket limit for each covered person (retail and mail combined).		
	Network	Out-of-Network
Retail – up to 34-day supply		
- Generic	Covered at 75%	Covered at 50%
- Formulary Brand	Covered at 70%	Covered at 50%
- Non-Formulary Brand	Covered at 50%	Covered at 50%
Mail Order – up to 90-day supply		
- Generic	Covered at 75%	Not available
- Formulary Brand	Covered at 70%	Not available
- Non-Formulary Brand	Covered at 50%	Not available
Preferred Home Delivery for Maintenance Prescriptions	For maintenance medications filled more than twice at retail store, you pay 100% for each refill at a retail store.	
Inpatient Hospital and Physician Services	Covered at 80% after deductible	
Outpatient Hospital and Surgical Services	Covered at 80% after deductible	
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 80% after deductible	
Preventive Care		
Routine Physical Exams	Covered at 80%; no deductible	
Routine GYN Exams	Covered at 80%; no deductible	
Well Child and Immunizations	Covered at 80%; no deductible	
Routine Vision Care	Covered at 80%; no deductible; limited to 1 exam per 24 months	
Outpatient Care		
Chiropractic Care Visits	Covered at 80% after deductible; limited to 20 visits per calendar year	
Physical and Occupational Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year	
Speech Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year	
Mental Health/Substance Abuse		
Inpatient	Covered at 80% after deductible	
Outpatient	Covered at 80% after deductible	
Special Services		
Durable Medical Equipment and Eligible Supplies	Covered at 80% after deductible	

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Refer to the UHC summary for more information.

Legacy TPC Pay-All Retiree Medical 400 – Medical Only

2012 Medical 400 – Medical Only	Benefit
Deductible	$400 (individual)/$800 (family)
Out-of-Pocket Limit	$2,000 (individual)/$4,000 (family)
Lifetime Maximum	$3,000,000
Office & Facility Visits	
Primary Care Office Visit (including allergy shots)	Covered at 80% after deductible
Urgent Care Facility Visit	Covered at 80% after deductible
Emergency Room	Covered at 80% after deductible
Prescriptions	No coverage
Inpatient Hospital and Physician Services	Covered at 80% after deductible
Outpatient Hospital and Surgical Services	Covered at 80% after deductible
Diagnostic X-ray/Lab Work and Therapeutic Services	Covered at 80% after deductible
Preventive Care	
Routine Physical Exams	Covered at 80%; no deductible
Routine GYN Exams	Covered at 80%; no deductible
Well Child and Immunizations	Covered at 80%; no deductible
Routine Vision Care	Covered at 80%; no deductible; limited to 1 exam per 24 months
Outpatient Care	
Chiropractic Care Visits	Covered at 80% after deductible; limited to 20 visits per calendar year
Physical and Occupational Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year
Speech Therapy	Covered at 80% after deductible; limited to 20 visits per calendar year
Mental Health/Substance Abuse	
Inpatient	Covered at 80% after deductible
Outpatient	Covered at 80% after deductible
Special Services	
Durable Medical Equipment and Eligible Supplies	Covered at 80% after deductible

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions. Should a disagreement exist between this document and the Plan document, the Plan document governs.

Retirees covering non-Medicare eligible family members are not eligible for this plan. Refer to the UHC summary for more information.

Other Important Information

Coordination Of Benefits

If you participate in the plan and another group medical plan, you must follow certain "coordination of benefits" rules.

According to coordination of benefit rules, you send your claim to the primary plan first. After the primary plan has paid benefits, you send your claim, along with the primary plan's explanation of benefits, to the secondary plan.

If Travelers' medical plan is secondary, it may pay benefits after the other plan has paid — but only if there are allowable expenses that exceed the primary plan's payment. Payment works as follows:

- Travelers' plan claims administrator determines the amount the Travelers plan would have paid if it were primary.
- If there is a difference between the amount actually paid by the primary plan and the amount that the Travelers plan would have paid as primary plan, Travelers will pay the difference.
- Travelers' plans do not coordinate benefits for outpatient prescription drug claims — that is, Travelers' plans will pay primary on your outpatient prescription drug claims, regardless of whether you have other prescription drug coverage.

