The Vanguard Group, Inc. Benefit Plan for Retirees 2018

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General Plan Information

This document serves as the Summary Plan Description (SPD) for The Vanguard Group, Inc. Benefit Plan for Retirees (the "Plan" or the "Retiree Plan") and, together with the Plan booklets (Plan booklets are available on CrewNet), serves as the Plan Document for the Plan. This SPD contains important information regarding the benefit provided by The Vanguard Group, Inc. to eligible retired crew members (as defined below) under the Plan.

This SPD reflects the Plan as amended and restated effective January 1, 2018. This SPD describes the basic features of the benefits available and how they operate. As used in this SPD, "Vanguard" refers to The Vanguard Group, Inc., Vanguard Marketing Corporation, Vanguard Advisers, Inc., Vanguard Fiduciary Trust Company, and Vanguard National Trust Company. As used in this document, "Retired crew member" or "Retiree" (used interchangeably) refers to their former employees who were eligible crew members on the U.S. payroll (each as defined in the SPD for The Vanguard Group, Inc. Benefit Plan) while employed by Vanguard and who met the requirements to qualify as a Retiree at the time of their termination of employment from Vanguard as set forth in Section I below in this SPD.

Organization of this SPD

This SPD document is separated into eight sections. Section I defines who is an Retiree for purposes of this SPD. Section II describes the Retiree Medical Account (RMA). Section III describes the health coverage you may purchase through the Plan. Section IV describes domestic partner coverage under the various benefits offered to Retirees under the Plan. Section V explains life insurance coverage and Section VI describes other benefits offered by Vanguard for which Vanguard pays the full cost. The remaining Sections explain the Plan's claims and appeals process and other administrative details. Please see Section VIII about your rights to receive information about your Plan and benefits.

SPD describes ERISA and Non-ERISA governed benefits

Benefits subject to ERISA are described in this SPD for purposes of satisfying the written instrument requirements of ERISA section 402. Similarly, benefits that are not subject to ERISA are described in this SPD and included solely as an administrative convenience to Vanguard, and shall not be construed as subject to ERISA.

Claims Procedures

Please be aware that if you have a claim or appeal for benefits under the Plan, Section VII – When You Have a Claim for Benefits, explains the requirements and timing deadlines applicable to all claims and appeals.

Please Note

This SPD describes the health and welfare benefit plans provided by Vanguard to eligible retired crew members and serves as the summary plan description required for benefits covered by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Every effort has been made to report correct information.

Some of the benefits described in this SPD have Plan booklets that are available on CrewNet. In the event of any differences between this SPD and the Plan booklets regarding the benefits covered or provided under the Plan (e.g. covered services, exclusions, pre-certification requirements, etc.), the Plan booklets will control. In contrast, this SPD will control rules for retiree and dependent eligibility for coverage, as well as enrollment and election rules; provided, however, that for fully insured benefits, the Plan booklets, which are certificates of insurance coverage and/or insurance policies must also govern rules for retiree and dependent eligibility for coverage. The fully insured benefits provided under the Plan are vision and life insurance. All other benefits described in this SPD and provided under the Plan are self-insured and paid out of Vanguard's general assets.

Vanguard has the right to amend, modify or terminate any and all benefits provided under the Plan at any time. No consent of any participant or beneficiary is required for Vanguard to exercise its right to do so.

This SPD (along with the Plan booklets) is made available electronically at the onset of retirement, on CrewNet External (https://crewnet.vanguard.com), and available by contacting Vanguard Crew Central™ at 844-VG1-CREW (844-841-2739). You may also request paper copies of the SPD or any part thereof free of charge by calling Vanguard Crew Central.

Whom To Call…

If you have questions about benefits or coverage under any of the programs described in this SPD, please call the following phone numbers and access the following. If you have any other questions, please call Crew Central at 844-VG1-CREW (844-841-2739), or you can find additional information through CrewNet External (https://crewnet.vanguard.com).

Benefit Program	Whom To Call	Website address
Best Doctors	Best Doctors 866-904-0910	www.bestdoctors.com
Crew Assistance Program	Carebridge 800-437-0911	www.myliferesource.com access code R6C39
COBRA Administrator	WageWorks 888-251-6982	https://benedirect.wageworks.com
Dental	Delta Dental 800-471-1282	http://www.deltadentalins.com/vanguard
Health Advocate	Health Advocate 855-424-9400	www.healthadvocate.com/vanguard
Medical	Aetna 800-938-0512	www.aetna.com
Prescription Drug	CVS Caremark 866-559-6903	www.caremark.com
Retiree Health Plan Administrator	PayFlex Systems USA, Inc. 1-888-678-7835	www.payflex.com
RMA Administrator	WageWorks 888-251-6982	https://myspendingaccount.wageworks.com
Vision	VSP 800-877-7195	http://vanguard.vspforme.com

Section I – Retirement

A. Definitions

The following definitions will help you understand Vanguard's Retirement Policy:

- **Affiliate** means, with respect to Vanguard, any company that is a member of a controlled group of corporations as defined in Section 414(b) of the Internal Revenue Code (Code), which also includes Vanguard as a member; any trade or business under common control, as defined in Section 414(c) of the Code, with Vanguard; any organization, whether or not incorporated which is a member of an affiliated service group, as defined in Section 414(m) of the Code, which includes Vanguard; and any other entity required to be aggregated with Vanguard pursuant to Treasury regulations under Section 414(b) of the Code.

- **Annual RMA Credit** is an annual increase in the amount of the RMA and Spousal RMA unfunded balance. As a Retiree, you are eligible to be credited with an Annual RMA Credit beginning the year following the year in which you terminate employment after meeting the requirements to qualify as a Retiree. Annual RMA Credits are added to the RMA and Spousal RMA early in the following year for the prior year. As an example, if you retire in 2018, your first Annual RMA credit will be for the 2019 calendar year and will be added to your RMA balance in early 2020.

- **Break in Service** is a calendar year in which you did not complete at least one Hour of Service.

- **Hour of Service** is any hour for which you are paid for services performed for Vanguard or an Affiliate. You also will be credited with an Hour of Service for every hour that Vanguard pays you for scheduled or unscheduled paid time off (PTO), holiday, layoff, bereavement, jury duty, and approved hours taken under a military leave as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Hour of Service excludes paid and unpaid leave hours other than military leaves under USERRA.

- **Retiree** is what you will qualify as, if, at termination of employment from Vanguard, (1) you are at least age 50; (2) you have 10 or more Years of Eligible Service; and (3) your age plus Years of Eligible Service total at least 65. "**Retired"** shall be construed accordingly.

- **Retiree Medical Account (RMA)** is an unfunded account established by Vanguard to reimburse a portion of after-tax health insurance premiums paid.

- **Spousal Retiree Medical Account (Spousal RMA)** is an unfunded account established by Vanguard for the spouse of a Retiree to reimburse a portion of after-tax health insurance premiums paid.

- **Vanguard** refers to The Vanguard Group, Inc., Vanguard Marketing Corporation, Vanguard Advisers, Inc., Vanguard Fiduciary Trust Company, and Vanguard National Trust Company.

- **Year of Eligible Service** is a 12-month period beginning on your date of hire, or rehire, in which you are credited with a minimum of 1,000 Hours of Service.

- **Year of Credited Service** is a 12-month period in which you work at least 1,000 Hours of Service, beginning with the month you reach age 40, or are hired, or rehired, whichever is later. You earn one full Year of Credited Service as soon as you work 1,000 Hours of Service in such 12-month period. For 12-month periods ending on or before December 31, 2014, you must work at least 1,000 hours and 6-months during your final 12-month period to earn a full Year of Credited Service.

B. Eligibility

You will qualify as a Retiree if, at termination of employment from Vanguard, (1) you are at least age 50; (2) you have 10 or more Years of Eligible Service; and (3) your age plus Years of Eligible Service total at least 65.

(Please see the Definitions in Section I.A.)

Examples at termination of employment from Vanguard:

- Joe is age 50 and has 15 Years of Eligible Service and qualifies as a Retiree.
- Jane is age 55 and has 10 Years of Eligible Service and qualifies as a Retiree.
- John is age 52 and has 12 Years of Eligible Service and does not qualify as a Retiree because his Years of Eligible Service (12) and his age (52) do not total 65.

If you terminate employment with Vanguard and then are rehired, you will be credited with your prior Years of Eligible Service and your prior years of Credited Service as follows:

- If you worked for Vanguard for five calendar years or less before you terminated employment and you incurred fewer than five Breaks in Service before being rehired.
- If you worked for Vanguard for more than five calendar years before you terminated employment and the number of Breaks in Service you incurred was fewer than the calendar years you originally worked at Vanguard.

Otherwise, you will not be credited with any prior service when you are rehired, and both your Years of Eligible Service and your Years of Credited Service will be calculated starting from your rehire date.

Section II – Retiree Medical Account

Introduction

Vanguard will establish an unfunded Retiree Medical Account (RMA) for Retired crew members who meet the eligibility requirements of Retiree (see Section I above) at the time they terminate employment from Vanguard. You may use your RMA to help offset up to 75% of the cost of after-tax health insurance premiums you paid for yourself, your spouse or domestic partner who is your tax dependent for health coverage purposes, or your eligible dependents up to age 26 as defined by the Plan.

Please note: Different rules apply for a small group of existing retirees. As a result, some retirees are not eligible for the RMA and the maximum reimbursement percentages differ for other retirees.

How the Account Works

When you terminate employment as a Retiree, Vanguard will establish an unfunded RMA on your behalf. Your RMA will be credited with a balance equal to $5,500 for each Year of Credited Service in which you work at Vanguard. A Year of Credited Service is a 12-month period in which you work at least 1,000 Hours of Service, beginning with the month you reach age 40, or are hired or rehired, whichever is later.

If you are married when you terminate employment as a Retiree, and except as described in the section below titled, "Crew Members Married to Crew Members or Former Crew Members", Vanguard will establish a Spousal RMA on behalf of your spouse in an amount equal to 50% of your initial RMA balance. If you get married after you become a Retiree, Vanguard will establish a Spousal RMA on behalf of your spouse in an amount equal to 50% of your RMA balance as of the date of the marriage.

For every calendar year after the calendar year in which you first terminated employment as a Retiree, $1,000 will be added to your RMA (and $500 will be added to your eligible spouse's Spousal RMA) as an Annual RMA Credit. Annual RMA Credits are then added to your RMA balance (and the Spousal RMA balance of your eligible spouse, if applicable) in the following calendar year. For example, if you retire in 2018, your first Annual RMA credit will be for the 2019 calendar year and will be added to your RMA balance in early 2020.

Example: On September 10, 2018, Joe qualifies as a Retiree when he terminates employment with Vanguard and his RMA is credited with a starting balance of $55,000. His spouse's RMA is credited with $27,500. In January 2019, Joe and his spouse do not receive an Annual RMA Credit because Annual RMA Credits credited in January 2019 are for 2018, the year in which Joe terminated employment as a Retiree. Their first Annual RMA Credit will be for 2019 (the year after Joe Retires from Vanguard) and will be credited in early 2020.

Please note: An RMA will not be established for other dependents, such as dependent children or domestic partners.

If you or your RMA covered spouse dies, the amount credited to the RMA of the decedent is forfeited. The surviving person may use only his or her own RMA. However, the surviving spouse or family member has until one year from the date of death to submit any amounts eligible for reimbursement that the decedent incurred prior to his or her death. If you get divorced, your ex-spouse ceases to be eligible for the RMA and no reimbursements will be available to the ex-spouse for amounts paid after the date of the divorce.

No reimbursements may be paid, from the account of a deceased Retiree, RMA covered spouse, or ex-spouse for expenses incurred after the date of death or divorce. If accidentally paid, such reimbursements must be paid back to Vanguard. If these expenses are not repaid to Vanguard within a predetermined time frame, the balance of your remaining RMA will be reduced by the ineligible reimbursements.

For details on what expenses are covered through your RMA, see the “Reimbursement from an RMA” section below.

Crew Members Married To Crew Members or Former Crew Members

If you and your spouse both work at Vanguard until each of you terminate employment as a Retiree, Vanguard will establish an RMA on behalf of each of you. Since both of you will be eligible to receive an RMA as Retirees of Vanguard, no Spousal RMA benefit is available.

If you are considered a Retiree and your spouse left Vanguard before becoming a Retiree, your spouse will receive a Spousal RMA established on their behalf and will not be entitled to an RMA of their own. The Spousal RMA balance will be calculated based on the date you terminate employment from Vanguard as Retiree, not the date your spouse left Vanguard. **If this scenario applies to you and your spouse, it is your responsibility to contact Crew Central to ensure the correct starting balance is established for the spousal RMA.**

If you terminate employment as a Retiree and your spouse is still employed at Vanguard, you may receive medical coverage, including prescription drug, dental, and vision, through their medical plan as long as your spouse is eligible for such benefits as an active crew member.

Please note: For details on how the RMA and Spousal RMA are credited, see the “Retiree Medical Account” section above.

