S I G N E T I C S

I N T E R N A L   C O R R E S P O N D E N C E

TO: Non-Exempt Employees

Date: November 28, 1989

FROM: Linda Francis, Manager
Compensation and Benefits

SUBJECT: EMPLOYEE GUIDE UPDATE #1

Enclosed is the FIRST UPDATE to your Employee Guide. From time to time, replacement pages and/or sections will be distributed. It is your responsibility to keep your Employee Guide handbook current. If you have any questions, please see your Division HR Manager or the Benefits Department.

Here are some HIGHLIGHTS of changes:

LIFE - new page reflects that coverage starts on date of employment (page 1)

DENTAL - new page reflects that coverage for dependents who are enrolled late starts January 1 (page 1)

PENSION - explanation of pension plan (complete section)

****

Please REMOVE:	Please INSERT:
LIFE - page 1 dated 1/86	LIFE - page 1 dated 8/89
DENTAL - page 1 dated 1/89	DENTAL - page 1 dated 1/89
	PENSION section dated 6/89

****

0288i

S I G N E T I C S

I N T E R N A L   C O R R E S P O N D E N C E

TO: Exempt Employees

Date: November 28, 1989

FROM: Linda Francis, Manager
Compensation and Benefits

SUBJECT: EMPLOYEE GUIDE UPDATE #1

Enclosed is the FIRST UPDATE to your Employee Guide. From time to time, replacement pages and/or sections will be distributed. It is your responsibility to keep your Employee Guide handbook current. If you have any questions, please see your Division HR Manager or the Benefits Department.

Here are some HIGHLIGHTS of changes:

LIFE - new page reflects that coverage starts on date of employment (page 1)

DENTAL - new page reflects that coverage for dependents who are enrolled late starts January 1 (page 1)

PENSION - explanation of pension plan (complete section & Signetics insert)

FAMILY SURVIVOR - explains what happens if you work past age 65 (page 3); automatic extension of health coverage for dependents is discontinued (page 7)

****

Please REMOVE:	Please INSERT:
LIFE - page 1 dated 1/86	LIFE - page 1 dated 8/89
DENTAL - page 1 dated 1/89	DENTAL - page 1 dated 1/89
	PENSION section dated 6/89
FAMILY SURVIVOR section dated 1/86	FAMILY SURVIVOR section dated 7/89

****

02881

S I G N E T I C S

I N T E R N A L   C O R R E S P O N D E N C E

To: Exempt Employees   Date: July 12, 1989

From: Linda Francis, Benefits Manager

Re: Employee Guide Book

Here is your new Employee Guide book, which contains information on benefits, policies, and your responsibilities as an employee of Signetics. Your guide contains the following sections:

Employee Handbook - explains work rules and your responsibilities, and has information on company policies such as time off, compensation, safety and security.

Health - explains the Metropolitan Medical plan.

PAR - explains the pre-admission review program under the Metropolitan Medical plan.

Life - explains your company-paid and optional life insurance coverage, and dependent life insurance plan.

Travel Accident - explains the Business Travel Accident Insurance policy.

Family Survivors - explains the Family Survivors Benefit, part of the exempt pension plan.

ESP - explains the Employee Savings Plan (401k plan).

Dental - explains the Metropolitan Dental plan.

EAP - explains the Employee Assistance Program.

Later in the year, you will receive sections explaining the Pension Plan and FLEX (Flexible Spending Account).

All sections in this guide are effective as of January 1, 1989. From time to time, revisions will be sent. It is your responsibility to keep your Employee Guide book up-to-date.

Please take the time to familiarize yourself with the information in your guide, and keep it with your important papers. You will be responsible for returning your guide book in good condition when you leave the company.

If you are missing any of the sections indicated above, or if you have any questions, please contact your Division Human Resource Manager, or the Benefits Department.