For more information on how coordination of benefits works and whether Travelers' medical plan is primary or secondary to your other group coverage, please refer to the UHC summaries or BCBS summary.

Third-Party Liability (Subrogation)

Third-party liability rules apply to situations where some or all of your family medical expenses are covered by workers' compensation or other employee liability laws or no-fault auto insurance, or for injuries occurring under other circumstances that create a legal obligation on behalf of someone else to pay your medical expenses. If this situation arises, the plan has the right to be reimbursed for any medical expenses it pays for you or your family members. See the UHC summaries or the BCBS summary for detailed subrogation rules.

Fraud/Misrepresentation

If you knowingly and with intent to defraud the plan file a claim that contains any materially false information including eligibility information, conceal information in order to mislead, or commit a fraudulent act, you may be subject to disciplinary action, and possible criminal and civil penalties. Travelers will consider such acts or omissions as intentional misrepresentation. This may result in a retroactive loss of coverage that is not a rescission.

Information Sharing

Travelers has engaged outside service providers to assist in the administration of its benefit plans. Travelers may need to share certain information about you and your family members with these service providers as appropriate for them to provide their services. Also, in certain circumstances, Travelers may be required to provide information to governmental agencies.

Claims And Appeal Procedures

If you are a retiree enrolled in an option under The Travelers Medical Plan, you should consult the "Claims And Appeal Procedures" in the active employee summary for a description of the claims procedure that applies to you. However, if you are a retiree enrolled in an option under The Travelers Retiree Medical Plan, this section below describes the claims procedure that applies to you.

Seeking Review Of Decisions You Disagree With

If you apply for a benefit and your claim is denied in whole or in part, the plan has a claims review procedure that you must follow in order to seek review of your claim – this procedure is described in the applicable "Benefit Claims And Appeal Procedure" section. Following the claims procedure is very important because it may affect your legal rights under the plan. (See the "Legal Action" section.)

The claims procedure is intended to provide a fair review of whether the terms of the plan have been followed in your case. The claims procedure is not intended as a way to air suggestions or complaints about the benefits offered by Travelers, and such matters will not be considered under the claims procedures.

If you believe the plan terms provide for your eligibility to participate, but you are not offered participation in the plan, or if you are denied participation when you inquire, you should follow the steps set out in the "Request For Eligibility Determination" section. Similarly, the procedures in that section are appropriate if you believe that your participation in the plan should be on different terms than are offered to you.

Inquiry vs. Benefit Claim

A retiree or beneficiary may call, send an e-mail or send a letter to the ESU asking a question or seeking assistance. Not all questions or requests for assistance are "claims for benefits" and it can be difficult to tell whether a claim for benefits was intended.

We encourage you to seek information and ask questions. Travelers will not treat a communication as a formal claim unless either:

- You use the plan's claim form; or
- Travelers notifies you in writing that it considers your communication to constitute a claim for benefits.

If you are unclear of the status of your inquiry or claim request, please ask.

Benefit Claims And Appeal Procedure – Other Than For Prescription Drugs

For full details about the benefit claims and appeals procedures for the plan, other than for prescription drug coverage through Express Scripts, you should refer to the UHC summaries or the BCBS summary.

In general, you can obtain claim forms from the ESU. If you have questions, please contact the ESU at 4-ESU@travelers.com or 800.441.4378. Send the completed form to the address listed on the form according to the instructions given.

For the Choice Plus Plan and BCBS Plan options, no claim forms are necessary if care is received in the network.

Claims And Appeal Procedures

The benefit claims and appeals process for medical coverage other than prescription drug coverage through Express Scripts is fully outsourced to the applicable claims administrator, UHC or BCBS. Travelers has no involvement whatsoever with decisions relating to benefit claims and appeals for medical coverage other than prescription drug coverage through Express Scripts.

Benefit Claims And Appeal Procedure – Prescription Drugs

If you fill your prescription at an Express Scripts network pharmacy and show your Express Scripts ID card, or if you use the Express Scripts mail order or CuraScript mail order pharmacies, your claim will be processed in the normal course of the plan's operation. That means that usually you will not need to take any other action to receive the full prescription drug benefit under the plan.