Examples of RMA Balance Calculation

Example 1

Don was hired at age 35 and qualifies as a Retiree when he terminates employment at age 60. His RMA was determined based on 20 Years of Credited Service (the years after age 40), giving him a balance of $110,000 for future health insurance premiums (20 years x $5,500). Since Don was married when he became a Retiree, his spouse received an RMA with a $55,000 balance (50% of $110,000). Vanguard will add $1,000 to Don's RMA and $500 to his spouse's Spousal RMA annually, first starting for the calendar year following the year of his retirement. If Don Retired in 2018, his first Annual RMA credit will be for the 2019 calendar year and will be added to his RMA balance (along with Spousal RMA balance) in early 2020.

Example 2
Denise was hired at age 55 and qualifies as a Retiree when she terminates employment at age 65. Her RMA was determined based on 10 Years of Credited Service, giving her a balance of $55,000 (10 years x $5,500). Since Denise was not married when she became a Retiree, there was no spousal RMA benefit. Vanguard will add $1,000 to Denise's RMA annually, first starting for the calendar year following the year of her retirement. If Denise Retires in 2019, her first Annual RMA credit will be for the 2020 calendar year and will be added to her RMA balance in early 2021.

Reimbursement from a RMA

As a Retiree, you may receive a reimbursement from your RMA for after-tax health insurance premiums (to include medical, prescription, dental and/or vision coverage) you paid on behalf of yourself, your spouse or domestic partner who is your tax dependent for health coverage purposes, or your eligible dependents. These include premiums for Vanguard and non-Vanguard-sponsored health plans, premiums for other employer-sponsored plans, COBRA premiums, individual policy premiums, Medicare premiums, and/or Medigap premiums. You may request a reimbursement for up to 75% of the after-tax premiums you paid. Premiums reimbursed may be those you paid while you were employed by Vanguard, however they must have been paid for on an after-tax basis, not through a pre-tax, cafeteria plan

You can request reimbursement for eligible expenses for up to two years from the date the expense was incurred. For example, you can submit a reimbursement request for your Medicare Part B expenses paid on December 31, 2014 through December 31, 2016. The only exception is in the event of the death of you or your spouse, in which case, eligible expenses incurred prior to the date of death must be submitted no later than one year from the date of death.

You cannot use your RMA for out-of-pocket expenses such as co-payments, deductibles, coinsurance, non-health care premiums (i.e., long-term care insurance premiums), or other expenses not covered by insurance (i.e., elective cosmetic surgery).

You can request reimbursement by submitting a claim form and proof of the expense (i.e., COBRA invoices, Medicare statements, etc.) via mail, fax, or online to Vanguard's RMA Administrator. You will be given the option to establish direct deposit with the RMA Administrator.

As a Retiree, you will have the ability to submit reimbursements through your own RMA, your spouse's RMA, or both. For example, based on age, costs, and RMA balances, you may want to submit a portion of your spouse's after-tax premiums through your own RMA and a smaller (or larger or equal) portion through your spouse's Spousal RMA.

You do not have to use your RMA immediately upon retirement. You decide when and how much you want to be reimbursed from the RMA, up to a maximum of 75% of your after-tax premiums. You will receive an annual statement of your RMA balance (and if applicable, your spouse's Spousal RMA balance).

Your RMA is an unfunded account. You may be reimbursed as you incur eligible expenses; however, you (or your spouse or other eligible dependents) are not eligible to receive a cash equivalent in lieu of the RMA.

Administration and Termination/Amendment

The Vanguard Group, Inc. Benefits Committee is the Plan Administrator for the RMA under the Retiree Plan and as such is responsible for the application and interpretation of the RMA benefit provided under the Retiree Plan. As with all the benefits provided under The Vanguard Group, Inc., Benefit Plan, Vanguard reserves the right to amend, modify or terminate retiree benefits and RMA benefits provided under the Retiree Plan and/or described in this SPD at any time. No consent of any participant (or Retiree) or beneficiary is required for Vanguard to exercise its right to do so. This means even after you retire, Vanguard may reduce or eliminate the Retiree Medical Account.

For More Information

To answer any questions you may have regarding benefits you are entitled to as a Retiree, contact Vanguard Crew Central by calling 844-VG1-CREW (844-841-2739).

Section III – Health Benefits

Introduction

The Plan offers comprehensive health benefits including medical with prescription drug, dental, and vision benefits (collectively referred to as "Health Benefits"). These Health Benefits are subject to ERISA.

Eligibility

You are eligible to elect health benefits, only if:

- You are a Retiree who meets the eligibility requirements in Section I;
- You are under the age of 65;
- You are not Medicare eligible; and
- Your Vanguard COBRA coverage has terminated.

You are eligible to elect health benefits for your dependents, only if:

- You are a Retiree who meets the eligibility requirements in Section I;
- You or your spouse/domestic partner are under the age of 65;
- Your dependents meet one of the following definitions of eligible dependent below;
- Your dependents are not Medicare eligible; and
- Your dependents' Vanguard COBRA coverage has terminated.

Your Eligible Dependents

You may enroll your eligible dependents for health benefits at the same time you enroll yourself. Your eligible dependents include the following:

- Your legally married spouse.
- Your eligible domestic partner. As used here and throughout this SPD, the words "domestic partner" means any individual who meets the eligibility requirements as defined by the Plan in Section IV of this SPD.
- Any child(ren) under age 26:
    - Natural children, legally adopted children (including a child who you are legally obligated to support in anticipation of adopting such child, even if the adoption is not yet final), foster children, and stepchildren.
    - Any child for whom you are required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree, or order (including a settlement agreement or administrative notice), issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process under state law that has the force and effect of law in that state, which creates or recognizes the existence of the right of a child to, or assigns to such child the right to, receive benefits for which a participant is eligible under the Plan, and which the Plan Administrator determines meets the requirements of ERISA. The effective date of coverage for the child shall be the date specified in the QMCSO, or if none, the date of the QMCSO. (You or your beneficiary may request a copy of Vanguard's QMCSO Procedures from the Plan Administrator without charge.)

- Any child(ren) age 26 and older who remains continuously mentally or physically disabled and primarily dependent upon you for support. A dependent child who meets the above eligibility requirements will continue to be eligible until the day he or she reaches the limiting age, unless he or she is disabled as described above. Application for continued coverage for a disabled child must be made within 31 days of the child's 26th birthday. Proof may be required to support the continuation of the disability. Coverage will stop at the earlier of: the end of the child's disability, failure to give proof that the disability continues, failure to have any required examination, or the end of the child's status as your dependent.

Note: No person may be covered as a dependent of more than one crew member or former crew member.

Enrollment

You may elect your benefits in the packet sent to you from the Retiree Health Plan Administrator or any other procedure approved by the Plan Administrator. You must pay for the cost of this coverage. The cost of coverage will be provided in the packet sent to you from the Retiree Health Plan Administrator and is subject to change.

You may enroll yourself and your eligible dependents in the Plan during the first 30 days after you terminate employment as a Retiree, after your Vanguard COBRA coverage has terminated, or during the annual open enrollment period.

You may not choose different options within the same benefit for your dependents. For example, if the Retiree is enrolling an eligible dependent (spouse, domestic partner or child) for coverage under a medical option (e.g., the HDHP) including prescription coverage, the eligible dependent must be enrolled in the same option (HDHP) as the Retiree.

Enrollment Changes

You may change your health benefit elections during the annual open enrollment period.

During the year, you cannot start or increase your level of your elected health benefits unless you have a permitted election change event, as described below. Please note, you do not need a permitted election change to stop or decrease your level of benefit coverage. If you experience a permitted election change event, you may be allowed to start or increase your level of elected health coverage for the balance of the Plan Year after the change, provided your election change is on account of and consistent with a change in status that affects eligibility, and is permitted under the terms of the Plan.

The following life events are among those that may be treated as permitted election change events ("Event"):

- A change in status which includes:
    1. A change in your legal marital status;
    2. A change in the number of your eligible dependents;
    3. Termination or commencement of employment, by you, your spouse, or your eligible dependent;

4. A change in work hours or employment status for your spouse or your eligible dependent (such as commencement of or return from unpaid leave) that results in a change in eligibility for your spouse or your eligible dependent for benefits under this Plan or another plan;
5. Your dependent satisfies or ceases to satisfy the eligibility requirement for a particular benefit; and
6. A change in place of residence or work for you, your spouse or your eligible dependent that affects benefits coverage;

- You, your spouse or your eligible dependent become entitled to a special enrollment right under a group health plan;
- A change in coverage attributable to your spouse's or your eligible dependent's employment;
- A significant increase or decrease in the cost of coverage of a Vanguard plan;
- A significant increase in the cost of your spouse’s or eligible dependent’s plan;
- You, your spouse or eligible dependent becomes enrolled under Medicare or Medicaid;
- You, your spouse or eligible dependent cease to satisfy the eligibility requirements under Medicaid or a state Children’s Health Insurance Program (CHIP);
- You, your spouse or eligible dependent become eligible for a premium assistance plan under Medicaid or CHIP;
- A qualified judgment, decree or order requires health coverage for a dependent child.

(Please refer to this Section below for Special Enrollment Rights and Section IV for eligible domestic partner status changes.)

Any change to the benefit elections must be on account of and consistent with the underlying Event.

If you want to start or increase your level of benefit coverage during the year because you experience an Event, you must notify the Retiree Health Plan Administrator within 30 days of such Event. There are two exceptions related to this general rule: If you or your eligible dependents lose coverage under Medicaid or CHIP, you have 60 days after the termination of coverage to notify the Retiree Health Plan Administrator to change your benefit elections; if you or your eligible dependent becomes eligible for Medicaid or CHIP, you have 60 days after eligibility is determined to notify the Retiree Health Plan Administrator to make a change to your benefit elections.

Once your dependent child(ren) reaches age 26 and no longer meets the eligibility requirements of the Plan, their coverage will end at midnight on the last day of the month in which they turn 26.

You must provide acceptable proof of your change in status and documentation that supports the change you are requesting to make to your benefit elections within 30 days of the date you notify the Retiree Health Plan Administrator of the change in status. Otherwise, you will have to wait until the next annual open enrollment period to make start or increase your level of benefit coverage.

The Retiree Health Plan Administrator will determine whether a requested change is on account of and consistent with a permitted election change and thus permitted under the terms of the Plan. The ability to make an election change may vary by benefit.

It is extremely important that you make sure your elections are accurate. If you find any errors, contact the Retiree Health Plan Administrator immediately. If you fail to report any errors: (i) within 30 business days after you receive your invoice or following an Event, or (ii) before the end of the plan year following the annual open enrollment period (e.g. December 31, 2018 for 2019 benefits coverage), you will be unable to start or increase your level of benefit coverage until the next open enrollment period or under special circumstances as described under Special Enrollment Rights.

Cost of Coverage

Your payments toward health care coverage (medical including prescription drug, dental, and vision) will be paid on an after-tax basis. The amount of these contributions will be provided in the enrollment materials and is subject to change. In addition to your premiums, you may also be required to pay a deductible or coinsurance at the time services are provided. The amount of the deductibles or coinsurance for each service/benefit will be provided in the annual enrollment materials as well as the Plan booklets and is subject to change.

Coverage Category Options

You may elect one of the following coverage categories:

Coverage category
Retiree only
Spouse/domestic partner (DP) only
Retiree and spouse/DP
Retiree and one child
Spouse/DP and one child
Retiree and spouse/DP and one child
Retiree and two or more children
Spouse/DP and two or more children
Family (Retiree and spouse/DP and two or more children)
Child
Children (two or more)

Provider Networks

Medical, prescription drug, dental, and vision benefits are administered by third-party administrators who have contracted with health care providers and pharmacies to provide treatment at negotiated rates and/or discounts. Coverage for services provided by network providers may differ from those provided by non-network providers. Please refer to the provider directories for each benefit for that third party administrator's list of network providers. Directories are located on each third party provider's website:

Dental	www.deltadentalins.com/vanguard
Medical	www.aetna.com
Prescription Drug (included with your medical coverage)	www.caremark.com
Vision	http://vanguard.vspforme.com

If you would like a hard copy of the provider directory, please contact the third party administrator for the specific benefit. While the provider directories are believed to be accurate as of the print date, they are subject to change without notice. Participating providers are independent contractors in private practice and are not employees or agents of the third party administrators or of their affiliates.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directories may be accepting new patients. Although the third-party administrators may have identified providers who were not accepting patients as known at the time the directory was created, the status of a provider's practice may have changed. For the most current information, you should call the third party administrator's number on the back of your ID card for that benefit.

Special Enrollment Rights

You may enroll yourself and your dependents in the Plan during the first 30 days after you retire, after your Vanguard COBRA coverage has terminated, or during the annual open enrollment period. If you do not enroll during either of these enrollment periods, and if you have declined enrollment for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may subsequently be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. However, if you have declined enrollment for yourself or your dependents (including your spouse) because of medical coverage under Medicaid or CHIP, you have 60 days after the termination of that coverage to request enrollment for yourself or your dependents.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you or your dependent becomes eligible for Medicaid or CHIP, you have 60 days after eligibility is determined to notify Retiree Health Plan Administrator if you want to make a change to your benefit elections.