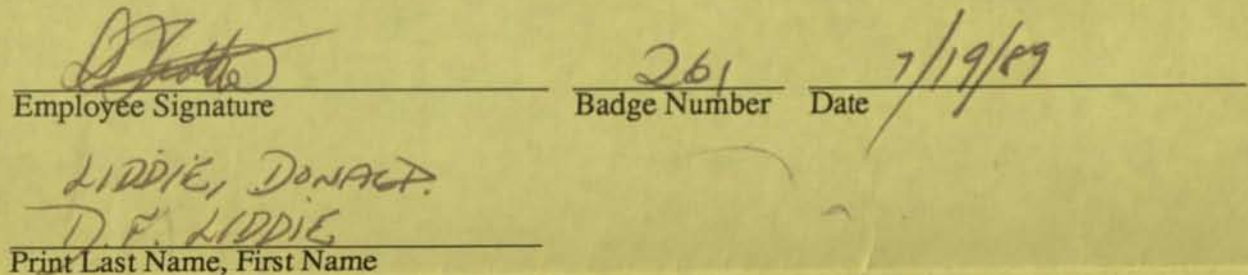
GUIDEBOOK ACKNOWLEDGEMENT

I have received a copy of the Employee Guidebook which outlines the benefits, policies, and employee's responsibilities at Signetics. I will read this guide, ask for more information if I need it, and comply with the policies, requirements, and procedures it describes.

The information in this guide is subject to change as situations warrant. I understand that changes in company policies may supersede, modify or eliminate the policies summarized in this book. Changes in policy may be communicated to me by my supervisor or through official notices or bulletin boards. I accept responsibility for keeping informed of these changes.

I will inform my supervisor of any changes in personal data such as phone number and address. I also accept responsibility for contacting my Division H.R. Manager if there are questions or concerns that need further explanation.

I agree to return this Guidebook in good condition when I leave the company.



Employee Signature　　261 Badge Number　　Date 7/19/89

LIDDIE, DONALD
D.F. LIDDIE
Print Last Name, First Name

THANK YOU -- EMPLOYEE RELATIONS

White copy: CHRIS Center　　Yellow copy: Employee

Employee Handbook

No section of this guidebook for salaried employees shall constitute either an express or implied contract of employment.

EMPLOYEE HANDBOOK

Employee handbook

Section | Page

Preface 1

Welcome to Signetics 2

Signetics – A Division of North American Philips Corporation 3

For Your Convenience...Human Resources 4

Our Commitment to Equal Employment Opportunity 4

Employee Referrals 5

Job Opportunity System 5

Our Policy on Outside Employment 6

Employment of Relatives 6

Immigration Assistance 7

Remaining Union Free 7

Drug-Free Workplace Policy 8
- Employee Assistance Program and Alternatives 8
- Inspections 10
- Employees in Sensitive Jobs 10
- Consequences for Violation of this Policy . . . 10
- Condition of Employment 10
- Contractors 10

Rules and Responsibilities 11

Talking Things Over is Our Policy 11
- Informal Complaint Procedure 11
- Formal Complaint Resolution 11
- 1st Level Review 12
- 2nd Level Review 12
- 3rd Level Review 12
- To Initiate A Formal Complaint 12
- To Appeal Further 12

Employee Proprietary Agreements 13

No-Smoking/Smoking Guidelines 13

Attendance and Punctuality 14

Corrective Action 14
- Performance Deficiencies 14
- Solicitation—Distribution 15
- Insubordination 16
- Other Violations 16

Business Fluctuations 17

When You Leave the Company 17

Employee handbook (continued)

Section | Page

Signetics Security Policy 18
Employee Badges 18
Property Passes 19
Employee's Responsibilities 19
Signetics Safety Policy 20
Signetics Safety and Environmental Training ... 21
Medical Facilities 21
Workers' Compensation 22
What's Not Covered? 23
Special Notes 23
Incidental Absences 24
Leaves of Absence 25
Medical Leave 25
Maternity Leave 25
Industrial Leave 25
Personal Leaves 25
Other Company Benefits
Educational Assistance 26
NAPC Scholarship Program 26
Signetics Scholarship Program for Children of Deceased Employees 26
Matching Gift Program 26
Employee Store 26
Vacation 27
Anniversary Bonus 27
Holidays 27
Flexible Time Off 28
Our Compensation Policy 28
Performance Reviews 28
Merit Increases 28
Automatic Deposit-"Sure Pay" 28
Payroll Deductions 29
Work Schedules 29
Shift Differentials 30
Extended Work Week 30
Additional Compensation 30

Preface

This section has been designed to provide you with information relevant to your employment with Signetics. It is in no sense a "contract", but is rather in the nature of a set of guidelines. Signetics reserves the right to modify, suspend, or withdraw any provisions of this section, or the entire section, at any time, without notice.