Claim For Benefits

However, there are cases when you will need to request benefits. In the rare event that you need to purchase prescription drugs where no network pharmacy is available, or you forget to use your ID card, you will need to pay the full cost of the prescription at the pharmacy, and then submit a claim form to Express Scripts for reimbursement. The Express Scripts claim form is available by calling the ESU. If you did have access to an Express Scripts network pharmacy, your reimbursement will reflect the discount contract rate that would have been charged had you used the Express Scripts network pharmacy less the applicable coinsurance. If you did not have access to a network pharmacy, your reimbursement will be based on billed charges less the applicable coinsurance.

You must submit claims within one (1) year of the drug purchase to receive reimbursement. If you submit your claim after the one (1)-year deadline, your claim will be denied.

You file a claim for benefits under the prescription drug plan by filing a claim form when you request to fill a prescription at either the retail, mail- order, or CuraScript pharmacy, or request written reimbursement for a prescription you have had filled.

Initial Review Procedure

In the event your physician prescribes a drug that was not dispensed or was denied prior authorization (PA), you may contact Express Scripts about an appeal. Note: The plan will not consider appeals for lower coinsurance levels on covered drugs.

There are two (2) kinds of prescription drug claims under the plan — pre-service claims and post-service claims. Pre-service claims are requests for prescription drugs which require prior authorization (see the "Prescription Drug Coverage" section for more details). All requests for prescription drugs which do not require prior authorization are considered post-service claims.

If your pre-service claim is denied, Express Scripts will respond to you depending upon the type of claim you have filed. If you have filed a pre-service claim, Express Scripts will respond within a reasonable time, but no later than 15 days after the date your claim is received, unless special circumstances beyond Express Scripts' control require a longer period of time for making the decision. If a longer period of time is required, you will be notified within the initial 15-day period. Express Scripts may take one 15-day extension.

Claims And Appeal Procedures

If your post-service claim is denied, your prescription will not be covered at the pharmacy. You can fill the prescription by paying for the cost of the medication out of your own funds. Then, you should contact Express Scripts as outlined below. Express Scripts will respond within a reasonable time, but no later than 30 days after the date your claim is received, unless special circumstances beyond Express Scripts' control require a longer period of time for making the decision. If a longer period of time is required, you will be notified within the initial 30-day period. Express Scripts may take one 15-day extension.

If your claim (whether pre-service or post-service) did not include the information necessary to process your claim, you will be notified and given at least 45 days to provide the missing information. The timeframe for deciding your claim will be suspended until you provide the missing information. If the missing information is not provided within the time specified, your claim will be decided without that information, which means it will likely be denied.

If your claim is wholly or partially denied, you will be furnished with a written notice of the denial which will cover:

- Specific reasons for the denial;
- Plan provisions on which the denial was based;
- Additional material or information needed to make the request for benefits acceptable and the reason it is necessary;
- A statement disclosing any internal rule, guideline, protocol, or similar criteria relied upon in denying your claim (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment (or a statement that such an explanation is available upon request); and
- The procedure for appealing the denied request for benefits.

Any reference to an "authorized representative" means a person you authorize, in writing, to act on your behalf, which authorization is filed with Express Scripts or the Administrative Committee. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

First-Level Appeal Procedure For Prescription Drug Claims

If all or any portion of your claim is denied and you want to pursue the matter further, you (or your authorized representative) must, within 180 days after you receive the denial, file a written appeal as described below. Your written appeal should describe all of the reasons why you believe the claim denial was in error, and should include all written comments, documents, records and other information that you have relating to your claim and that you want to have considered in support of your appeal. Your appeal will be decided based on all the available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

During the 180-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

Address your appeal to:

Express Scripts, Inc.
Pharmacy Appeals – SST
6625 W. 78th St. - BL0390
Bloomington, MN 55439
877.494.7472

If the advice of a medical expert was obtained in connection with the initial benefit decision, the name of each expert will be provided upon request, regardless of whether the advice was relied on in making the decision on your claim.

A decision on the appeal will be made by MCMC, a third party contracted by Express Scripts to decide appeals, within 15 days (for a pre-service claim appeal) or 30 days (for a post-service claim appeal) of the date your appeal is received. You will receive a written decision including the specific reason(s) and plan references on which the decision is based.