Once you have requested a change to your benefit elections, you must provide acceptable proof of your change in status to the Retiree Health Plan Administrator and submit the benefit election changes within 60 days of the event. Otherwise, you will have to wait until the next annual open enrollment period to make any changes.

If you experience an event that triggers special enrollment rights (dependent loses coverage under other plan, marriage, birth, adoption or placement for adoption) you may change both the level of your coverage (for example, from retiree only to retiree plus spouse) and the benefit option (for example, from the high deductible health plan to the Aetna Retiree Choice POS II). Such changes must generally be requested within 30 days after the occurrence of the triggering event.

In the event of a special enrollment right due to marriage, birth, adoption, or placement for adoption, coverage is retroactive to the date of the event, provided that you request enrollment of your dependent within 30 days of the event. The invoice following the period in which the Retiree Health Plan Administrator is notified will reflect the change in the cost of your benefits.

Termination of Coverage

Termination of your medical and prescription, dental, and/or vision coverage (and that of a spouse, domestic partner or dependent) for a particular health benefit under the Plan occurs at the earliest of the following:

- The Plan or the offered benefit terminates;
- The date the Retiree is no longer eligible for the benefit; or
- The date the Retiree fails to make any required contribution at the end of the period for which a contribution was required.

A. Medical and Prescription Drug Benefits

Eligibility

Vanguard offers medical and prescription drug benefits to Retirees and their dependents who meet the eligibility requirements above, in Section III. Medical benefits include prescription drug benefits.

If You Retire From Vanguard After You Are Eligible For Medicare Coverage

You will be offered COBRA coverage at your retirement; however, because you are eligible for Medicare coverage, you will not be eligible to enroll in a Vanguard-sponsored health care option after your COBRA coverage ends. COBRA rates are set annually. If you choose not to elect COBRA coverage at your retirement, you may purchase any other health care coverage available, including Medicare, or other individual or association policies, and use your RMA for reimbursement for up to 75% of the after-tax health insurance premium you paid.

If your spouse and/or eligible dependents are not eligible for Medicare coverage, your spouse and/or eligible dependents may continue to participate in any of the Vanguard-sponsored health care options (medical coverage, including prescription drug, dental, and vision) by paying the retiree medical rates until your spouse and/or eligible dependents are eligible for Medicare coverage or no longer eligible dependents as defined by the Plan. These rates are set annually. Vanguard will not make any contributions to the Health Reimbursement Arrangement or to the Health Savings Account for those enrolled in a Vanguard-sponsored medical option.

If You Retire From Vanguard Before You Are Eligible For Medicare Coverage

You may continue to participate in any of the Vanguard-sponsored health care options (medical, including prescription drug, dental, and vision coverage) either through COBRA or by purchasing the coverage as an individual and paying retiree medical rates. These rates are set annually.

When you retire, you will be offered the opportunity to initially continue your Vanguard-sponsored health care coverage through COBRA. You may use your RMA to be reimbursed for up to 75% of your COBRA premiums, and/or any other after-tax premiums for any other eligible coverage. You are eligible to elect retiree health benefits once your COBRA coverage has terminated. If you do not initially elect to continue coverage through a Vanguard-sponsored health care option, you may elect to enroll at a later date as long as your enrollment is due to a loss of your other coverage within 30 days. Proof of this loss must be provided to reenroll in a Vanguard-sponsored health care option. You will also be offered the opportunity to enroll or change plans during the regular annual open enrollment process (typically in November of each plan year). However, once you or your spouse becomes eligible for Medicare, the Medicare-eligible person is not eligible to participate in a Vanguard-sponsored health care option.

Retirees under the age of 65 are eligible to elect a Vanguard-sponsored health care option after retirement; however, Vanguard will not make any contributions to your Health Reimbursement Arrangement or to your Health Savings Account for those enrolled in a Vanguard-sponsored health care option.

If you do not want to continue in a Vanguard-sponsored health care option, you may purchase any other health care coverage available (i.e., individual or association policies) and use your RMA for reimbursement for up to 75% of the after-tax health insurance premium you paid.

Medical Coverage

Retirees may choose from the following medical benefit options:

Aetna Retiree Choice POS II

1. $950/ $1,900 deductible option
2. $1,250/ $2,500 deductible option

The Aetna Retiree Choice POS II allows you to choose providers from the Aetna network without requiring you to designate a primary care physician or to obtain a referral. If you go to an out-of-network provider, those expenses are covered at a lower percentage, based on "reasonable and customary" (R&C) fees. This consumer-directed health option is designed to give you more control over how you use your medical coverage. It features 100% preventive care coverage with no office copays. While preventive care is covered at 100% for in-network providers, this plan has a deductible and coinsurance for nonpreventive care. Prescription drug copays and coinsurance do not count toward the deductible. You will be able to choose from two deductible options: one with a higher deductible and a lower cost; the other with a lower deductible and a higher cost.

Rolling over unused Health Reimbursement Arrangement balances at Retirement

If you are enrolled in the Aetna HealthFund when you retire and have a balance in the Health Reimbursement Arrangement (HRA) at the time of your retirement and elect COBRA, that balance will be used to offset deductible expenses for the period that you are enrolled in Aetna HealthFund COBRA continuation coverage. If you have a HRA balance at the time of retirement and forego COBRA, or if you have a balance at the time your COBRA coverage expires, you may roll that amount into an account to be used for reimbursement of eligible expenses, such as coinsurance and deductibles, but not for premiums. Contact Vanguard Crew Central at 844-VG1-CREW (844-841-2739) within 60 days of becoming a Retiree or exhausting COBRA to request a rollover of your HRA balance. This step will ensure your HRA balance is preserved in an individual HRA to assist with out-of-pocket health care costs in retirement.

Retirees under the age of 65 are eligible to elect a Vanguard-sponsored health care option after retirement; however, Vanguard will not make any contributions to your HRA for those Retirees enrolled in a Vanguard-sponsored medical option.

High Deductible Health Plan (HDHP)

The HDHP covers preventive care at 100% like the Aetna HealthFund but has a higher deductible and greater coinsurance obligation for nonpreventive care than the Aetna HealthFund. However, unlike the Aetna HealthFund, the costs of your nonpreventive prescriptions will be applied toward your deductible and out of pocket limit in the HDHP. This medical benefit option allows you to choose providers from the Aetna network without requiring you to designate a primary care physician or to obtain a referral. If you go to an out-of-network provider, those expenses are covered at a lower percentage, based on R&C fees. This consumer-directed health option increases your control over how you use your medical coverage while providing the option to **set up** a health savings account (HSA) that offers tax advantages. The HDHP also covers preventive care at 100% but has a higher deductibles and coinsurance of the two plans for nonpreventive care. However, nonpreventive prescription drug costs will count toward the deductible and out-of-pocket totals for the HDHP.

If you are enrolled in the HDHP when you retire and have an HSA balance, you may continue to access your HSA balance to reimburse yourself for eligible out-of-pocket health care expenses. Please refer to HealthEquity to determine what meets the definition of eligible expenses. They may be reached at 866-346-5800.

Retirees under the age of 65 are eligible to elect a Vanguard-sponsored health care plan after retirement; however, Vanguard will not make any contributions to your HSA for those Retirees enrolled in a Vanguard-sponsored medical option.

For More Information

You should read the *Medicare & You* handbook to make an informed decision regarding your health care options after you retire from Vanguard. This handbook is published by Centers for Medicare & Medicaid Services via www.medicare.gov, and is updated on an annual basis.

Please see the Aetna Retiree Choice POS II benefit Plan booklet or the HDHP benefit Plan booklet. This SPD together with the Plan booklets serve as the full Plan Document. The Plan booklets are available on CrewNet External (https://crewnet.vanguard.com). You may also request the booklet(s), or additional paper copies of the SPD, free of charge by calling Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

Prescription Drug Coverage

If you enroll in medical coverage, you will automatically receive prescription drug coverage through CVS Caremark. With CVS Caremark, you can purchase prescription drugs through both a nationwide network of participating pharmacies and a mail service program.

Your prescription drug coverage will vary based on the medical option that you choose, as the prescription coverages are different for the Aetna Retiree Choice POS II and HDHP. However, regardless of which medical option you choose, Vanguard will pay 100% of the cost of select generic preventive medications that help improve certain chronic conditions. Under the prescription benefit, if you are enrolled in the Aetna Retiree Choice POS II, you will be responsible for a copay when purchasing generic drugs. When purchasing brand-name drugs you will be

responsible to pay a percentage of the cost of the medicine, referred to as coinsurance. There is a separate out of pocket maximum from your medical plan for prescription costs. Once you meet the prescription maximum, copays or coinsurance will not be required for the remainder of the plan year.

Under the HDHP, the coverage will be based on whether a drug is considered to be supporting preventive care or not. Additionally, under the HDHP, nonpreventive prescription drug cost will count toward the medical deductible and out-of-pocket totals. There is not a separate out of pocket maximum for prescription costs.

For maintenance or long-term medications, you are required to use either of the following options – both of which have the same copay. Just choose the option that is most convenient for you:

- Use the mail service program to have a 90-day supply of medication delivered to your home.
- Have the prescription filled at CVS/pharmacy.

CVS Caremark also has a Primary/Preferred Drug List (relevant to both medical plans) that consists of preferred medications chosen for clinical and cost-effectiveness. This list, as well as the Fully Covered Drug List and more, can be found by searching "drug list" on CrewNet External (https://crewnet.vanguard.com). Instructions on how to use the mail service program can also be found on the CVS Caremark website. Once you have set up a prescription through the mail service program, you can order refills by phone (866-559-6903) or online (www.caremark.com).

Important Prescription Drug Considerations

- You cannot obtain prescription drug coverage through Vanguard unless you enroll in a Vanguard medical option.
- What you pay for preferred and nonpreferred brand name drugs is based on coinsurance, a percentage of the amount that Vanguard pays for the drug. If the actual cost is less than the minimum, you will pay only that actual cost. If the drug costs more than the minimum, you will pay the coinsurance amount. You will never pay more than the maximum coinsurance amount for a prescription.
- Use Caremark's Check Drug Cost & Coverage tool found under the Plan & Benefits section at www.caremark.com to help you estimate the costs of your prescriptions and find cost-saving alternatives.

For More Information

Please see the CVS Caremark Prescription Drug Plan booklet. This SPD together with the Plan booklet serve as the full Plan Document for Prescription Drug coverage. The Plan booklet is available on CrewNet External (https://crewnet.vanguard.com). You may also request the booklet(s), or additional paper copies of the SPD, free of charge by calling Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

B. Dental Benefits

Eligibility

Vanguard offers dental benefits to Retirees and their dependents who meet the eligibility requirements above, in Section III.

Dental Coverage

Vanguard offers two dental benefit options through Delta Dental – Standard and Enhanced. You'll have different covered services and benefits reimbursement percentages depending on the plan you choose.

The following table highlights the options and what they each cover:

	Standard	**Enhanced**
Annual deductibles (individual/family)	$25/$50	$25/$50
Preventive (exams, cleanings, x-rays, sealants, periodontal maintenance)	100% (no deductible)	100% (no deductible)
Basic Restorative (fillings, posterior composites, emergency palliative treatment)	50%	80%
Endodontics, periodontics, and oral surgery (root canals and gum treatment	50%	80%
Other restorative (recementation of inlay, crown, or bridge)	50%	50%
Major restorative (crowns, inlay, onlays; bridges, dentures and implants)	None	50%
Orthodontia	None	50% (lifetime limit of $3,000 per individual)
Annual limit (Annual limit can increase. Refer to Preventive Incentive below.)	$500 per individual	$2,000 per individual (excluding orthodontia)

Delta Dental's Network

The dental plan is administered by Delta Dental with three tiers of dentists from which to choose:

- PPO participating dentist: Choose a PPO dentist for the greatest savings. PPO dentists have agreed to accept a discounted fee and cannot charge more for the service than Delta Dental has negotiated to pay.
- Premier participating dentist: Choose a Premier dentist for some savings. Premier dentist have agreed to accept a discounted fee – although not as large of a discount as PPO dentists – and cannot charge more for the service than Delta Dental has negotiated to pay.
- Out-of-network or non-participating dentist: You may also visit a provider that is not in Delta Dental's network, but your costs will be the highest with this option. The reimbursement amount for non-participating dentists is calculated using Delta Dental's Premier network amount, and then limited to the applicable percentage outlined in the summary chart above.
  Out of network or non-participating dentists may:
  - "Balance bill" you up to their full fees. In other words, they can charge the difference between Delta Dental's Premier allowed amount and their actual fee.
  - Require you to pay for services out-of-pocket and submit a claim form to Delta Dental for reimbursement.

To find out if your current provider is in Delta Dental's network, go to www.deltadentalins.com/vanguard and click the link under "Finding a Delta Dental dentist". Once there, you will be able to search by dentists in your area in the Premier or PPO networks. You can also find out by calling Delta Dental at 800-471-1282 or by asking your dentist in which Delta Dental plan he or she participates.

