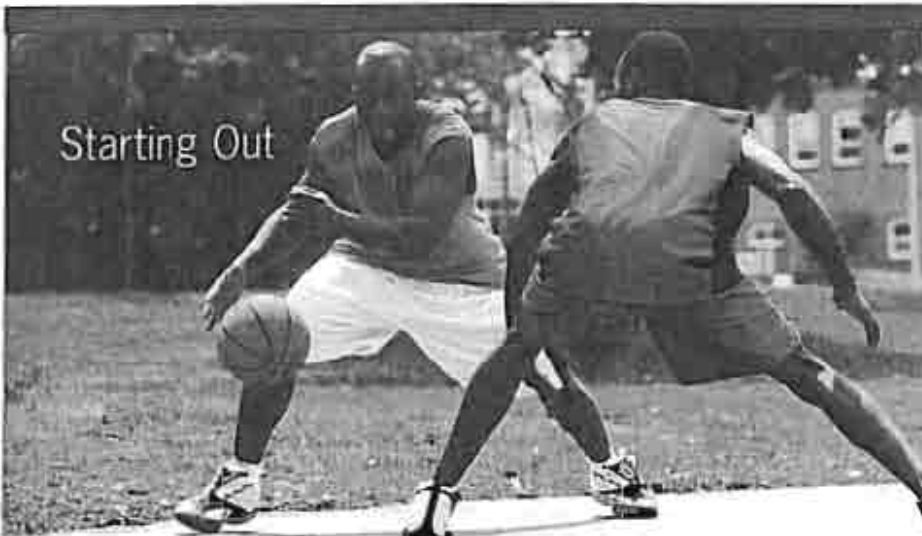


LANI



# Health insurance options for you.

Help with minor medical expenses.



Starting Out

## Benefit Highlights:

- Doctor visits as low as \$10
- Up to \$1,500 Outpatient Care
- Up to \$5,000 Accident Coverage
- Term Life Insurance
- Prescription Programs
- CIGNA 24-Hour EAP<sup>SM</sup>

Rates starting at only

**\$10.<sup>79</sup>** per paycheck



On Your Way



Family First

## Also Available:

- Dental Plan

Hurry! Your opportunity to enroll is now.

### Who is eligible?

All temporary, temp-to-hire, part-time, and payroll employees are eligible.

### When may I enroll?

Within 31 days of eligibility, or during the company's "Open Enrollment" period. It may not be necessary to wait until the next Open Enrollment period if you qualify as a "Special Enrollee."

### When will my coverage begin?

Your coverage will begin the first day of the month following your date of eligibility. Once your employer has approved your enrollment, you will receive your ID Cards and Summary Plan Description booklet containing claim forms.

Starbridge Select is not a major medical plan.

**STARBRIDGE** *Select*

A CIGNA Health Insurance Plan

a limited-benefit medical plan

1-877-552-5015

[www.starbridgeselect.com](http://www.starbridgeselect.com)

# STEP 1: Choose a Limited-Benefit Medical Plan.

Which plan is right for you? Whether you are single or married, young or middle-aged, with or without children, Starbridge Select has the right coverage for you. In order to take advantage of the best coverage available, you should enroll in Level 2. If it's too expensive, there are other plans to choose from below.



## Level 2

You are looking for more coverage than Level 1, but still within your budget. Additional benefits that help with bills for minor surgeries and maternity care are valuable to you.

- \$10 Doctor Visits
- \$1,500 Outpatient Care
- \$3,000 Inpatient Care
- \$300 Prescription Benefit
- Prescription Discounts<sup>4</sup>
- \$1,500 Surgery Benefit/ \$1,500 Maternity Benefit
- \$5,000 Accident Coverage
- \$15,000 Accidental Death Benefit
- CIGNA 24-Hour Employee Assistance Program<sup>SM</sup>
- Online Tools
- Beech Street Network



## Level 1

You feel you are healthy and only see a doctor once in awhile. However, you want a plan that provides basic coverage and allows you to get medical attention if needed.

- \$15 Doctor Visits
- \$1,000 Outpatient Care
- \$2,000 Inpatient Care
- Prescription Discounts<sup>4</sup>
- \$2,000 Accident Coverage
- \$10,000 Accidental Death Benefit
- CIGNA 24-Hour Employee Assistance Program<sup>SM</sup>
- Online Tools
- Beech Street Network

The benefits above are provided by policy form SBC11-GMP-02. Starbridge Select is not a major medical plan.