Second-Level Appeal Procedure For Prescription Drug Claims

If MCMC upholds the original decision to deny your claim, and you want to pursue the matter further, you or your authorized representative must appeal MCMC's decision to uphold the denial. You must file your written appeal with the Travelers Administrative Committee no later than 90 days after you receive written notification of the denial of your claim. Your written appeal must describe all the reasons why you believe the claim denial was in error, and should include all written comments, documents, records and other information that you have relating to your claim and that you want to have considered in support of your appeal. Your appeal will be decided based on all of the available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

Travelers makes a form available for your use in preparing and submitting your second-level appeal. Appeals can be most meaningfully reviewed when you understand the plan and clearly express why you believe your claim was incorrectly denied, taking the plan's terms into consideration. The appeal form is essential in this process. Travelers requires you to use the appeal form, which is available by contacting the ESU at 4-ESU@travelers.com or 800.441.4378, when you submit your second-level appeal.

During the 90-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

The Administrative Committee will review your appeal, without deference to the initial adverse decision. If your appeal involves an adverse decision based on medical judgment, your claim will be reviewed by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse decision nor is the subordinate of anyone consulted in connection with the initial adverse decision.

Address your appeal to:

Administrative Committee
The Travelers Companies, Inc.
385 Washington Street, 9275-SB02L
St. Paul, MN 55102

A decision on your second-level appeal will be made within 15 days (for a pre-service claim appeal) or 30 days (for a post-service claim appeal) of the date your appeal is received. You will receive a written decision including the specific reason(s) and plan references on which the decision is based.

Legal Action

If you have gone through the entire claims process, you have the right to file a lawsuit challenging the denial. The claims procedures described above are required by federal law and are designed to ensure that disputes regarding the plan are decided by the appropriate plan fiduciaries. Therefore, courts almost always require that a claimant exhaust a plan's claims procedures before filing suit (both filing the initial claim and appealing a denied claim). If you fail to do so, the court will likely dismiss your lawsuit. In a lawsuit, the court generally will review a decision on appeal based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the appropriate plan fiduciaries during the claims process.

You may pursue legal action only after you have completed the claims process described above. In addition, if you have completed the claims process above and want to bring a lawsuit, you must do so within one (1) year of the final denial of your claim. Failure to file a lawsuit within one (1) year will cause your rights to expire.

Scope Of Discretionary Authority

UHC and BCBS are the plan fiduciaries for benefit claims and appeals other than for prescription drug coverage through Express Scripts. The Administrative Committee is the plan fiduciary for final appeals for the prescription drug coverage Express Scripts provides. The appropriate plan fiduciary has the final and discretionary authority to determine claims and appeals, and has the final and discretionary authority to interpret all terms of the plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the appropriate plan fiduciary on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is very broad and is limited only by the duties imposed under ERISA. The determination is intended to be given deference by courts to the maximum extent allowed under ERISA.

Request For Eligibility Determination

If you believe that you or a family member are eligible to participate in the plan under its terms, or if you believe that your participation should be on different terms than what has been offered to you, you should contact the ESU at 4-ESU@travelers.com or 800-441-4378. Your contact will be treated as an informal inquiry regarding your eligibility. If the ESU informs you that you are not eligible to participate in the plan, and you disagree with this response, you or your authorized representative may file a written eligibility determination request under this procedure at the following address. You must file your eligibility determination request within 30 days of the date the ESU responds to your informal inquiry.

Address your eligibility determination request to:

Travelers Administrative Committee
c/o Employee Services Unit
The Travelers Companies, Inc.
385 Washington Street, 9275-SB02L
St. Paul, MN 55102

Or by e-mail: 4-ESU@travelers.com

Travelers makes a form available for your use in preparing and submitting your eligibility determination request. The form assists you in this process. The form is available by contacting the ESU.

The Administrative Committee will review your eligibility determination request and will respond to you in writing as soon as administratively practicable.

If your eligibility determination request is denied, the denial will include:

- The specific reasons for the denial; and
- Reference to the pertinent plan provisions upon which the denial is based.