The Preventive Incentive

To encourage preventive cleanings, each individual covered under the plan that has at least one preventive cleaning and exam in a calendar year will have an increased annual limit for dental services in the following calendar year. The annual limit will increase an additional $100 for those enrolled in the Standard plan and $250 for those enrolled in the Enhanced plan. After two consecutive years of preventive cleanings, you will receive another $100 for the Standard plan or $250 for the Enhanced plan, up to a maximum of $700 and $2,500, respectively.

Important Dental Plan Considerations

- Deductibles apply to all services except preventive.
- If you are to undergo a treatment expected to cost more than $300 or a procedure for a condition that has more than one acceptable method of treatment, you are encouraged to have your dentist submit a "predetermination" request to Delta Dental. Doing so will provide an explanation - prior to the treatment - of what the plan will cover, as well as any out-of-pocket expenses that you can anticipate.

For More Information

Please see the Delta Dental Standard Dental booklet and the Delta Dental Enhanced Dental Booklet. This SPD together with the Plan booklets serve as the full Plan Document for the Dental benefits. The Plan booklets are available on CrewNet External (https://crewnet.vanguard.com). You may also request the booklet(s), or additional paper copies of the SPD, free of charge by calling Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

C. Vision Benefits

Eligibility

Vanguard offers the vision benefits through VSP to Retirees and their dependents who meet the eligibility requirements above, in Section III, regardless of whether they elect or waive medical including prescription coverage. Vision coverage is not automatic; you must elect it.

Vision Coverage

The vision benefit covers the cost of two pairs of corrective glasses, two pairs of contact lenses, or one pair of each. All services and supplies must be furnished or prescribed by a licensed ophthalmologist, optometrist, physician, or an optician.

Vision benefits under the Plan are fully insured.

Refer to the chart below for high-level coverage information.

<table>
<tr><th></th><th>In-network coverage</th><th>Out-of-network reimbursement**</th></tr>
<tr><td>Exam*</td><td>Covered in full</td><td>$45</td></tr>
<tr><td>Single-vision lenses</td><td>Covered in full</td><td>$30</td></tr>
<tr><td>Bifocals</td><td>Covered in full</td><td>$50</td></tr>
<tr><td>Trifocals</td><td>Covered in full</td><td>$65</td></tr>
<tr><td>Frames</td><td>Up to $130 for any frame of your choice or $150 for featured frame brands</td><td>$70</td></tr>
<tr><td>Evaluation/fitting for contacts</td><td>Covered in full</td><td rowspan="2">$200
Note: This amount covers reimbursement for the evaluation, fitting, and contacts.</td></tr>
<tr><td>Contacts</td><td>Covered in full up to $200</td></tr>
</table>

*Contact lens evaluations and fittings are not considered part of a regular exam.
**All out-of-network reimbursements are paid up to the listed amount (e.g., if an out-of-network vision exam is $30, then reimbursement is $30 and not the full $45).

For More Information

Please see the VSP vision Plan booklet. This SPD together with the Plan booklet serve as the full Plan Document for vision benefits. The Plan booklet is available on CrewNet External (https://crewnet.vanguard.com). You may also request the booklet(s), or additional paper copies of the SPD, free of charge by calling Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

D. Coordination of Benefits

The health benefits provided under the Plan are intended to help you pay for those costs that you or your dependents incur for necessary medical, prescription, dental, and vision services and supplies.

Sometimes individuals may be covered by more than one "group plan" and total benefits may exceed the actual expenses. If full payments were made by all plans involved, the cost of medical care would increase unnecessarily for everyone. Accordingly, under this Coordination of Benefits (COB) provision, health benefits payable by the Plan are coordinated with benefits payable under another group plan or Medicaid so that the total benefit received by the individual does not exceed the allowable expense.

Other group plans subject to the Plan's COB provision are group benefit plans that provide health coverage (including medical, dental, prescription or vision coverage) on an insured or uninsured basis. Examples of other group plans include health plans made available by an employer other than Vanguard and health plans made available through an educational institution. Other group plans also include no-fault, uninsured, and underinsured motorist insurance required by law, or heath care benefits paid through settlement of a lawsuit. Any individual health insurance policy you may have is not subject to the COB provision.

To obtain all the benefits for which you are eligible, claims should be filed with each of your sources of coverage. In general, the secondary payer pays the difference between what the primary plan paid and what the secondary payer would have paid if they were the primary payer. The maximum amount payable by our Plan is limited to the amount that would be paid if there were no other plan involved. When our Plan is the secondary payer, Plan benefits will be reduced by any amount payable by the primary plan.

Which Plan Pays?

Except with respect to Medicaid as described below, the primary payer will be determined in accordance with the following rules:

- ***Plans Without COB Provision***
  If the other group plan does not include a provision to coordinate benefits, it will be the primary payer.

- ***Plans Covering Employees***
  Any other group plan, or this Plan, that covers an individual as an employee is primary over plans that cover the individual in any other capacity, including as a COBRA coverage recipient.

- ***Plans Covering Dependents***
  Any other group plan, or this Plan, that covers an individual in a capacity other than as a dependent is primary over plans that cover the individual as a dependent.

- ***Plans Covering Same Dependent***
  The "birthday rule" will determine which of two parents' health care plans the primary payer is for a dependent child in cases where both parents are enrolled in group plans and the other group plan has a birthday rule, except when the parents are divorced (see below). The birthday rule makes the plan of the parent with the earlier birth date (month and day only) the primary payer for health care services the child receives. If the other plan does not have a birthday rule, the plan of the male parent is primary, except when the parents are divorced (see below).

- ***Divorce or Legal Separation***
  Unless otherwise required by a court order, the primary payer of benefits for a dependent child whose parents are divorced or legally separated is determined as follows:
  - The plan covering the parent with custody of the child is primary.
  - If the parent with custody of the child has remarried, the stepparent's plan is primary over the plan of the parent without custody.
  - The birthday and gender rules apply where the parents have joint custody.

  A court decree may determine the primary plan. You should advise Vanguard of any court decree.

- ***Responsibility Not Determined***
  When the determination cannot be made under the above rules, then the plan that has covered the individual for the longest period of time will be the primary plan.

- ***Continuation Coverage***
  The plan that covers an active employee (or dependent of such employee) or Retiree is primary over a plan that provides coverage under a right of continuation under federal or state law.

Plan's Rights

The Plan retains the right to release or obtain, without consent of, or notice to any person, any information that is deemed necessary in order to apply the COB provision of the Plan. Any individual claiming benefits under the Plan is required to furnish any written information requested by the Plan to implement the COB provision. The Plan retains the right to recover any amount of payments made that should not have been made under the COB provision from the person it paid or from the person for whom it has paid or any other group plan to which the Plan was secondary.

For More Information

Please see the Aetna Retiree Choice POS II benefit Plan booklet, the HDHP benefit Plan booklet, the CVS Caremark Prescription Drug Plan booklet, the Delta Dental Plan booklets, and/or the VSP Plan booklet. These booklets constitute the plan provisions, including all benefits, limitations and exclusions, for the medical benefit plan**. In the event of any discrepancy between this SPD and the Plan booklet, the Plan booklet controls.** These booklets are available on CrewNet External (https://crewnet.vanguard.com). You may also request the booklet(s), or additional paper copies of the SPD, free of charge by calling Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

E. Continuing Coverage under COBRA

The right to purchase a temporary extension of health coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law commonly known as COBRA. COBRA requires that Retirees and their covered eligible dependents be offered the opportunity to purchase such continuation coverage in certain instances where coverage under the Retiree Plan would otherwise end. The following generally explains COBRA continuation coverage, when it may become available to your eligible dependents, and what you need to do to protect your right to receive it. **Both you and your spouse/domestic partner should take the time to read this carefully and keep it with your records.**

For purposes of this section, the phrase "group health plan" includes medical with prescription drug, dental, vision, the Crew Assistance Program, and the Best Doctors program.

You May Have Other Options Available To You When You Lose Group Health Coverage

You may be eligible to buy an individual plan through the Health Insurance Marketplace ("Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health plan coverage, which would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are described later in the document under the "Who is Covered?" section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your eligible dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Continuation coverage is the same group health plan coverage that the Plan provides to other participants and beneficiaries who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants and beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Under the Plan, however, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Generally, you and your spouse or domestic partner will receive an initial notice describing COBRA rules and responsibilities within 90 days after you first become eligible under the group health plan.

COBRA Continuation Coverage for Retirees under Active Plan

If you are a crew member who was covered by a Vanguard sponsored group health plan while employed by Vanguard and who has terminated employment after qualifying as Retiree, you are a qualified beneficiary and have the right to choose COBRA continuation coverage for yourself and your covered eligible dependents under The Vanguard Group, Inc. Benefit Plan for active employees (the "Active Plan") because you are no longer eligible for health coverage as an actively employed crew member of Vanguard. More information regarding your COBRA rights under the Active Plan may be found in Section II.B.6 of the SPD for the Active Plan.

If you are terminating employment after qualifying as a Retiree and timely elect to continue health coverage for yourself and your covered dependents under the Active Plan through COBRA, Vanguard will subsidize 100% of the cost for the first three months of this COBRA coverage. This subsidy is not taxable to you. You will be responsible for the timely payment of the full cost of COBRA coverage for yourself and your covered dependents after this subsidy expires.

Who Is Covered As A Qualified Beneficiary Under Retiree Plan?

Covered Spouse/Domestic Partners. If you are the spouse or domestic partner of a Retiree covered by a Vanguard sponsored group health plan, you are a qualified beneficiary, and have the right to choose continuation coverage for yourself, if you lose Vanguard sponsored group health coverage as a result of any of the following qualifying events:

- Your spouse/domestic partner dies;
- Your spouse/domestic partner terminates employment from Vanguard as a Retiree (see rules for Retirees above); or
- You become divorced or legally separated from your spouse/domestic partner.

Covered Dependent Children. A dependent child of a Retiree covered by a Vanguard sponsored group health plan is also a qualified beneficiary, and has the right to continuation coverage, if he or she loses Vanguard sponsored group health coverage as a result of any of the following qualifying events:

- The parent-Retiree dies;
- The parent-Retiree terminates employment from Vanguard as a Retiree (see rules for Retirees above);
- The parent-Retiree is divorced or legally separated; or
- The covered child ceases to meet eligibility requirements for coverage under the plan as a "dependent child."

Children Eligible for COBRA coverage. A child born to, or placed for adoption with, the covered person during a period of continuation coverage is also a qualified beneficiary. In accordance with the terms of the group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification and proof to the COBRA Administrator of the birth or adoption. If the covered person fails to notify the COBRA Administrator and submit proof in a timely fashion (in accordance with the terms of the group health plan), the covered person will NOT be offered the option to elect COBRA coverage for the child.

Separate elections. Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage under the Plan, each qualified beneficiary eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse/domestic partner or dependent child is entitled to elect continuation of coverage even if the covered Retiree does not make that election. Thus, you, your spouse/domestic partner, and/or your dependent children (where applicable) would each, as a qualified beneficiary, have the option to elect continuation coverage as described below. Notwithstanding these independent election rights, you may elect continuation coverage on behalf of your spouse/domestic partner, and parents may elect continuation coverage on behalf of their children.

Your Duties Under The Law

Under the law, the Retiree or a family member has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the group health plan. This notice must be provided within 60 days from the later of (1) the date of the event or (2) the date on which coverage would end under the plan because of the event. *If the Retiree or a family member fails to provide this notice to the COBRA Administrator during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect COBRA continuation coverage.* When the COBRA Administrator is notified that one of these events has happened, the COBRA Administrator will notify you that you have the right to elect continuation coverage. Any individual who is either a Retiree covered under the group health plan, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of you or a qualified beneficiary may provide the notice.

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records, of any notice you send to the COBRA Administrator.

Vanguard's Duties Under The Law

Vanguard has the responsibility to notify the COBRA Administrator of the employee's death, termination of employment (including as a Retiree, but not a termination for gross misconduct). Notice must be given to the COBRA Administrator within 30 days of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will notify you that you have the right to elect continuation coverage.

Electing COBRA Continuation Coverage

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described above or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect continuation coverage. **If you do not elect continuation coverage within the time period described above, you will lose your right to elect continuation coverage.** If you elect continuation coverage, Vanguard is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the group health plan to similarly situated Retirees or family members. This means that if the coverage for similarly situated Retirees or family members is modified, your coverage will be

modified. "Similarly situated" refers to a current Retiree or dependent who has not had a Qualifying Event.

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

In addition, as discussed above in the section titled "COBRA Continuation Coverage for Retirees under Active Plan", if you are terminating employment after qualifying as a Retiree and timely elect to continue health coverage under the Active Plan for yourself and your covered dependents through COBRA, Vanguard will subsidize 100% of the cost for the first three months of this COBRA coverage. This subsidy is not taxable to you. You will be responsible for the timely payment of the full cost of COBRA coverage for yourself and your covered dependents after this subsidy expires. More information regarding your COBRA rights under the Active Plan may be found in Section II.B.6 of the SPD for the Active Plan.