The existence of this Employee Handbook shall not be construed as modifying the "at-will" employment relationship you have with Signetics; you may resign at any time without expressing a reason and, likewise, Signetics may terminate your employment at any time.

Welcome to Signetics

You have been carefully chosen to be one of our employees. We want the time you spend on the job to be as interesting, productive, and pleasant as possible. This section of the employee guidebook has been written to provide you and your family more information about Signetics. We think that the more you understand about the Company, the more fulfilling your job will be.

This section of the employee guidebook contains sections on general information, benefits, compensation, and Company rules. Please read this information and keep it as a handy reference.

From time-to-time, new sections may be sent out to keep you informed of changes to policies, benefits, or rules. The Company may change or alter programs/policies covered in these sections at any time and without prior notice.

Good luck in your work. Remember, when you succeed, so do we.

Signetics - a division of North American Philips Corporation

Signetics was the first company in the world established for the sole purpose of developing, manufacturing and marketing integrated circuits (ICs).

In 1961 a group of pioneers in the development of integrated circuits formed Signetics, an acronym for Signal Network Electronics, in Silicon Valley. Today, with more than 9,000 employees worldwide, Signetics maintains its headquarters in Sunnyvale, California, with fabrication facilities in Albuquerque, New Mexico, and Orem, Utah; and assembly plants in Bangkok, Thailand and Seoul, Korea.

In 1975, Signetics was acquired by N.V. Philips of The Netherlands, creating a combined position as one of the top 10 semiconductor manufacturers in the world. Signetics is now a division of North American Philips Corporation.

Signetics' three divisions—Standard Products, Customer Specific Products and Commercial and Industrial Products—manufacture and market ICs for application in such diverse markets as electronic data processing, industrial controls, instrumentation, consumer electronics, data communications, telecommunications, automotive and military.

We have a long-established reputation for a broad selection of high-speed bipolar products, and we are one of the world's largest suppliers of bipolar parts. And in keeping with the industry trend toward intelligent integrated solutions, we are introducing new CMOS product design in all our product divisions.

The companies using our products are as diverse as our product line. Signetics ICs have helped revolutionize many facets of modern life including the personal computer, medical equipment, satellites, telecommunications, and automotive controls.

Now into our third decade, Signetics still retains the ideals which made it a leader in semiconductors. And with the maturity gained through our years in the forefront of the industry, our wealth of top industry professionals, plus the resources of Philips, we will continue to take possibilities and turn them into exciting realities.

For your convenience... human resources

A Human Resource Manager is assigned to each division and operating unit. This person has a full range of skills from problem solving to providing general information about pay, benefits, and the like. If you have a question that your supervisor can't answer or you need guidance with a problem, feel free to contact this individual.

Our commitment to equal employment opportunity

Signetics has long supported and maintained a policy of Equal Employment Opportunity (EEO). We are committed to taking the affirmative actions necessary to employ and promote qualified people from all segments of our society.

It is Signetics' policy to hire, train and promote without regard to race, color, religion, marital status, sex, national origin, age, non-disqualifying handicap, or status as a disabled or Vietnam-era veteran. Furthermore it is our policy to make reasonable accommodations for the employment of handicapped persons. Employees who have questions or concerns about the application of this policy should direct those questions to their Human Resource Manager or the Employee Relations Manager.

Furthermore, we want to maintain a work place that is productive and free of harassment of any kind. Employees who believe they have suffered or witnessed sexual, racial harassment or other violations of Equal Employment Opportunity are requested to discuss this matter with their Human Resource Manager or the Employee Relations Manager.

Employee referrals

Our goal is to use our vast employee network as a major resource in referring qualified applicants to fill open positions.

The employee referral system is coordinated by the Employment Department. Although referrals are always encouraged and appreciated, sometimes special employment needs are targeted. At such times, incentives may be added for recommending qualified applicants. Positions with special incentives will be posted on Job Opportunity System (JOS) bulletin boards. Descriptions of these jobs may also be reviewed in the Employment Department.