The plan procedures do not allow an appeal of any decision made on eligibility by the Administrative Committee. However, you may file a formal claim for benefits pursuant to the claims review procedure outlined in the applicable "Benefit Claims And Appeal Procedure" section and your eligibility for that benefit will be reviewed at that time.

When Coverage Ends

Retirees

Your medical coverage ends on the earliest of the following:

- Your death;
- If you elect to waive coverage, the last day of the month in which your election is effective;
- The end of the period for which you made the last required premium payment (see "Failure To Pay Premium" in this section);
- The end of the month preceding the month in which you become Medicare eligible (e.g., age 65) if you have access-only coverage and you are a Travelers Retiree; or
- The date the plan terminates (or your retiree coverage is eliminated by an amendment to the plan).

Surviving Family Members

The same rules regarding termination of coverage for you apply to your surviving spouse or domestic partner if he or she is receiving coverage after your death. Specifically:

- If you had access-only coverage and were a Travelers Retiree, your surviving spouse or domestic partner can continue access-only coverage until the end of the month preceding the month in which (i) your surviving spouse or domestic partner reaches becomes Medicare eligible (e.g., age 65), or (ii) you would have become Medicare eligible (e.g., age 65), if earlier.
- If you had special retiree medical coverage as a Legacy St. Paul Companies Retiree, Legacy USF&G Retiree or either access-only coverage or special retiree medical coverage as a Legacy TPC Retiree, your surviving spouse or domestic partner can continue coverage until his or her death (unless coverage ends earlier due to nonpayment of premium, plan termination or amendment to eliminate the coverage, or another event occurs to terminate coverage)

Eligible Family Members

Coverage for an eligible family member ends on the earliest of the following:

- The end of the month preceding the month in which the individual becomes Medicare eligible (e.g., age 65) for access-only coverage if you are a Travelers Retiree;
- The end of the month in which your (the retiree's) coverage ends for any reason other than death;
- The end of the month in which your (the retiree's) death occurs if there is no surviving spouse or domestic partner;
- If you or your surviving spouse or domestic partner elect to change from family to single coverage, the last day of the month immediately following receipt of the written request to change;
- The end of the month in which your surviving spouse's or domestic partner's death occurs;

- The end of the period for which the last required premium payment for family coverage was paid (see “Failure To Pay Premium” in this section);
- The end of the month in which the individual no longer qualifies as an eligible family member.

Failure To Pay Premium

If you or your surviving spouse or domestic partner fails to pay the required premium for your coverage within 60 days of the due date, coverage will terminate at the end of the period for which the last required premium payment was made.

If coverage is terminated for failure to pay premiums, it may be reinstated on the first occurrence of termination if you or your surviving spouse (or domestic partner) pay all back premiums due within 30 days of the termination notice. If premiums are not paid by then or if coverage was previously terminated and reinstated due to failure to pay premiums, coverage will not be reinstated.

Continuation Coverage

Continuation Of Active Employee Coverage

When you first retire and become eligible for either access-only or special retiree medical coverage, you and your covered eligible family members will be given the opportunity to elect continuation of your active employee coverage under the plan for up to 18 months of coverage. If you or any covered family members elect such continuation coverage, the continuation period will end after 18 months.

At the end of that continuation period of active employee coverage, if you are eligible for retiree medical coverage, you can elect to enroll in your available retiree medical coverage.

Continuation Of Retiree Medical Coverage

If you enroll in your available retiree medical coverage, coverage for you and your covered family members will end upon the occurrence of certain events as described in the immediately preceding "When Coverage Ends" section. However, your covered family members may have the right to continue medical coverage for a limited time in certain situations.

For example, if you are eligible for access-only coverage and you are a Travelers Retiree, termination of your retiree medical coverage at age 65 is not considered a COBRA qualifying event for you, but it is a qualifying event for your covered family members because they would otherwise lose their retiree medical coverage. This means that they would each be entitled to elect continuation coverage under the retiree medical plan for up to a maximum of 36 months.

If you die while covered under the retiree medical plan, your surviving spouse or domestic partner will not lose his or her retiree medical coverage, so your death will not be considered a COBRA qualifying event for your surviving spouse or domestic partner. However, if any other covered family members would lose their retiree medical coverage due to your death (e.g., because there is no surviving spouse), your death would be considered a COBRA qualifying event for them, and they would each be entitled to elect continuation coverage under the retiree medical plan for up to a maximum of 36 months.