Duration of Coverage

Continuation coverage is a temporary continuation of coverage. The chart below outlines the maximum coverage periods based on the initial termination reason:

Reason For Termination of Coverage Under Plan	Period
Termination of employment as a Retiree (Active Plan only)	18 months
Death of Retiree	36 months
Divorce, legal separation, or termination of domestic partnership	36 months
Dependent child no longer qualifies as a dependent under the group health plan	36 months

There are circumstances under which continuation coverage may be extended. If your family experiences another qualifying event while receiving 18 months of continuation coverage (in accordance with the chart above), your spouse/domestic partner and dependent children can get 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. The extension may be available to the spouse/domestic partner and dependent children receiving continuation coverage if the Retiree dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred.

Special rules for disability. The 18 months may be extended to 29 months if the Retiree or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are Qualified Beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension the Retiree or a family member must inform the COBRA Administrator of a determination by the Social Security Administration and that the Retiree or covered family member was disabled during the 60-day period after the Retiree's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the Retiree or family member is no longer disabled, the individual must inform the COBRA Administrator of this predetermination within 30 days of the date it is made. If another Qualifying Event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours for the family members other than the Retiree.

Early Termination of Continued Coverage

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Vanguard no longer provides group health coverage to any of its Retirees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary becomes covered - after the date COBRA is elected - under another group health plan (whether or not as an employee) or the Marketplace;
- The qualified beneficiary becomes entitled to Medicare benefits after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Continuation coverage under COBRA is provided subject to your eligibility for coverage under the Vanguard sponsored group health plan; Vanguard reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Premium Payments

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may be required to pay up to 102 percent of the entire premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay 150 percent of the premium beginning with the 19th month of continuation coverage. The cost of group health coverage periodically changes. If you elect continuation coverage, the COBRA Administrator will notify you of any changes in the cost.

The initial payment for continuation coverage is due 45 days from the date of your election. If you do not make your first payment for continuation coverage in full no later than 45 days from the date of your election, you will lose all continuation coverage rights under the Plan.

After you make your initial payment, you will be required to make periodic payments for each subsequent coverage period. Periodic payments are made on a monthly basis, with payment due on the first day of the month. If you make a periodic payment on or before the first day of the month, your coverage under the Plan will continue for that month without any break. The Plan will not, however, send periodic notices of payments due for these coverage periods.

Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the month to make your periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that month. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment by the end of the grace period for a particular month, you will lose all rights to continuation coverage under the Plan.

For More Information

Additional information about COBRA can be obtained by calling WageWorks at 888-251-6982 or Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW. If you have changed your marital status, if you or your spouse/domestic partner has changed addresses, or if a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you are responsible for promptly notifying WageWorks or Crew Central.

For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through the EBSA website.

Section IV – Domestic Partners

Introduction

A Retiree who meets the eligibility requirements in Section I.B may elect health benefits, including medical with prescription coverage, dental coverage, and vision coverage, through the Plan for his or her eligible same- or opposite-sex domestic partner, under the age of 65 and the eligible domestic partner's children. In addition, these eligible dependents may take advantage of Best Doctors, Crew Assistance Program and Health Advocate.

No Retiree Medical Account will be established for the eligible domestic partner.
(Please refer to Section II of this SPD for details regarding the Retiree Medical Account.)

Eligibility

The benefits listed above are offered to same- or opposite-sex domestic partners who meet the eligibility criteria listed below. Retirees must complete and submit Vanguard's *Affidavit of Domestic Partnership* ("Affidavit"), which is available on CrewNet External (https://crewnet.vanguard.com) or by contacting Vanguard Crew Central at 844-VG1-CREW (844-841-2739). In order to be considered under the Plan as an eligible domestic partnership, so that the Retiree may elect benefits for their domestic partner, both the Retiree and the domestic partner must certify that they:

- Have been living in a committed, exclusive relationship, have continually resided in the same primary residence for a period of at least six months, and intend to continue to reside together permanently;
- Are each other's sole domestic partner and intend for our domestic partnership to be permanent;
- Are jointly responsible for each other's common welfare and financial obligations, or the non-Retiree domestic partner is chiefly dependent upon the Retiree for care and financial assistance;
- Are not married (either legally or by common-law) to anyone else, a domestic partner of anyone else, or legally separated from anyone else;
- Are 18 years of age or older;
- Do not have a blood relationship that would bar marriage under the laws of the State in which we reside, (or if applicable, were married) and have otherwise satisfied all other marriage requirements imposed by such State;
- Are not in this relationship solely for purposes of obtaining benefits; and
- Have provided the documentation requested by Vanguard (see Affidavit of Domestic Partnership) supporting their domestic partnership.

If an individual is an eligible domestic partner, Retiree may elect to provide health benefits for any child(ren) of the Retiree's eligible domestic partner who is under the age of 26, even if coverage is not elected for the eligible domestic partner.

If you retire from Vanguard and have an eligible domestic partner, the domestic partner may elect to purchase coverage through a Vanguard-sponsored health care plan (medical coverage, including prescription drug, dental, and vision) at the retiree medical plan rates until the domestic partner becomes eligible for Medicare.

Affidavit of Domestic Partnership

The Retiree and the domestic partner will be required to sign Vanguard's Affidavit. In support of your Affidavit, you and your domestic partner must provide verification of your economic interdependency by submitting a photocopy of one item from List A (below) and one item from List B (below) with the affidavit:

List A

- Joint deed, mortgage, or lease for the past six months;
- Proof of civil union (no item from List B needed); or
- Any documentation proving that the Retiree and domestic partner have lived in the same residence for at least the past six months and will continue living at the same residence for the duration of the domestic partnership.

List B

- Joint obligation of any loan agreement or credit card agreement;
- Any life insurance policy, including a Vanguard policy, or last will and testament, on which the domestic partner is named as the beneficiary or vice versa;
- Any durable or health care power of attorney granting power of attorney to the domestic partner or vice versa; or
- Any documentation indicating joint ownership of property, such as automobiles, bank accounts, or real estate.

The entire record of evidence presented with Vanguard's Affidavit will be considered in deciding whether an individual is an eligible domestic partner.

Termination of Domestic Partner Benefits

A Retiree may remove their domestic partner from his or her benefits coverage by submitting a status change to the RMA Administrator by calling 888-251-6982. Reasons coverage may end include:

- The domestic partner has obtained coverage elsewhere.
- The domestic partner relationship ends.
- The domestic partner no longer meets the eligibility requirements.
- The Retiree dies.

Section V – Life Insurance

Introduction

Vanguard provides Retirees with term life insurance coverage equal to $10,000. This benefit is subject to ERISA.

Please note: Coverage amounts are less for a small group of existing Retirees.

Eligibility

Vanguard offers life insurance to all Retirees who meet the eligibility requirements in Section I.B.

Cost of Coverage

This automatic coverage is paid for entirely by Vanguard.

Beneficiary

We will pay the death benefit to the beneficiary or beneficiaries. A beneficiary is named by you to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You cannot name the policyholder or an associated company of the policyholder as a beneficiary.

Any amount of insurance under a coverage for which there is no beneficiary at your death will be payable to the first of the following: (a) your lawful spouse, if living, otherwise: (b) your natural or legally adopted child (children) in equal shares, if living, otherwise; (c) your parents in equal shares, if living, otherwise; (d) your brothers and sisters in equal shares, if living, otherwise; (e) the personal representative of your estate.

You may change the beneficiary at any time without the consent of the present beneficiary.

Termination of Coverage

It is intended that this plan will be continued for an indefinite period of time however Vanguard reserves the right to change or terminate the plan. As long as you remain a Retiree ("covered person"), you are entitled to the coverage stated above. Failure to remain a covered person may result in partial or total loss of your benefits.

If you die while a covered person, the amount of your retiree term life insurance under this coverage is payable when Minnesota Life, Vanguard's third-party life insurance company, receives written proof of death.

Conversion Right

Please see the Minnesota Life Insurance Plan booklet for life insurance for information regarding your ability to covert this life insurance coverage to a new individual life insurance policy if all or part of your life insurance under the group policy terminates.

For More Information

Please see the Minnesota Life Insurance Plan booklet. This SPD together with the Plan booklet serve as the full Plan Document for life insurance benefits. The Plan booklet is available on CrewNet External (https://crewnet.vanguard.com). You may also request the booklet(s), or additional paper copies of the SPD, free of charge by calling Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

Section VI – Other Benefits

A. Best Doctors

Introduction

Best Doctors is a confidential program that allows Retirees and their families access to medical advice from nationally recognized doctors. The program can be used to obtain advice on anything from minor surgery to serious issues like cancer and heart disease. With Best Doctors, Retirees can have an expert doctors review their diagnosis and treatment plan to make sure it is right for them. This benefit is subject to ERISA.

Eligibility

All Retirees and spouses, domestic partners, dependent children, parents and parents-in-law of Retirees are eligible for coverage under this benefit.

Participation

Eligible individuals may use Best Doctors through self-referral. Any Retiree and their eligible dependents seeking to participate in Best Doctors should call Best Doctors at 866-904-0910.

Cost of Coverage

Vanguard pays the full cost of your Best Doctors benefit. There is no charge for using this benefit.

How the Benefit Works

Contact Best Doctors in order to take advantage of these four services to help you and your family make the right medical decisions:

1. **In-Depth Medical Review** – Best Doctors is like getting a second opinion, only through a process called InterConsultation™. Best Doctors will collect all records, images and test samples and a leading doctors will review those along with the diagnosis and/or treatment plan and provides their detailed recommendation.
2. **Critical Care Support** - Best Doctors can get an expert involved when a medical event that requires emergency treatment, intensive care, or an extended hospital stay occurs. The expert will work with the local medical team to get the best care.
3. **Ask the Expert** – Get answers to basic questions about a diagnosis, treatment options and health conditions from an expert by calling Best Doctors. They will discuss concerns and will work with the most appropriate specialists. Best Doctors will also help determine what questions for you to ask.
4. **Find a Doctor** – Best Doctors can help find a local doctor or specialist who is approved by a health plan, using a database of more than 53,000 medical experts in over 450 specialties and subspecialties worldwide.

Termination of Coverage

Termination of the coverage under Best Doctors occurs at the earliest of the following events:

- The date this Plan terminates;
- The date the Retiree is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to Best Doctors other than on account of an inadvertent error.

B. Crew Assistance Program

Introduction

Vanguard contracts the professional services of Carebridge to provide Retirees with the Crew Assistance Program (CAP). This benefit is subject to ERISA.

Eligibility

All Retirees, and the spouses, domestic partners, dependent children and children of domestic partners of such Retirees are eligible for coverage under this benefit.

Participation

Through self-referral Retirees (and the spouses, dependent children, domestic partners or a child of domestic partners) may use Carebridge for help with concerns such as:

- Alcohol and drug abuse
- Depression and anxiety
- Difficult emotional problems
- Family/parenting problems
- Financial pressures
- Grief and loss
- Legal concerns
- Marital and relationship issues
- Stress management
- Spousal/child/parent abuse
- Troubling personal matters
- Work relationships

You may access Carebridge's website, www.myliferesource.com. The site offers self-help articles and multimedia resources related to relationships, life concerns, wellness and work. The site also offers the ability to research child care, elder care, college planning, financial and legal advice, parenting, and adoption.

Cost of Coverage

Vanguard pays the full cost of CAP. There is no charge for using this benefit.

How the Benefit Works

Carebridge involves the use of professional counselors – external to Vanguard – that provide a resource for assistance with personal, family, alcohol, or drug concerns. The individual will be evaluated by a Carebridge counselor and, if appropriate, will be offered counseling up to four sessions per year. Carebridge CAP sessions are provided at no cost to the Retiree, spouse, dependent child, domestic partner, or a child of a domestic partner. In most cases, issues can be resolved within CAP. However, if longer-term treatment is necessary, the CAP professional will refer the individual to an appropriate resource.

Confidentiality

Your Carebridge CAP assistance is confidential and conforms to HIPAA requirements. Participation in the program or in treatment is not disclosed to anyone at Vanguard without the participant's written permission except in the following situations:

- By court order;
- Imminent threat of harm to self or others; or
- Situations of abuse (such as child or elder abuse).

Termination of Coverage

Termination of coverage under the Carebridge CAP occurs at the earliest of the following events:

- The date this Plan terminates;
- The date the Retiree is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to Carebridge other than on account of an inadvertent error.

C. Health Advocate

Introduction

Health Advocate, Inc. is a healthcare advocacy and assistance company and helps employer plan participants navigate the healthcare system. This benefit is not subject to ERISA.

Eligibility

All Retirees and spouses, domestic partners, dependent children, parents, and parents-in-law of Retirees are eligible to participate in this benefit under the Plan.

Participation

Retirees and their eligible dependents may access Health Advocate by calling 855-424-9400 or by emailing them at: answers@HealthAdvocate.com.

Cost of Coverage

Vanguard pays the full cost of your Health Advocate benefit. There is no charge for using this benefit.

How the Benefit Works

Health Advocate's Core Health Advocacy program is a free and confidential service that centers around a team of Personal Health Advocates (PHAs) who help handle any health care and insurance-related issues you and your family encounter. PHAs will assist you and your family with clinical and administrative issues involving your medical, hospital, dental, pharmacy and other health care needs.