Anytime you have an applicant to refer, just forward a copy of that person's resume or application to the Employment Department with a completed referral form. Referral forms are available in building lobbies. We count on your good referrals to keep making our Company strong. Our referral system is conducted in strict compliance with our commitment to equal employment opportunity.

JOS

Job opportunity system

We want Signetics employees to meet their needs for new challenges and opportunities. We aid in this goal by offering an internal Job Opportunity System (JOS).

The JOS provides information on local and branch openings authorized for relocation benefits, up to and including positions in salary grade 53. These openings are ordinarily posted on bulletin boards in each building, every week.

The application procedure is simple, and all employees, except those under Corrective Action, are allowed to apply. Other guidelines are:

1. **Non-exempt employees must have completed six months in their present position before applying, and**
2. **Exempt employees must be in their present positions nine months before applying for an upward move and 12 months for a lateral move.**

Just fill out a form—available near bulletin boards or from lobby receptionists or Human Resources—and send it to the Employment Department or to your Human Resource Manager.

Your Supervisor, the Employment Department, or your Human Resource Manager can answer your questions about this program.

Our policy on outside employment

If you accept outside employment you must be aware that as a full-time employee of Signetics you will be expected to competently meet all requirements of your Signetics job.

If you have other employment or are thinking of beginning another job, in addition to your position at Signetics, you must discuss this with your supervisor to ensure you avoid the following:

1. **Working for a subcontractor, customer, or vendor that could place you in a position of conflict of interest.**
2. **Working for a competitor if you have access to proprietary or confidential information.**

Employment of relatives

Signetics accepts and reviews applications from relatives of employees. However, the Company realizes that uncomfortable situations may sometimes arise between relatives that affect both employees and the Company. Our policy is that an applicant may not be hired if he or she would report directly or indirectly to a relative or to the same supervisor to whom a relative reports. Also, a person may not be hired if he or she would work in a relative's chain of command. Employment of relatives may be prohibited when one or both individuals has or would have access to confidential or proprietary information. (A "relative" is anyone related to an employee by adoption, blood, or marriage, or in cohabitation with an employee.) If other issues arise related to employment of relatives, they will be decided on a case-by-case basis.

Immigration assistance

Signetics complies with laws and regulations regarding the employment of aliens. These laws and regulations require nonresident aliens to obtain the appropriate US visa status prior to being employed at Signetics. Contact your Human Resource Manager or Signetics' Immigration Services Administrator if you have questions about visa status.

Remaining union free

During our history, Signetics has operated without a union. We want to maintain this union-free status. Over the years, management has established an environment where third-party assistance is not needed. Signetics has a friendly, helpful atmosphere where employees and supervisors at all levels solve problems, discuss issues, and establish and achieve mutual goals and objectives. This interaction is healthy and very important. Ample evidence exists showing that unions impede these activities.

Signetics is anxious to maintain technological leadership in an industry experiencing daily and weekly technical advances. To do this, flexibility, creativity, and freedom to make quick, innovative decisions is crucial. We do not believe that a union can help us achieve these objectives. We will strive to maintain a people-oriented environment where employees do not feel the need for or value of third-party interference.

Drug-free workplace policy

Signetics is committed to and supports a drug-free culture and workplace. Employees are our most valuable resource and the health and safety of our employees therefore is a concern.

In order to provide a drug-free workplace and comply with the requirements of the Drug-Free Workplace Act of 1988, Signetics provides a Drug-Free Awareness Program consisting of the following elements:

1. An Employee Assistance Program for employees in need of counseling and treatment for drug or alcohol problems.
2. An informational program to provide employees with education about drugs and alcohol.
3. A corrective action process to redirect employees who do not adhere to the Drug-Free Workplace requirements.

Employee Assistance Program and Alternatives

Early recognition and treatment of alcohol or drug abuse is important for successful rehabilitation, and for reduced personal, family, and social disruption. Signetics encourages the earliest possible diagnosis and treatment for alcohol or drug abuse. However, the decision to seek diagnosis and accept treatment for alcohol or drug abuse is the responsibility of the employee.

Signetics' Employee Assistance Program (EAP), provides assessment, counseling and referral services for employees with substance abuse problems (EAP handbooks are available through Benefits or Human Resources). Signetics offers leave options for employees who need time off work for treatment of substance abuse problems. To ensure that these benefits are available, however, employees must voluntarily seek help. These benefits may not be available to employees who do not seek help on their own.