# STEP 2: Choose the Supplemental Plan.



## Dental/Vision\* Plan

The key to a healthy smile is to take care of your teeth before problems begin.

- Reimburses for 45 dental procedures/\$25 annual deductible
- Save on eye exams, frames, lenses & contacts

Cost Per	Myself only . . . . .	\$4.25
Paycheck* -	Myself and 1 dependent . . . .	\$8.20
	Family . . . . .	\$12.15

\*The discount vision program is not insurance. The rates above include the cost of the discount vision program. (\$.20 employee only; \$.50 employee + 1; \$.70 family)

<sup>4</sup>The prescription discount program is not insurance.

Questions, call a Benefits Specialist: 1-877-552-5015 • [www.starbridgeselect.com](http://www.starbridgeselect.com)

Once you've enrolled, you'll also receive access to **Healthy Rewards, a discount health and wellness program.** You can save up to 60% on fitness center memberships, weight management programs, health-related magazines, and much more!



**Level 2 – Cost Per Paycheck**

Myself only .....\$19.84  
 Myself and 1 dependent .....\$47.78  
 Family .....\$71.61

**Level 1 – Cost Per Paycheck**

Myself only .....\$10.79  
 Myself and 1 dependent .....\$25.61  
 Family .....\$38.16

# STEP 3: Enroll Now.

Choose Your Enrollment Method *(select one)*

Your Group Number: 2076

- A) Enroll by Fax: Simply complete this enrollment form and fax it to LANI's Human Resources Dept. at (949) 271-4703.
- B) Enrollment Form: Complete this enrollment form and run it in to your manager.
- C) If you have benefit questions, please call customer service at (877) 552-5015. LANI ID# 2076.

First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender M / F  
 Soc. Sec # \_\_\_\_\_ Hire Date \_\_\_\_\_ Unit # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Which Plan or Plans?**

*Check your desired plans. Prices reflect cost per paycheck. Once enrolled, changing to another plan level may only be done annually.*

- I want the **Level 2 Plan**
- I want the **Level 1 Plan**
- I want the **Dental Plan**

**Who Do You Want to Cover?**

*Check only one, even if multiple plans are chosen.*

- I want to cover myself only
- I want to cover myself and 1 dependent
- I want to cover my family

**Dependents**

*If additional spaces are needed, please attach separate sheet.*

Full Name	Gender	Relationship	Date of Birth

**Beneficiary**

*Person who will receive benefits in the event of your death.*

Print Full Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

X \_\_\_\_\_  
 Sign Here To Enroll Date

**Authorization:** By signing above I indicate my desire to enroll in Starbridge Select; confirm that I have named my beneficiary; and authorize my employer to deduct or reduce my pay for any contributions required by the plan.

*Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and maybe subject to fines and confinement in prison.*

**Declination Notice:** No, I do not wish to enroll in the coverage offered above. **WAIVER OF COVERAGE:** Failure to elect coverage (for yourself and/or any of your dependents) during the Open Enrollment Period may result in no coverage until the next Open Enrollment Period. It may not be necessary to wait for the next Open Enrollment Period if you qualify as a Special Enrollee. Please fill out top, sign, and date.

X \_\_\_\_\_  
 Signature if Declining Coverage Date

Some people need more than just a medical plan.



## Dental/Vision Plan

The Dental Plan provides coverage for common preventive and basic procedures, and you can save even more money by visiting a CIGNA Network dentist with more than 69,000 participating nationwide.\*

- \$25 annual deductible
- Reimbursement amounts examples:
  1. Exam - \$17
  2. Routine Cleaning - \$30
  3. Tooth Removal - \$39
  4. Filling (3 surfaces) - \$56

The key to a healthy smile is to take care of your teeth and gums before problems begin. Receiving regular dental care often catches minor problems before they become major and expensive to treat. For every \$1 spent on preventive dental care, \$8-\$50 could be saved in restorative and emergency treatment (Source: American Dental Hygienist Association). You'll find that coverage for most preventive services is provided at a reasonable cost.

### Example of How the Dental Plan Works For illustrative purposes only. Actual fee schedules vary by location.

Periodic Oral Exam (6 month cleaning)	Average Cost	\$36	
	<b>CIGNA Network Discount*</b>	-\$12	<b>You Save \$29</b>
	Dental Plan reimburses you	-\$17	
	<b>You Pay</b>	<b>\$7</b>	

\* For a complete list of covered procedures and participating network dentists visit [www.starbridgeselect.com](http://www.starbridgeselect.com)

## Vision Discount Program The vision discount program is not insurance.

You and your covered family members also receive a membership in the Vision One Network.