Travelers currently extends the same continuation coverage options to your state spouse or domestic partner, but any such continuation would not be required by law and would not be under COBRA. Your family members qualify for this coverage if they would otherwise lose coverage due to a qualifying event (see table below). The coverage that your family members may continue is the same coverage they had under the plan before the event. They must pay the entire cost of this coverage, plus a 2% administrative fee. The cost of coverage may change each year.

Qualifying Events For Continuation Of Retiree Medical Coverage

This chart describes the events that permit the continuation of retiree medical coverage.

If this qualifying event happens:	Your family member's maximum continuation period is:
You (the retiree) are divorced, legally separated or your domestic partnership terminates	36 months
Your children become ineligible under the plan	36 months
You (the retiree) become entitled to Medicare	36 months for covered family members of Travelers Retirees only
You (the retiree) die and there is no covered surviving spouse or domestic partner	36 months for covered family members

Continuation Coverage

When Continuation Coverage Stops

Continuation coverage will stop before the end of the maximum continuation period in the table above if:

- The person continuing coverage becomes covered under another group plan or Medicare (unless the new plan limits or excludes a pre-existing condition);
- Travelers no longer provides group coverage for any of its retired employees; or
- The person continuing coverage did not pay the required premium on or before the due date.

Notification Requirements

If a covered family member loses coverage by reason of divorce, legal separation, termination of domestic partnership or a child losing eligibility status, you or a covered family member must notify ESU, in writing, within 60 days of the qualifying event in order for the covered family member to qualify for continuation coverage. The written notice must state the name of the employee and/or family members, the plan(s) under which they are covered (medical, dental, etc.), the qualifying event, and the date on which the event occurred. Failure to notify ESU within 60 days of the divorce, legal separation termination of domestic partnership or the loss of eligibility status will result in your covered family member's loss of continuation coverage rights. Travelers will consider a failure to notify Travelers when a family member becomes ineligible as an intentional misrepresentation. This may result in a retroactive loss of coverage for the family member that is not a rescission.

Premium Payments

If a covered family member elects continuation coverage, the first premium must be paid within 45 days of the date he or she elected to continue the coverage or coverage under the plan will end. If the covered family member fails to pay subsequent premiums within 30 days after they are due, his or her coverage will end as of the last day of the month for which payment was made.

Newborns/Adopted Children

Newborns and adopted children placed for adoption may be covered immediately under a parent's continuation coverage policy without regard to when the qualifying event occurs. Their continuation coverage ends 36 months after the qualifying event.

Role Of Insurer/TPA Provider

ERISA requires Travelers to disclose certain information about the role of each provider in the administration and financing of the Plan. This information is provided in the table below.

Name of Third Party Administrator	Plan Option	Whether Benefits are Guaranteed	Medical Plan Role
United Healthcare	Choice Plus, Out-of-Area, High Deductible, Health Plan 200, Medical 200 Plan, Medical 400 Plan, Comp. Plan-Medicare Eligible, Medicare Supplement and POS Medical Plans	United Healthcare does not guarantee payment of any benefits. All claims are payable by the Employee Benefit Trust and/or general assets.	Claims Administration, Claim Fiduciary
Blue Cross Blue Shield of Minnesota	BCBS Plan	Blue Cross Blue Shield does not guarantee payment of any benefits. All claims are payable by the Employee Benefit Trust and/or general assets.	Claims Administration, Claim Fiduciary
Express Scripts	All options	Express Scripts does not guarantee payment of any benefits. All benefit claims are payable by the Employee Benefit Trust and/or general assets.	Claims Administration, Claim Fiduciary first-level appeal*

*Express Scripts has contracted with MCMC, LLC for first-level claim appeal reviews for Travelers prescription drug plans.