Employees with alcohol or drug abuse problems should request the assistance of EAP, Health Services, or other specialized treatment program of their choice. Employees may seek help without the approval or even knowledge of their supervisor. EAP or Health Services will provide assistance and will refer the employee to appropriate counselling and treatment services. The names of those employees who seek help with EAP are kept in confidence.

Drug-free workplace policy (continued)

Voluntary requests for assistance for alcohol or drug abuse problems will not prevent disciplinary action for violation of Signetics' Drug-Free Workplace Policy, however. Employees who undergo voluntary counselling or treatment and who continue to work must meet all established standards of conduct and job performance.

The following are violations of Signetics policy:

1. Use, possession, manufacture, distribution, dispensation or sale of illegal drugs or drug paraphernalia on Company premises or during Company business, in Company supplied vehicles, or during work hours;
2. Unauthorized use or possession, or any manufacture, distribution, dispensation or sale of a controlled substance on Company premises or during Company business, in Company supplied vehicles, or during working hours;
3. Unauthorized use, manufacture, distribution, dispensation or possession or any sale of alcohol on Company premises or during Company business, in Company supplied vehicles, or during working hours;
4. Storing in a locker, desk, automobile or other repository on Company premises any illegal drug, drug paraphernalia, any controlled substance whose use is unauthorized, or any alcohol;
5. Being under the influence of an unauthorized controlled substance or illegal drug on Company premises or during Company business, in Company supplied vehicles, or during work hours;
6. Use of alcohol off Company premises that adversely affects the employee's work performance, his or her own or others' safety at work;
7. Possession, use, manufacture, distribution, dispensation or sale of illegal drugs off Company premises that adversely affects the employee's work performance, his or her own or others' safety at work;
8. Conviction under any criminal drug statute for a violation occurring in the workplace.

Drug-free workplace policy (continued)

Inspections

Whenever Signetics suspects that an employee's work performance or on-the-job behavior may have been affected in any way by alcohol or drugs, the Company may search the employee, the employee's locker, desk or other Company property under the control of the employee, as well as the employee's personal effects or automobile on Company property.

Whenever Signetics suspects that an employee has sold, purchased, or used or possessed alcohol, drugs, or drug paraphernalia on Company premises, the Company may inspect the employee, the employee's locker, desk or other Company property under the control of the employee, as well as the employee's personal effects or automobile on Company property.

Employees in Sensitive Jobs

Signetics is particularly concerned about alcohol and drug abuse by employees in jobs involving access to proprietary or classified information, operation of dangerous machinery or equipment, use of chemicals, or involving other special risks to public or employee safety.

Consequences for Violation of this Policy

Signetics may terminate any employee working in a sensitive job who violates this policy.

Even for employees in non-sensitive jobs, violation of Signetics' Drug-Free Workplace Policy may result in severe disciplinary action, including discharge, even for a first offense, at the Company's sole discretion.

Condition of Employment

Compliance with Signetics' Drug-Free Workplace Policy is a condition of employment. Failure or refusal of an employee to cooperate fully will be grounds for termination.

Contractors

Signetics' Drug-Free Workplace Policy applies not only to its own employees but equally to all employees of contractors and subcontractors while they are on Signetics' premises.

Rules and responsibilities

This section describes some of your responsibilities as an employee at Signetics and informs you of some general rules and corrective action procedures. Please read this section carefully and clarify any questions you might have with either your supervisor or your Human Resource Manager.

Talking things over is our policy

Signetics has an open door policy and encourages employees to talk things over with their management or Human Resource representative. Additionally, it is the policy of Signetics to provide prompt resolution of concerns, problems or complaints which may arise during the course of employment. To assist in the resolution of such matters, employees may choose to use either the Informal or (if applicable) Formal Complaint Resolution Procedure.

Informal Complaint Procedure

Employees should initially discuss the concern, problem or complaint with their immediate supervisor. Supervisors will make every effort to resolve the issue at this level. If an issue is unresolved, employees may request to meet with the next level manager or with Human Resources. This process may continue up to and including the respective Unit Manager or Plant Manager.