When you call Health Advocate you will be assigned your own PHA, typically a Registered Nurse, who is supported by a team of medical directors and benefits specialists. This highly personalized assistance program offers a number of services to include:

- Resolve insurance claims and billing issues
- Find the right doctors
- Schedule appointments
- Clarify insurance coverage
- Assist with elder care issues
- Obtain cost estimates for procedures
- Assist in the transfer of medical records

Health Advocate follows careful protocols and complies with all government privacy standards so that you may rest assured your medical and personal information will remain strictly confidential.

Termination of Coverage

Termination of coverage under Health Advocate occurs at the earliest of the following events:

- The date this Plan terminates;
- The date the Retiree is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to the Health Advocate other than on account of an inadvertent error.

Section VII – Claims and Appeals Procedures for Plan Benefits

Under DOL regulations, participants are entitled to full and fair view of any claims for benefits made under the Plan. This section explains the Plan's claims and appeal procedures and explains how to file claims for Plan benefits, when you will be notified of benefit decisions, and how to appeal any decisions that deny Plan benefits (also called adverse benefit decisions).

Please note that certain deadlines for submitting a claim or appeal apply - each is described below (except Severance Plan claims and appeals procedures are described in Section VI).

Definitions

The following terms are used throughout this Section and, where capitalized, have the specific meanings given below.

- **Adverse Benefit Determination** – a denial, reduction, termination of or failure to provide or make payment (in whole or in part) for benefits (including a service or supply) under the Plan. An Adverse Benefit Determination also includes the rescission of coverage.
- **Appeal** – a written request to the Claims Fiduciary to reconsider a denial of benefits (such denial also called an Adverse Benefit Determination).
- **Claim** – any request for a Plan benefit(s) made in accordance with these claim procedures. A request for benefits that is not made in accordance with these claims procedures will not be treated as a Claim under these procedures.
- **Claimant** – you, your eligible dependents, or your designated beneficiary (as applicable) once a request is made for a Plan benefit(s) in accordance with these claim procedures.
- **Claims Processor** – the party responsible for processing claims. A Claims Processor does not have discretionary authority to interpret the Plan or to make discretionary benefit decisions. When a Claims Processor determines that a benefit is not payable under the Plan, any appeals of Adverse Benefit Determinations would be reviewed by the Claims Fiduciary. The Claims Processor may vary depending on the benefit under review.
- **Claims Fiduciary**– the party who is the fiduciary responsible for making decisions regarding Claims and Appeals and the party with discretionary authority to interpret the Plan to make benefit decisions. The Claims Fiduciary may vary depending on the benefit under review.
- **Day** – when mentioned in these claims procedures, the term indicates calendar day.
- **Final Internal Adverse Benefit Determination** – an Adverse Benefit Determination that has been upheld by a Claims Fiduciary after completing the internal appeals process (or an Adverse Benefit Determination after the internal appeals process has been exhausted.
- **Final External Adverse Benefit Determination** – An Independent Review Organization (IRO) decision regarding a Claim after completing an external review.
- **Independent Review Organization (IRO)** – an entity that conducts independent external reviews of Adverse Benefits Determinations and Final Internal Adverse Benefit Determinations.

- **Authorized Representative** – this individual may act on behalf of a Claimant with respect to a Claim or Appeal under these procedures. However, no person (including a treating health care professional) will be recognized as an Authorized Representative until the Plan receives an Appointment of Authorized Representative form signed by the Claimant, except that for Urgent Care Claims, the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (e.g. the treating physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise.

Benefits Claims and Appeals Procedures

Plan benefits are subject to the claims and appeals procedures in this Section of the SPD. However, particular benefits described in this SPD may have claims procedure information in addition to what is described below, and would be provided in the applicable Plan booklet to this SPD (or other materials provided by the Claims Fiduciary). This additional claims procedure information (if any) is in addition to, and does not override, the claims procedure information described in this SPD.

Some of the benefits described in this SPD are not subject to ERISA and thus-the specific claims and appeals procedures and deadlines required by ERISA do not apply to these benefits.

Filing a Claim

If you wish to file a Claim, you must complete a written Claim on the proper form and submit it to the Claims Fiduciary or Claims Processor, as applicable, responsible for reviewing the Claim if it is not already submitted on your behalf by your provider. (See below for the list of Claims Fiduciaries and Claims Processors.) Claims must be filed by the deadline stated in the procedures described below for the particular benefit under which the Claim is being filed.

You can obtain the necessary claim forms on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW. Most Claims relate to the provision of specific benefits under the Plan. Any other Claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with Crew Central. Please see the sections below to find the party you should file your Claims with and where you can find a copy of the claims procedures for the particular benefit you are claiming.

A request for prior approval of a benefit or service where prior approval is not required is not a Claim under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid is not a Claim under these rules.

The claims and appeals procedures for the benefits offered under the Plan are grouped according to the claims and appeals procedures applicable to the benefits:

(1) Group health benefits subject to ERISA (medical with prescription drug, dental, vision, Crew Assistance Program, and Best Doctors)

Please note that the procedures for a group health benefit Claim depend upon the particular type of Claim. The types of Claims that you generally may bring under group health benefits are:

- ***Pre-Service Claim*** – Is a type of claim for a particular benefit that is conditioned upon you receiving prior approval in advance of receiving the benefit. A Pre-Service Claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is being requested. You will be notified if you have failed to follow the procedures for filing a Pre-Service Claim as soon as possible, but not later than 5 days (24 hours in the case of an Urgent Care Claim) following the failed attempt.

- ***Post-Service Claim*** – Is a type of claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. Claims relating to Crew Assistance Program and Best Doctors will always be treated as Post-Service Claims. A Post-Service Claim must contain the information requested on a Claim form provided by the applicable provider.

- ***Urgent Care Claim*** – Is a type of claim for benefits or services involving a sudden and urgent need for such benefits or services. A Claim will be considered to involve urgent care if the Claims Fiduciary or a physician with knowledge of your condition determines that the application of the claims procedures for non-urgent Claims (1) could seriously jeopardize your life or your health, or your ability to regain maximum function or (2) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the Claim.

- ***Concurrent Care Claim*** – Is a type of claim relating to the continuation/reduction of an ongoing course of treatment.

(2) Life insurance benefit and RMA - subject to ERISA

If Your Claim Is Denied

If your Claim for an ERISA benefit is denied in full or in part (otherwise referred to as an Adverse Benefit Determination), ERISA requires the Claims Fiduciary to provide you with written notice of the denial (except that a denied Urgent Care Claim will be provided orally) to include:

- Sufficient information to identify the Claim to include: the date of service, the health care provider, and the claim amount (if applicable);
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A request for any additional information needed from the Claimant to reconsider the claim and the reason this information is needed;

- A description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination (if the denial is based on an internal rule, guideline, protocol, or other similar criterion) or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request, if applicable;
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances (if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit) or a statement that a copy of such explanation will be provided to you free of charge at your request, if applicable; and
- An explanation of the Plan's appeal procedures, including the time limits applicable for such procedures.

If your Claim for a non-ERISA benefit is denied, you will receive notice, either written or electronically, from the Claims Processor.

Appealing a Denial

If you receive an Adverse Benefit Determination on your initial Claim (including a decision to discontinue or reduce benefits relating to an ongoing course of treatment), you may appeal the denial by filing a written request (or an oral request in the case of an Urgent Care Claim) with the appropriate Claims Fiduciary. **The standard appeal process described below, and in the applicable booklets, must be exhausted before you can pursue the Claim in court.**

If you decide to appeal a denied Claim for benefits, under the Plan you are entitled to a "full and fair review" that must include the following:

- An opportunity for you to submit written comments, documents, records, and other information relating to your Claim for benefits (regardless of whether such information was considered in your initial Claim) to the Claims Fiduciary for review and consideration;

- Access to review the Claim file, including having access to, and copies of, all documents, records and other information that are relevant to your Claim as well as any new or additional evidence the Claims Fiduciary considers, relies upon or generates by the Plan in connection with the Claim, free of charge; and

- New or additional rationale for the denial of the Claim at the internal claims appeal stage, free of charge, and the Claimant shall have no less than 45 days to respond to such new evidence or rationale, except with respect to Appeals of Urgent Care Claims (in which event the Claimant will be provided no less than two days to respond to the new evidence or rationale

With regard to group health plan Claims; you are entitled to additional rights (in addition to the above criteria) as part of a "full and fair review" of your Appeal:

- A review that has no bearing on the initial Claim, and is conducted by an individual who is neither the individual who issued the first denial nor the subordinate of that person, and

measures are taken to ensure the independence and impartiality of the persons involved in making the decision;

- If the whole or part of the Appeal is based on a medical judgment, the individual reviewing the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify any expert whose advice was obtained on behalf of the Plan regarding the Appeal regardless of whether the advice was relied upon in making the benefit determination;

- An expedited review process, in the case of an Urgent Care Claim, and allow for the Appeal to be requested orally or in writing and maintain that all necessary information relating to the Appeal shall be transmitted between you and the Plan by telephone, fax, or other similar expeditions method.

You (or your Authorized Representative) can appeal and request a claim review. (Please see the applicable deadlines for the Claim you wish to have reviewed under the "Time Deadlines for Claims and Appeals Procedures" chart below) You must file your Appeal in writing with the appropriate Claims Fiduciary responsible for reviewing the Claim. (Please see the "Time Deadlines for Claims and Appeals Procedures" chart below for the appropriate Claims Fiduciary) In some cases, the Claims Fiduciary may be Vanguard in which case you must file your written Appeal with Crew Central. If you are unsure who the Claims Fiduciary is, you may contact Crew Central. Your Appeal must state the specific reasons that you believe entitle you to benefits, or to greater or different benefits.

Denial of Appeal

If your Appeal is denied in full or in part, you will be notified in writing of the Claims Fiduciary's final and binding decision. This notice of denial will include:

- Sufficient information to identify the Claim to include: the date of service, the health care provider, and the claim amount (if applicable);

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reason or reasons for the denial. In addition, if the denial is based on new or additional rationale you submitted, the rationale for the denial must be included or sent to you as soon as possible and sufficiently in advance of the date on which the notice of the final benefit denial is required to be provided to give you a reasonable opportunity to respond prior to that date;

- Specific references to the pertinent Plan provisions on which the decision is based;

- Reasonable access to, upon request and free of charge, copies of all documents, records and other information relevant to the Claim for benefits. A document, record, or other information shall be considered relevant to your Claim if the item was relied upon in making the benefit determination; and was submitted, considered, or generated in the

course of making the benefit determination without regard if it was relied upon in making the determination;

- A description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination (if the denial is based on an internal rule, guideline, protocol, or other similar criterion) or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request, if applicable;

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit) or a statement that a copy of such explanation will be provided to you free of charge at your request, if applicable; and

- A statement of your right to bring a civil action in Federal court under Section 502 of ERISA, if applicable. In the case of a medical or prescription Claim for benefits, if you have completed the standard appeal process (outlined above) you may request an "External Review". An External Review is a review of an Adverse Benefit Determination by an (IRO). You must complete all levels of the standard appeal process before the request can be made.

To request an External Review, you need to submit the "Request for External Review Form" to Aetna (for medical) or CVS Caremark (for prescription), as applicable, within 123 days of the date you received the Adverse Benefit Determination. This process is voluntary and you are not required to undertake it before pursuing legal action. If you do not file for voluntary External Review, the Plan will not find that you have failed to exhaust your administrative remedies because of that decision.

If you would like more information on how to request an External Review or how the process works, please see the Aetna Retiree Choice POS II $950/$1900 Plan booklet, the Aetna Retiree Choice POS II $1250/$2500 Plan booklet, the HDHP Plan booklet, or the CVS Caremark prescription drug Plan booklet.

If you feel your right to a benefit that is subject to ERISA has been improperly denied please see the "Your Rights Under ERISA" section for information on legal action you can take if after you have completed the standard appeals process.

ACA Compliance

Please note that notwithstanding anything else in this SPD, the Plan will comply with the applicable requirements of the Affordable Care Act (unless the group health benefit in question is an "excepted benefit" to which the Affordable Care Act does not apply). This means that Claimants shall have the following rights:

- Review of Claim File - The right to review the Claim file, including access to and copies of documents, records and other information relevant to the Claim at issue;

- Opportunity to Present Evidence and Testimony - The opportunity to present evidence and testimony as part of the Appeals process. The terms “evidence” and “testimony” shall be interpreted in accordance with DOL guidance;

- Disclosure of New Rationale and Opportunity to Respond - Be advised if the Claims Fiduciary considers, relies upon, or generates additional evidence in connection with the Claim, or is considering a new or additional rationale for the denial of the Claim at the internal claims appeal stage, free of charge, and shall give the Claimant no less than 45 days to respond to such new evidence or rationale, except with respect to Appeals of Urgent Care Claims (in which event the Claimant will be provided no less than two days to respond to the new evidence or rationale);

- No Conflict of Interest - To the extent Plan personnel are involved in the claims process, the Claims Fiduciary will not consider, in connection with any decisions matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any Claimant, whether or not such individual is likely to support the denial of benefits to a Claimant;

- External Review – An External Review for Final Adverse Benefit Determinations involving (1) medical judgment (excluding those involving only contractual or legal interpretation without any medical judgment) as determined by the IRO, or (2) rescission of coverage (i.e. a retroactive termination of coverage, whether or not the rescission has any effect on any particular benefit at the time). If the Claim is an Urgent Care Claim or involves an ongoing course of treatment, Claimants may process with expedited External review at the same time as the internal appeals process. External Review is not available for Final Adverse Benefit Determinations involving a failure to meet the Plan’s eligibility requirements.