The Travelers Employee Benefit Trust will be credited with any favorable claims experience, or charged for any unfavorable claims experience, during the year. Favorable claims experience will occur when the premiums paid during the year exceed the amount paid out in benefit claims and administrative expenses (including administrative service fees). Likewise, unfavorable claims experience will occur when the amount paid out in claims and administrative fees exceeds the annual premiums.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under ERISA, the Employee Retirement Income Security Act of 1974.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

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

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

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

Continue Group Health Plan Coverage

You may be able to continue coverage if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary and the documents governing the plan for the rule governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

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

Your Rights Under ERISA

Assistance With Your Questions

If you have any questions about your plan, you should contact UHC at 866.679.0947, Blue Cross Blue Shield of Minnesota at 888.279.4242 or Express Scripts at 877.494.7472. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Information

Plan Name

The Retiree Medical booklet describes two (2) separate plans: The Travelers Medical Plan, a component program under The Travelers Trusteed Employee Benefit Plan and the Travelers Retiree Medical Plan. The following plan options are offered under the applicable plan:

The Travelers Medical Plan, a component program under The Travelers Trusteed Employee Benefit Plan	The Travelers Retiree Medical Plan
• Choice Plus Plan • BCBS Plan • Out-of-Area Plan • High Deductible Plan	• Comprehensive Plan – Medicare Eligible • Comprehensive Plan – Medical Eligible – Medical Only • Medicare Supplement Plan • Medicare Supplement Plan – Medical Only • POS Plan • Medical 200 Plan • Medical 200 Plan – Medical Only • Medical 400 Plan • Medical 400 Plan – Medical Only

Type Of Plan

Both plans are welfare benefit plans.

Plan Sponsor And Administrator

Travelers is the "sponsor" and the "administrator" of each plan for purposes of ERISA. Travelers has contracted with Blue Cross Blue Shield of Minnesota, United Healthcare, and Express Scripts to provide claims administration under each plan. Travelers acts as administrator through its Administrative Committee, which is responsible for the general management and administration of both plans. Day-to-day administrative functions are performed by Blue Cross Blue Shield of Minnesota, United Healthcare, and Express Scripts.

You can obtain additional information about the Administrative Committee by contacting the ESU at 4-ESU@travelers.com or 800.441.4378.

General Information

Named Fiduciaries

Blue Cross Blue Shield of Minnesota is a named fiduciary for claims purposes for the BCBS plan option. Its address is:

P.O. Box 64338
St. Paul, MN 55164

United Healthcare is a named fiduciary for claims purposes for all medical plan options administered by UHC. Its address is:

P.O. Box 30990
Salt Lake City, UT 84130

MCMC, LLC is a named fiduciary for first-level claim appeal purposes for all Express Scripts administered prescription drug plans. Its address is:

Express Scripts, Inc.
Pharmacy Appeals – SST
6625 W. 78th St – BL0390
Bloomington, MN 55439

Medium For Providing Benefits

Benefits under the plans are provided through the Travelers Employee Benefit Trust and/or the general assets of Travelers.

Source Of Contributions

There are both employer and employee contributions.

Plan Year

The plan year for each plan is the calendar year.

Plan Number

The Travelers Retiree Medical Plan has been assigned the following identification number: 523.

Employer Identification Number

Travelers' federal employer identification number is 41-0518860.

General Information

Agent For Service Of Legal Process

Legal process may be served on Travelers at the following address:

Travelers Companies, Inc.
c/o Corporate Secretary
385 Washington Street, 9275-NB16A
St. Paul, MN 55102

Status of Plans Under Health Care Reform

The Travelers Retiree Medical Plan is not subject to the Patient Protection and Affordable Care Act (the Affordable Care Act, also known as Health Care Reform) because it only covers retirees (and not active employees), and therefore only provides coverage that is exempt from the HIPAA portability rules, as determined by the Internal Revenue Service (IRS) and Department of Labor (DOL). From time to time The Travelers Retiree Medical Plan may choose to voluntarily comply with certain laws that would not otherwise apply to retiree-only plans—for example, special enrollment rights under HIPAA. Such compliance is not intended to subject The Travelers Retiree Medical Plan to such rules, as a matter of law or to change the status of The Travelers Retiree Medical Plan as a separate retiree-only plan.

The Travelers Medical Plan, a component program under The Travelers Trusteed Employee Benefit Plan, covers both retirees and active employees and is administered in compliance with Health Care Reform.

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The Travelers Indemnity Company
and its property casualty affiliates
One Tower Square
Hartford, CT 06183

travelers.com