Formal Complaint Resolution

The Formal Complaint Procedure may only be used when the employee believes that an express policy of Signetics has been violated to his or her disadvantage. Complaints relating to management's right to establish or change business and personnel policies, practices, rules or regulations are not subject to the Formal Complaint Procedure.

The Formal Complaint Procedure allows for three separate reviews. After each review a determination will be issued to all parties involved. The employee may file an appeal to the determination after both the first and second review. This appeal will move the complaint to the next level of review. The third review is final and binding on all parties. The following indicates the designated respondent at each review level of the Formal Complaint Procedure.

Talking things over is our policy (continued)

1st Level Review

Employee Relations Manager for Sunnyvale employees.

– OR –

Plant Human Resource Manager for Albuquerque and Orem employees.

2nd Level Review

Unit Manager for Sunnyvale employees.

– OR –

Plant Manager for Albuquerque and Orem employees.

3rd Level Review

Staff Vice President or Group Human Resource Manager

To Initiate A Formal Complaint

Employees must submit the complaint in writing to their Human Resource Manager within 30 days of the event upon which the complaint is based.

In addition to the employee's name, division, supervisor's name, date and description of the circumstances, the complaint must include a statement of the proposed remedy or correction desired.

The Human Resource Manager will forward the complaint to the respondent indicated above who will investigate the complaint. The respondent will issue a written determination to all parties involved within 30 days of receipt of the complaint.

To Appeal Further

The complaint will be considered closed unless a written notice of appeal is filed with the Human Resource Manager within five business days of receipt of the determination by the dissatisfied party. The respondent for second level review (indicated above) will investigate the complaint and issue of written determination to all parties involved within 15 business days of receipt of the complaint file.

If either party is dissatisfied with the determination of the second level review, an appeal must be filed with the Human Resource Manager within five business days from receipt of the determination. This appeal will be reviewed by the third level respondent, and a final and binding determination will be issued within 15 business days of receipt of the complaint file.

Signetics may increase any time limit in this process as circumstances warrant.

Employee proprietary agreements

When you joined the Company, you were required to sign an agreement concerning inventions, trade secrets, conflict of interest and confidential information, and an agreement regarding data and software security. By signing these documents you agree not to discuss, either inside or outside of the Company, or use any confidential information or data, except as required in the normal course of business. These agreements remain in effect even after you leave the Company.

If you have questions about these documents, discuss them with your supervisor or Human Resource Manager.

No-smoking/smoking guidelines

It is Signetics' policy to accommodate employees who request a smoke-free immediate work area. An immediate work area means either an enclosed office or the area immediately around the desk, chair, work table, file or other equipment used primarily by the employee.

Employees may post a "No Smoking" sign in their immediate work area. Signs are available from Human Resources.

Smoking is prohibited for all employees in auditoriums, classrooms, conference rooms, all lobbies, non-smoking section of cafeterias, elevators, hallways, health services, restrooms, and stairwells.

Employees who believe that this does not provide them an adequately smoke-free environment in the immediate work area must attempt to resolve the matter with their supervisors.

Employees may obtain copies of this policy from their Human Resource Manager.

Attendance and punctuality

Each area's smooth and efficient operation depends on employees being on the job every scheduled day, ready to work and on time. Employees are expected to maintain the attendance standards established by their department.

Telephone your supervisor by the start of the shift any time you are going to be absent or late. Failure to report your absences or absenteeism and tardiness may lead to corrective action up to and including termination.

Corrective action

Signetics has a flexible set of steps that may be used for correcting problems involving performance and some acts of misconduct. This Corrective Action Procedure usually consists of a verbal warning and a written warning. For some problems, a probationary period may also be used. If the problem recurs or other problems develop, a step may be eliminated or termination may be initiated. Signetics reserves the right to vary from this system whenever the situation warrants such action. Any violation may result in immediate termination. A list of violations which ordinarily result in immediate termination is also included in this section.

Take time to learn these rules. If you need advice or disagree with the corrective action taken, contact your supervisor, or your Human Resource Manager. You may also use the Complaint Resolution Procedure if you think an action is unfair. Your Supervisor or Human Resource Manager can provide you with a copy of the Complaint Resolution Procedure.