Claimants Must Follow Claims Procedure

No person may bring an action for any alleged wrongful denial of Plan benefits in a court of law unless these claims procedures are exhausted and a final determination is made by the Plan Administrator (or its delegate).

If the Claimant or other interested person challenges a decision of the Plan Administrator (or its delegate), a review by the court of law will be limited to the facts, evidence and issues presented to the Plan Administrator (or its delegate) during the claims procedure set forth above. Facts and evidence that become known to the Claimant or other interested person after having exhausted the claims procedure must be brought to the attention of the Plan Administrator (or its delegate) for reconsideration of the claims determination. Issues not raised with the Plan Administrator (or its delegate) will be deemed waived.

Time Limit For Legal Action

Any suit or legal action brought by a Claimant under the Plan must be brought by the Claimant no later than one year (unless specified elsewhere in a Plan booklet; the dental benefits and LTD benefits have a three year time limit for legal action) following the final determination by the Plan

Administrator (or its delegate) regarding the claim for benefits under these claims procedures. The one-year statute of limitations on suits for benefits applies in any forum where a Claimant brings such suit or legal action. If a civil action is not filed within this one year period, the Claimant's benefit claim is deemed permanently waived and abandoned.

Please note: You do not have to request and complete External Review (applicable for medical and prescription drug Claims only) before bringing a legal action. However, if you complete the External Review and receive a Final External Adverse Benefit Determination, you may still bring legal action against the Plan, Plan Administrator, Claims Fiduciary or any other person with respect to a medical or prescription drug Claim.

If you feel your right to a benefit that is subject to ERISA has been improperly denied please see the "Your Rights Under ERISA" section for information on legal action you can take if after you have completed the standard appeals process.

Governing Law and Jurisdiction and Venue

The Plan will be governed by ERISA and to the extent not preempted by ERISA, by the laws of the Commonwealth of Pennsylvania. Exclusive jurisdiction and venue of all disputes arising out of and relating to the Plan, matters of Plan interpretation or factual determinations made by the Plan Administrator or its delegates is in any court of appropriate jurisdiction in the Commonwealth of Pennsylvania.

Claims and Appeal Procedure Time Deadlines

It is important to know what type of Claim you have because the claims and appeal procedures and deadlines vary depending on the type of Claim involved. All of the deadlines for each type of benefit Claim are summarized in the chart below.

(1) Group health benefit claims subject to ERISA

The applicable Claims Fiduciary for the group health benefits as well as the location of their claims procedures are listed below:

Claims for the following benefits: Medical, Prescription, Dental, Vision, Crew Assistance Program and Best Doctors		
Deadline for Claimant to file a Claim (if deadline is not specified here, please contact the applicable Claims	**Medical**	**90 days** after the date you receive services
	Prescription	For a claim that requires prior-authorization, there is **no deadline**; For a post-service request claim, you have **365 days** after the date you receive services
	Dental	Within **12 months** after the date you receive services
	Vision	Within **365 days** after the date you receive services
	Crew Assistance Program	**90 days** after the date you receive services

<table>
<tr><td>Fiduciary, listed below)</td><td colspan="2">Best Doctors</td><td colspan="2">Within 6 months after the date you receive services</td></tr>
<tr><th colspan="5">TYPES OF GROUP HEALTH CLAIMS</th></tr>
<tr><th>Responsible Party</th><th></th><th>Urgent Care Claim</th><th>Pre-Service Claim</th><th>Post-Service Claim</th></tr>
<tr><td>Claimant</td><td colspan="4">Claimants must submit an initial Claim within the applicable statute of limitations period. If a Claimant fails to submit the Claim within such time period, the Claim may be time-barred. Please refer to the booklet that corresponds to your specific benefit for further details about the applicable statute of limitations.</td></tr>
<tr><td>Claims Fiduciary</td><td>Deadline for Claims Fiduciary to approve or deny Claim</td><td>As soon as possible, but not later than 72 hours after receiving the initial Claim, if it was proper and complete.

OR

As soon as possible, but not later than 24 hours in the case of a Concurrent Care Claim if you request to extend the treatment at least 24 hours before it would otherwise end.</td><td>A reasonable period, but not more than 15 days after receiving the initial Claim.

OR

In the case of a Concurrent Care Claim, you will be notified in advance of any reduction or termination of treatment so you may Appeal the decision.</td><td>Claims Fiduciary is not required to notify you of a Claim approval for Post-Service Claims.

If your Claim is denied, you must be notified within a reasonable period, but not more than 30 days after receiving the initial Claim.</td></tr>
<tr><td>Claims Fiduciary</td><td>Extension of deadline for Claims Fiduciary to approve or deny Claim

Claims Fiduciary <u>must provide notice</u> to Claimant of extension <u>before</u> the first time limit expires to approve or deny Claim</td><td>No extension permitted.</td><td colspan="2">One 15-day extension of the first time limit for the Claims Fiduciary to review the claim for “matters beyond the control of the plan” with notice to the Claimant. In the case of a Concurrent Care Claim, the same time frames apply.</td></tr>
</table>

Claims Fiduciary	**If Claim submission is incomplete, Claims Fiduciary may give Claimant opportunity to provide additional information**	N/A	If an incomplete Claim is filed by the Claimant, the Claims Fiduciary may deny the Claim or notify the Claimant of the incomplete Claim. Claimant must be given at least **45 days** to provide missing information as specified in the notice. The time for the approval or denial is put on hold from the date the notice of incomplete submission is sent to the Claimant until the date the Claimant responds with additional information. The Claims Fiduciary has **15 days** from the date in which they received the missing information to approve or deny the Claim.	
Claimant	**Deadline to submit an Appeal following a denial**	**180 days** after receiving notice of initial decision.		
Claims Fiduciary	**Deadline for Claims Fiduciary to approve or deny the Appeal and notify Claimant of decision for Prescription (administrative claims only), Dental, Vision and Crew Assistance Program, claims** ***THIS ONLY APPLIES FOR BENEFITS THAT PROVIDE ONE LEVEL OF APPEAL***	For benefits that only provide one level of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the Appeal **as soon as possible**, but not later than **72 hours** after receiving the Appeal**.** If the Appeal is denied, your Appeal rights are exhausted.	For benefits that only provide one level of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the Appeal no later than **30 days** after receiving the Appeal. If the Appeal is denied, your Appeal rights for are exhausted. In the case of Concurrent Care, the Claims Fiduciary must notify Claimant of their decision **before treatment ends or is reduced** when the plan's decision is to reduce or terminate	For benefits that provide one level of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the Appeal within a reasonable period of time but no later than **60 days** after receiving the Appeal. If the Appeal is denied, your Appeal rights are exhausted.

			the concurrent care early.	
Claims Fiduciary	**Deadline for Claims Fiduciary to approve or deny Appeal and notify Claimant of decision for Medical and Prescription (for all other claims besides administrative claims) claims** ***ONLY FOR BENEFITS THAT PROVIDE TWO LEVELS OF APPEAL***	N/A (please see External Review below for further review)	For benefits that provide two levels of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the **first and second level of Appeal** no later than **15 days** after receiving the Appeal. *for deadline to submit second level appeal, see immediately below.	For benefits that provide two levels of Appeal, the Claims Fiduciary must notify the Claimant of their decision **on their first and second level of Appeal** within a reasonable period of time but no later than **30 days** after receiving the Appeal. *for deadline to submit second level appeal, see immediately below.
Claimant	**Deadline to submit a second level Appeal following a denial of a level one Appeal**	**60 days** after receiving notice of the level one Appeal denial		
Claimant	**Deadline to request External Review—available** ***For Medical and Prescription benefits only***	**Four months** after receiving Final Internal Adverse Benefit Determination. An Urgent Care Claim may qualify for expedited External Review. Please see below.		
Claimant	**Deadline for correcting the External Review request (if Claimant sent incomplete request)**	Claims Fiduciary must permit the Claimant to complete the request within the **four-month filing period** or, if later, **48 hours** after notification.		

IRO	**Deadline to provide notice of preliminary External Review eligibility**	**Six business days** after receiving the request for External Review.
IRO	**Deadline to provide notice of External Review decision**	**45 days** after Independent Review Organization's (IRO) receipt of a qualifying request for External Review.
IRO	**Deadline to provide notice of preliminary expedited External Review eligibility**	**Immediately** upon receipt of a qualifying request for an expedited External Review.
IRO	**Deadline to provide notice of expedited External Review decision**	**72 hours** after reviewer's receipt of a qualifying request for expedited External Review.

Claims Fiduciary

The applicable Claims Fiduciary for the group health benefits as well as the location of their claims procedures are listed below:

Benefit	Claims Fiduciary	Where to File Your Claim	Specific Location of Claims and Appeals Procedures
Medical	Aetna	Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106 1-800-938-0512	HealthFund plans: Plan booklet D HDHP plan: Plan booklet F
Prescription	CVS Caremark	Call 1-866-559-6903 to inquire	Plan booklet G
Dental	Delta Dental	Delta Dental P.O. Box 2105 Mechanicsburg, PA 17055-6999 1-800-471-1282	Plan booklets H & I
Vision	VSP	VSP PO Box 385018 Birmingham, AL 35238-5018	Plan booklet J
Crew Assistance Program	Carebridge	Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Contact Carebridge for claims and appeals procedures

Best Doctors	Vanguard Crew Central	Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Contact Crew Central for claims and appeals procedures

RMA and Life Insurance Benefit Claims Subject to ERISA

It is important to know what type of claim you have because the claims and appeal procedures and deadlines vary depending on the type of claim involved. The time deadlines for the RMA and life insurance benefit claims are summarized below.

Benefit	Claims for RMA and Life Insurance
Deadline to file a Claim (if deadline is not specified here, please contact the applicable Claims Fiduciary, listed below)	**RMA:** Up to **2 years** from the date the expense was incurred **Life Insurance:**
Deadline for Claims Fiduciary to approve or deny Claim	**A reasonable period**, but not more than **90 days**
Extension of deadline for Claims Fiduciary to approve or deny Claim **Claims Fiduciary must provide notice to Claimant of extension before the time limit expires to approve or deny Claim** **If Claim submission is incomplete, plan may give Claimant opportunity to provide additional information**	**One 90-day extension** for "special circumstances" is permitted with notice to the Claimant before time limit expires to approve or deny Claim
How many levels of Appeal do the plans permit?	1 level of Appeal
Deadline for Claimant to submit an Appeal following a denial	**60 days** after receiving notice of initial decision
Deadline for Claims Fiduciary to review Appeal from Claimant	**A reasonable period**, but not more than **60 days**
Extension of deadline for Claims Fiduciary to review Appeal	**One 60-day extension** for "special circumstances" is permitted with notice to the Claimant.

The applicable Claims Fiduciary for the life insurance benefits as well as the location of their claims procedures are listed below:

Benefit	**Claims Fiduciary**	**Where To File Your Claim**	**Location of Claims and Appeals Procedures**
RMA	Vanguard Crew Central	WageWorks Spending Accounts PO Box 34700 Louisville, KY 40232	Contact Crew Central for claims and appeals procedures
Life Insurance	Minnesota Life Insurance Company	Minnesota Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098 1-866-293-6047	Contact Minnesota Life for claims and appeals procedures

Section VIII – Administrative Information

A. Subrogation and Reimbursement Rights

Subrogation

The Plan reserves the right to be subrogated to any and all claims of or on behalf of a participating Retiree or covered spouse or dependent ("Covered Person") against a third party that involves recovery of amounts paid or payable under the terms of the Plan. Acceptance of benefits under the Plan establishes an equitable lien by agreement by the Plan over any proceeds received by a Covered Person with respect to a benefit claim made under the Plan in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a third party, (2) a liability insurer for a third party, or (3) any other source (including but not limited to any form of uninsured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverage, or any other form of insurance coverage) ("Recovery") to the extent paid (or payable) by the Plan for the claim at issue.

Please consult the Plan booklet, applicable to the medical option you have selected. If the booklet has Summary of Coverage (SOC) language, (e.g. it mentions a Subrogation and Right of Recovery Provision), the policy in the booklet will govern. If the booklet has no mention of SOC language, the policy outlined here will apply.

If a Covered Person receives any Recovery, the Covered Person must repay the Plan in full for any such benefits which have been paid or which will in the future have to be paid under the Plan for expenses already incurred or which are reasonably foreseeable at the time of said recovery. Reimbursement to the Plan will be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in collecting payment (whether by judgment, settlement, payment or compensation) for the claim at issue. The Plan may require a Covered Person as a precondition to benefit payments to both sign a reimbursement agreement and to agree, in writing, to assist the Plan to secure the Plan's right to reimbursement of payment from a third party.