- Save up to 60% on frames and lenses
- Save up to \$10 on eye examinations

## What you get with the Starbridge Select limited-benefit medical plan.

Starbridge Select is a basic health plan to help cover the bills for minor illnesses and off-the-job accidents such as the flu or a broken arm. After you enroll, we'll provide you with tools to help save you money and get the most out of your benefits.

	Level 2	Level 1
<b>Doctor Office Visits*</b> copay plan pays	\$10 100%	\$15 100%
<b>Outpatient Care</b> deductible plan pays/you pay maximum amount paid by plan	\$100/year 80%/20% \$1,500/year	\$50/year 80%/20% \$1,000/year
<b>Inpatient Care</b> deductible plan pays maximum amount paid by plan	\$0 100% \$3,000/year	\$0 100% \$2,000/year
<b>Additional In-Hospital Surgery</b> deductible plan pays Maximum amount paid by plan	\$0 100% \$1,500/occurrence	Included in Inpatient Benefit
<b>Additional Maternity Benefit</b> deductible plan pays maximum amount paid by plan	\$0 100% \$1,500/occurrence	Included in Inpatient Benefit
<b>Non ER Care in ER Room*</b> deductible plan pays/you pay maximum amount paid by plan	\$100/occurrence 50%/50% \$500/year	\$100 / occurrence 50%/50% \$500/year
<b>Wellness Benefit<sup>†</sup></b> copay plan pays number of occurrences maximum amount paid by plan	\$20 100% 1/year \$100	not included
<b>Prescription Benefit</b> copay plan pays maximum amount paid by plan	discount program included <sup>§</sup> \$15/generic, \$30/Pref. brand 100% \$300/year	discount program included <sup>§</sup>
<b>Accident Coverage</b> deductible plan pays/you pay number of occurrences maximum per occurrence maximum amount paid by plan	\$50/occurrence 80%/20% 2/year \$2,500 \$5,000/year	\$50/occurrence 80%/20% 2/year \$1,000 \$2,000/year
<b>Accidental Death Benefit</b> plan pays	\$15,000	\$10,000
<b>Additional Services</b>		
<b>CIGNA 24-Hour EAP<sup>SM</sup></b> health information line audio library of health topics EAP consultation	unlimited unlimited 3 per presenting problem	unlimited unlimited 3 per presenting problem
<b>Online Tools</b> locate doctors in our network compare doctors by price track status of claims	included	included

The benefits above are provided by policy form SBCII-GMP-02. All yearly benefits are paid per coverage year.

\* The total amount Starbridge Select pays will count toward your Outpatient Care maximum.  
<sup>§</sup> The prescription discount program is not insurance.    <sup>†</sup> Provision varies by state.

## SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or Qualified Medical Child Support Order you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Loss of coverage (non-COBRA) that can qualify for Special Enrollment includes, but is not limited to:

Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage when a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

To request special enrollment or obtain more information, contact a Customer Service representative at 1-877-552-5015. Representatives are available Monday through Friday, 5 AM to 6 PM, Mountain Standard time.

**LIMITATION FOR PRE-EXISTING CONDITION**<sup>1</sup> – A Pre-existing Condition is one in which you have been diagnosed, treated or sought advice from a physician during the 6 months before becoming insured. A condition will no longer be pre-existing after 12 months of continuous coverage.

Benefits are not paid for a Pre-Existing condition. Pre-existing coverage does not apply to a pregnancy or to newborn or adopted children. The pre-existing limitation can be reduced by the amount of time you were previously insured if you became insured under this policy within 63 days after termination of prior coverage.

**BENEFIT LIMITATIONS**<sup>1</sup> – Coverage is not provided for services, supplies or equipment when a charge is not usually made in the absence of insurance.