Corrective action may be used for, but is not limited to, the following problems or violations:

Performance Deficiencies

- Making repeated errors or failing to complete assigned work.
- Failing to do work of acceptable quality and/or quantity.
- Receiving an overall rating of less than "Fully Effective" on a Performance or RMO Review.
- Acting in a manner that interferes with or disrupts the morale, teamwork or the work environment. This includes co-employee harassment of any sort.

Corrective action (continued)

Absenteeism/Tardiness that exceeds departmental standards, such as:

- Failing to notify the supervisor of an absence or late arrival.
- Leaving the work site without prior notification of or approval from the supervisor.
- Failing to return from breaks, lunch, errands, etc. in a timely manner.
- Sleeping or loafing on the job.

Violating Safety or Security rules that do not ordinarily carry the risk of property loss, damage or bodily harm, such as:

- Entering restricted areas or other work areas without the supervisor's permission.
- Failing to display the Company badge or present proper identification upon request of any security or management representative.
- Enabling or allowing another person to enter Company premises for purposes that are not business related.

Solicitation—Distribution

- Soliciting another employee for any reason while either employee is on work time. Work time does not include an employee's own time, such as meal periods, scheduled breaks, time before or after shifts, and personal clean-up time.
- Distributing or posting non-Company literature or other written materials in work areas at any time.
- Posting non-Company information on bulletin boards or other Company property.

The following is a list of violations which ordinarily result in immediate termination.

Theft of or causing damage to, Company or another person's property, including equipment, work in progress, finished goods, buildings and fixtures, or automobiles.

A dereliction of duty that leads to a substantial monetary loss to the Company.

Corrective action (continued)

Violating Safety and Security rules that ordinarily carry a risk of property loss, damage, or bodily harm, such as:

- Engaging in horseplay or mischievous activity.
- Bringing lighted materials into or smoking in restricted areas.
- Bringing cameras onto Company premises without the Security Manager's written permission.
- Refusing to allow a Security representative to search your belongings, including your vehicle, or your person, on Company premises.
- Possessing, selling, using or being under the influence of alcoholic beverages or drugs while on Company property.
- Removing Company products, property, or materials from their designated locations without appropriate documentation from the responsible supervisor.
- Failing to follow departmental or Company safety practices.
- Bringing weapons, such as firearms, knives, or explosives, onto Company property.

Insubordination

- Failing to comply with work requests.
- Undermining the authority of the supervisor or his or her designee.

Other Violations

- Discriminating against any person on the basis of any factor protected by law. This also prohibits sexual and racial harassment in any form, including verbal, physical, or visual harassment.
- Fighting, using threatening gestures or language, or disrupting the work environment.
- Misusing or failing to carry out supervisory responsibility.
- Committing or being charged with acts that are fraudulent, dishonest, illegal, or otherwise socially unacceptable.
- Violating employee proprietary agreements.
- Failing to reimburse overpayments, clear expense reports, or repay debts owed to the Company or the Employee Services Center.
- Falsifying Company records such as time cards, expense reports, work reports, etc.
- Smoking in designated no-smoking areas.

Corrective action (continued)

- Making an entry on another employee's time card or work papers without having official authorization.
- Being on probation more than twice, for any reason, within a 12-month period.
- Being absent for three consecutive work days, or two consecutive work days if nonstandard work week, without informing the supervisor (no-call, no-show).
- Conducting personal business on Company property, such as using Company facilities, supplies, telephones, or equipment.

Business fluctuations

Signetics was established in 1961 and since that time has grown into a major manufacturer of integrated circuits. Our work force has been subject to the fluctuations brought about by the ebb and flow of a dynamic industry. When layoffs (reductions-in-force) are necessary, we make an effort to retain the most talented and capable employees. While length of service may influence the order in which individuals are considered for reduction-in-force, a combination of factors will govern the selection process. These factors include, but are not limited to: past performance and productivity, qualifications, attendance and/or punctuality, and current and prior corrective action status.

Employees who are rehired within one year after being reduced-in-force are eligible for reinstatement privileges. Such rehires may enroll in any existing or new benefit programs for which they are otherwise eligible. Their original or adjusted hire date will also be reinstated and used to determine service-related benefits, such as vacation and service awards.