The Plan has the right to be paid first from any recovery described above and any and all related monies paid (or payable) to, or for the benefit of a Covered Person, to the extent of the benefits paid or payable by the Plan, whether or not the Covered Person has been made whole for injuries received. The Plan's right to recover will apply regardless of the manner in which the recovery is structured or worded (e.g., the recovery may seek to limit the Plan's reimbursement by stating that amounts paid do not represent medical expenses). The Plan's recovery will not be reduced by attorney's fees.

Covered Persons have an obligation and duty to reimburse the Plan for any amounts that should be paid to the Plan pursuant to these subrogation and reimbursement rights. Covered Persons are considered to give the Plan a first lien on any and all amounts to which the Plan is entitled. If the Plan does not receive payment of any such amounts, it may take legal action against the Covered Person, offset the amount of any future claim payment under the Plan to the Covered Person by the amounts that are owed or discontinue benefits under the Plan.

B. Amendment and Termination

Vanguard reserves the right to amend or terminate the Plan or any of its component benefit programs, plans and/or options at any time by action of its Board of Directors or such other officers as may be authorized from time to time by the Board. Additionally, The Vanguard Group, Inc. Benefits Committee has authority to make any amendment to the Plan.

C. ERISA Information

Vanguard provides employee benefit plans for eligible crew members and eligible Retirees in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law relating to the funding and administration of employee benefit plans.

Plan Sponsor

The Vanguard Group, Inc.

The plans described in this summary apply to crew members and Retirees of:

The Vanguard Group, Inc.
Vanguard Marketing Corp.
Vanguard Advisers, Inc.
Vanguard Fiduciary Trust Co.
Vanguard National Trust Co.

Address
100 Vanguard Boulevard
Malvern, PA 19355
610-669-1000

Employer Identification Number

Vanguard's Employer Identification Number (EIN) is 23-1945930.

Plan Administrator

The Plan Administrator for the Plan is:

The Vanguard Group, Inc.
Benefits Committee
P.O. Box 876
Valley Forge, PA 19482

Questions can also be directed to Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

The Plan Administrator is responsible for making sure that the Plan operates according to the terms of ERISA and the appropriate documents, contracts, or other agreements. In this respect, the Plan Administrator is the sole judge of the application and interpretation of the Plan provisions, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. The Plan Administrator also has the authority to delegate certain of its powers and duties to a third party and has delegated certain administrative functions under the Plan to insurance companies and other claims administrators. The Plan Administrator has also delegated its fiduciary authority to determine and decide claims for benefits as well as any appeals of such claims for benefits to certain of its third party administrators (including insurance companies). As the Plan Administrator's delegate, each of these third party administrators has the authority to make decisions under the Plan relating to benefit claims.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

In addition, the Plan Administrator has designated Vanguard Crew Central to be responsible for the day-to-day administration of the benefit plans described in this SPD. Vanguard Crew Central can answer benefit-related questions or help you with the processing of claims. Vanguard Crew Central is located at the address listed below. Any inquiries should be made to:

The Vanguard Group, Inc.
Crew Central, Mailport M20
P.O. Box 876
Valley Forge, PA 19482

Questions can also be directed to Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

Agent for Service of Legal Process

If you feel you must take legal action for any reason regarding your benefits, legal action can be served on the Plan Sponsor in care of:

The Vanguard Group, Inc.
100 Vanguard Boulevard
Malvern, PA 19355

Questions can also be directed to Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

Service of legal process may also be made on the Plan Administrator.

Plan Name

The Vanguard Group, Inc. Benefit Plan

Plan Number

506

Plan Type

The Plan includes medical, dental, vision, prescription drug, life insurance, crew assistance, retiree medical accounts and wellness benefits provided by Vanguard to eligible Retirees.

Plan Funding/Administration

Vanguard's benefits are funded through contributions made by Vanguard, and in some cases, by crew members and retirees. Cost will vary depending on the benefit.

Plan Year

The Plan Year is January 1 - December 31.

D. Your Rights Under ERISA

As a participant in certain of the benefits described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all participants in a plan covered by ERISA 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, including insurance contracts, 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, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan 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

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules 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 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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, which are described in this SPD.

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 that is denied or ignored, in whole or in part, 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.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. 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 (EBSA), 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.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA toll-free phone number at 866-444-EBSA (3272), or by visiting the EBSA web site at www.dol.gov/ebsa.

E. HIPAA Privacy

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act and the related regulations (collectively, "HIPAA") impose numerous requirements on employer group health plans concerning the use and disclosure of individual health information (referred to in this notice as "health information"). This information, known as protected health information, includes virtually all individually identifiable health information held by a group health plan — whether received in writing, in an electronic medium, or as an oral communication.

This notice describes the privacy practices that the Plan will follow in order to comply with the requirements of HIPAA with respect to the following benefits:

- Medical
- Prescription Drug
- Dental
- Vision
- Crew Assistance Program

This notice does not apply to health information collected or maintained by Vanguard on behalf of the non-health employee benefits that it sponsors, including disability benefits, life insurance, accident death and dismemberment insurance, and worker's compensation insurance.

The Plan may share health information with each other to carry out treatment, payment, or health care operations. The medical, prescription, and dental benefits are self-insured plans. These plans are collectively referred to as the "Plan" in this notice, unless specified otherwise. **It is important to note that Vanguard does not routinely have access to your individual health information. We use third party administrators, such as Aetna, to perform the daily administrative functions of our plans.** It is Vanguard's policy to train the limited number of crew members who have access to Plan personal health information in the manner necessary and appropriate to permit them to carry out their plan functions in compliance with HIPAA.

The Plan's Duties With Respect To Health Information About You

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to Vanguard's benefit plans, referred to as the Plan, and not to Vanguard as an employer. If you participate in an insured plan option (such as the VSP Vision Plan), you will receive a notice directly from the insurer regarding its privacy practices.

How The Plan May Use Or Disclose Your Health Information

The HIPAA privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Health care operations** include activities by the Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use summary information about crew member and Retiree claims to review the effectiveness of wellness programs.*

- **Treatment** includes providing, coordinating, or managing health care by one or more doctors or other health care providers. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan, through our third party administrators, may share health information about you with physicians who are treating you. Or, the Plan, through its third party administrators, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.*

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan, through our third party administrators, may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

The Plan may disclose your health information to third parties that assist the Plan in its operations. For example, the Plan may share your health information with its business associates if the business associate is responsible for paying medical claims for the Plan. The Plan's business associates have the same obligation to keep your health information confidential as the Plan does. The Plan must require its business associates to ensure that your health information is protected from unauthorized use or disclosure.

The amount of health information used, disclosed or requested will be limited to the "minimum necessary" to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses protected health information for underwriting purposes, the Plan will not use or disclose protected health information that is your genetic information for such purposes.

Other Allowable Uses Or Disclosures Of Your Health Information

In certain cases, your health information can be disclosed **without** authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a

similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information **without** your written authorization for the following activities:

Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); this includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you will be notified of the Plan's disclosure if informing you will not put you at further risk).
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by

	researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

How The Plan May Share Your Health Information With Vanguard

The Plan, or its third party administrator, may disclose your health information without your written authorization to Vanguard for plan administration purposes. Vanguard may need your health information to administer benefits under the Plan. Vanguard agrees not to use or disclose your health information other than as permitted or required by the Plan documents or by law.

Here are some examples of additional information that may be shared between the Plan and Vanguard, as allowed under the HIPAA rules:

- The Plan, or its third party administrator, may disclose "summary health information" to Vanguard, as the Plan sponsor, if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. (Summary health information is information that summarizes crew member and Retiree claims information, but from which names and other identifying information has been removed.)
- The Plan, or its third party administrator, may disclose to Vanguard information on whether an individual is participating in the Plan.

Note that the Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

Vanguard cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Vanguard from a source other than the Plan (e.g., you or your health care provider) for purposes such as administering its family and medical leave policy, fulfilling its obligations under the Americans with Disabilities Act, or administering its workers' compensation program, is *not* protected under HIPAA's privacy rules (although the privacy of this type of information may be protected under other federal or state laws).

Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures of your health information for marketing purposes and disclosures that constitute the sale of your health information require an authorization. Other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Plan has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

Your Individual Rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. All requests made pursuant to these rights must be made in writing. To exercise any of these rights, you may first call Vanguard Crew Central at 844-VG1-CREW (844-841-2739) for instructions. Or you may submit the request in writing to the following address:

The Vanguard Human Resources Department
Attention: HIPAA Privacy Official
Mailport M22
P.O. Box 876
Valley Forge, PA 19482

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid in full out of pocket for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; records relating to enrollment, payment, or claims adjudication; case or medical management record systems maintained by a plan or its third party administrators; or a group of records the Plan uses to make decisions about individuals. However, you do **not** have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information. The Plan may also charge reasonable fees for copies or postage. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set to the extent that it is inaccurate or incomplete. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures that were required by law, that were made in connection with public health activities, or that were made in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on these types of disclosures of your health information going back for six years from the date of your request.

You do **not** have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or a law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agree to receive this notice electronically may request a paper copy at any time.

Right to Breach Notification
You have the right to, and will receive, notification if a breach of your unsecured health information requiring notification occurs.

Changes To The Information In This Notice

The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If the Plan materially changes any of its privacy practices covered by this notice, it will revise this notice, and provide you with the revised notice within 60 days of the revision (or within such other time frame required under the regulations), or if the Plan posts the notice on its website it shall: (1) prominently post the material change or the revised Notice on its website by the effective date of the material change to the notice; and (2) provide the revised notice, or information about the material change and how to obtain the revised notice during the next annual enrollment or at the beginning of the plan year if there is no annual enrollment process. In addition, copies of the revised notice will be made available to you upon your written request, and any revised Notice will also be available on CrewNet External (https://crewnet.vanguard.com).

Complaints

If you believe your privacy rights have been violated or the Plan has not followed its legal obligations under HIPAA, you may complain to the Plan's Privacy Official or with Office for Civil Rights of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint. If you have any questions about filing a complaint, you may call Vanguard Crew Central at 844-VG1-CREW (844-841-2739). All complaints must be made in writing and sent to the following address:

The Vanguard Human Resources Department
Attention: HIPAA Privacy Official
Mailport M22
P.O. Box 876
Valley Forge, PA 19482

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, call Vanguard Crew Central at 844-VG1-CREW (844-841-2739).

F. Notice Under Woman's Health and Cancer Act of 1998

If you have had or going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Federal law requires group health insurance to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy; thus the health plans offered by Vanguard will provide coverage for those services in accordance with this law. The required mastectomy coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed:
- Surgery and reconstruction of the other breast to produce a symmetrical appearance:
- Prostheses: and
- Treatment of physical complications at all stages of the mastectomy, including lymphedema.

The benefits for these services will be provided in a manner determined in consultation with the attending physician and patient. These reconstructive benefits are subject to annual Plan deductibles and coinsurance provisions like other medical and surgical benefits covered under your medical plan.

G. Notice Under the Newborn and Mothers Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay for up to 48 hours (or 96 hours) as applicable.

H. Notice of Creditable Coverage

Important Notice from Vanguard about Creditable Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it with your benefit records.

The purpose of this notice is to advise you that the prescription drug coverage under The Vanguard Group, Inc. Benefit Plan (the "Plan") is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in year 2018. As such, the Plan's prescription drug coverage constitutes "creditable coverage."

Why is This Important?
This notice is important because it proves that you have creditable coverage. Because our prescription coverage is creditable coverage, you may be protected from having to pay a penalty if you subsequently lose or drop this coverage. This protection applies as long as you do not have a break of 63 days or more between the time creditable coverage under the Plan ends and your Medicare Part D prescription plan coverage begins.

Notice of Creditable Coverage

Please read this notice carefully. This notice has important information about your current Vanguard medical plan (including prescription drug coverage) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan if you become covered by Medicare in 2018. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current Plan coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- Vanguard has determined that the prescription drug coverage administered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, (for example, you leave employer coverage) you will be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Vanguard coverage will not be affected. You may coordinate the Vanguard medical plan (including prescription) with a Medicare prescription drug plan. If you decide to enroll in a Medicare prescription drug plan and drop your Vanguard medical plan (including prescription), be aware that you and your dependents may not be able to get your Vanguard coverage back during the current plan year, unless you have a change in status as described in the Plan. However, provided you remain eligible, you may enroll back in Vanguard's medical plan (including prescription) during the next open enrollment period under the Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Vanguard and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium will go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You will have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next October to join.

For More Information About This Notice
For more information about this notice or your current prescription drug coverage or to request a copy of this notice, contact Vanguard Crew Central by calling 844-VG1-CREW (844-841-2739). A copy of this notice will also be posted on CrewNet External (https://crewnet.vanguard.com).
Note: You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage or if this Vanguard coverage changes.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is contained in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here are additional resources for information about Medicare prescription drug plans:

- Visit Medicare's website at www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you were required to pay a higher premium (a penalty).