No coverage is provided for loss caused by or resulting from:

1. Injury or sickness arising out of or in the course of employment;
2. War or act of war;
3. Expenses which are not ordered by a Physician;
4. Cosmetic surgery. This does not apply to reconstructive surgery due to:
  - a. trauma, infection, or other disease; or
  - b. congenital disease or anomaly of a covered dependent newborn or adopted infant; or
  - c. surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
5. Hearing examinations or hearing aids;
6. Vision services and supplies other than for a disease process, radial keratotomy, keratomileusis or excimer laser photorefractive keratotomy or similar type procedures or services;
7. Charges made by a health care provider who is a member of your family or who is living with you;
8. Custodial Care confinement in a Hospital or Skilled Nursing Facility;
9. Home Health Care Services, unless provided in place of a Hospital confinement.
10. Commission of a felony;
11. Manipulations of the musculoskeletal system;
12. Treatment of mental or nervous disorders, alcoholism, or any form of substance abuse;
13. Intentionally self-inflicted injury or suicide attempt;
14. Dental care and treatment, except that required by injury and rendered within 6 months of the injury;
15. Treatment which is experimental or investigational;
16. Any expense incurred after the date the policy terminates.

**DEFINITION OF DEPENDENT**<sup>1</sup> – Your Dependent is:

1. Your spouse;
2. Your unmarried children under 19 years old, and
3. Your unmarried children who are 19 years old through 25 years old if the child is attending an accredited school full time and is dependent on you for support.

**ACCIDENTAL DEATH** – No coverage is provided by death caused by:

1. War or act of war;
2. Suicide within 2 years of your effective date;
3. Medical or surgical treatment of sickness of disease; or
4. Flight except as a passenger in a commercial airline.

### DENTAL EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

1. Services or supplies for which a charge is not customarily made in the absence of insurance;
2. Injury arising out of or in the course of employment; or which is compensable (in South Dakota, which is paid) under any Workers' Compensation or Occupational Disease Act or Law;
3. Declared or undeclared war, or act of war;
4. A service furnished to a Covered Person for:
  - a. Cosmetic purposes, unless needed as a result of injury. Facing on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic;
  - b. Dental care of a congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule of Benefits);

5. Replacement of lost or stolen appliances.

6. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint. In Arkansas, treatment for the temporomandibular joint is not excluded.

7. A service not furnished by a Dentist, except:

- a. That performed by a Dental Hygienist under the supervision of a Dentist;
- b. X-rays ordered by a Dentist.

8. Any service furnished during the 30-day period starting on the date coverage becomes effective for a Covered Person, unless needed as a result of injury. This limitation applies only to a Covered Person who must submit evidence of good health before coverage becomes effective. This exclusion does not apply to Maryland residents.

9. Intentionally self-inflicted injury or suicide attempt.

### TERM LIFE INSURANCE EXCLUSIONS

If a Covered Person should die while insured under the policy, We will pay the amount of life insurance in force on the Covered Person's life at the time of death. Payment will be made in one sum to the beneficiary designated by the Covered Person. Payment will be made upon Our receipt of due proof of death. If there is no surviving named beneficiary, payment will be made to the Covered Person's estate. In such case, at Our option, payment may be made to any one or more of the following relatives: wife, husband, father, mother, child or children, brothers or sisters.

### Change of Beneficiary

The Covered Person may name a new beneficiary at any time by filing with the Holder a written request on forms furnished by Us. The Holder will send the request to Us. When the request is received by Us from the Holder the change will relate back to and take effect as of the date it was signed. This is the case whether the Covered Person is alive or not when We receive the request. Even though the change of beneficiary will relate back to the date it was signed it will be without prejudice to Us on account of any payment We have already made.

### Benefit Limitations

No coverage is provided for loss caused by or resulting from:

1. Death as a result of aviation or any air travel or flight;
2. Death while the Covered Person is a resident outside the United States, U.S. Territories, and Canada; or
3. Death within 2 years from the Covered Person's effective date of coverage as a result of suicide, while sane or insane.

### TERMINATION

A Covered Person's coverage will terminate at 12:01 a.m. Standard Time at Your home

on the earliest of the following:

1. The date the Policy terminates;
2. The date this Certificate terminates;
3. The date coverage is terminated by Us for all certificate holders in Your state;
4. The date We receive Your written request to have Your insurance terminated;
5. The end of the period for which premium is paid, subject to the Grace Period;
6. The date a Covered Person enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces;
7. With respect to a Dependent spouse, the date the spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage provision;
8. With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment premium.

### FOOTNOTES

<sup>1</sup> This provision or limitation varies by state.

Underwritten by Connecticut General Life Insurance Company. This plan is not available in WA. Plan design and rates may vary. "CIGNA" and "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

This brochure is intended as a brief summary of the Starbridge Select Plan; the Insurance Certificate, the insurance policy and state specific variations, are the official documents governing this Plan. Administered by: Connecticut General Life Insurance Company, P.O. Box 55270, Phoenix, AZ 85078-5270.

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