When you leave the company

The employment relationship is a mutual one that may be severed at any time by either party. Nothing in this section or Signetics Policies and Procedures in any way diminishes or limits the parties' right to terminate the employment relationship.

If you decide to resign, we ask that you give one pay period of notice. You must return your badge and all property belonging to Signetics. Final checks are distributed from the CHRIS Center area, unless special instructions are given.

Signetics security policy

The Signetics Security Department provides an effective system of safeguards to protect employees, Company property, and facilities from loss and damage. This includes guarding of Company proprietary information, data security, and protecting facilities against fire, theft, pilferage, fraud, misuse, and malicious destruction. Security is also responsible for maintaining order among employees and visitors on Company property in accordance with established rules.

Maintaining effective security is the responsibility of everyone. While Security is responsible for establishing the protective program and defining local procedures in accordance with general Company policies, supervisors and managers are responsible for some aspects of security in their respective areas.

Employee Badges

Signetics controls access to all of its buildings. Control is necessary to help enforce Security and Safety procedures developed for the protection of Signetics personnel and property.

All employees are provided with a badge which has "Signetics" in bold print across the top, with the employee's picture and name below. The color of the print designates how long an employee has worked for Signetics.

Yellow 0-3 years	Green 10-14 years
Blue 3-4 years	Silver 15-19 years
Red 5-9 years	Gold 20-25 years
	Maroon 25+ years

If a badge is lost, notify Signetics Security within 72 hours so that a replacement badge can be made. If a badge is found after a new badge has been issued, return it to Security.

Signetics security policy (continued)

Property Passes

A property pass system has been devised to track removal or transfer of personal or Company property within the Corporation. Property passes are available from the Security Office or your building receptionist.

Employee's Responsibilities

As a Signetics employee you have the following responsibilities:

- Show your badge to the security officer, receptionist or Mardix automated system when entering a Signetics building.
- Wear the badge in plain sight, above the waist at all times while on Company property.
- To refrain from drug and/or alcohol use on Company premises.
- Do not bring photographic and photodocumentation equipment, tape recorders and radios in the building without proper clearance from the Signetics Security Department.
- Offer for inspection any package or container leaving or entering the premises, including briefcases and purses. Security is also authorized to inspect any vehicle that is on Company property.
- Park your private vehicles in authorized areas only. Do not park in No Parking, Handicap, fire lanes, loading zones, or areas which might block the flow of normal traffic. Persons parked illegally on Company premises are subject to citation or towing.
- To use your own stationery and postage if you are using the internal system for your personal mail.

Security Programs are most effective when the Security Department has the cooperation of everyone at all levels.

Signetics safety policy

Signetics has developed a set of Safety Requirements with the primary objective of eliminating job related injuries and illness resulting from improper material handling and/or hazardous or negligent work practices. All Signetics employees are required to exercise the following safety procedures, when and where applicable, to ensure the safety and health of all.

1. Always wear protective equipment required by Signetics for safe execution of your job.
2. Report all unsafe or hazardous conditions to your supervisor or the Safety and Health Department.
3. Report all injuries immediately and know emergency procedures!
4. Keep emergency doorways and aisles clear at all times.
5. Always keep doors in fire corridors closed.
6. Know emergency and evacuation procedures. Memorize exits and grouping areas.
7. Don't touch electrical equipment unless it is part of your job and you have been properly trained and certified to do so.
8. Never tamper with fire extinguishers.
9. Never place papers, books, or materials on the floor or in undesignated storage areas.
10. Dispose of rubbish and used materials properly.
11. Know who your Safety Committee representative is.
12. Strictly adhere to all safety regulations regarding entering or working in designated Fab areas.
13. MAINTAIN A GOOD SAFETY ATTITUDE AT ALL TIMES:
    - Learn the safe way to do your job. Don't take any chances.
    - Get help if you need it. If you don't know the safe way to do a particular operation, ask your supervisor for assistance or instruction.
    - Don't try to do a job by yourself if two people could do it more safely.
    - Don't ever do a job without proper training or hands-on instruction from your supervisor.

Signetics safety policy (continued)

- Read all labels and understand all instructions and warnings BEFORE beginning a job.
- Be organized in your approach to your work.
- Use your common sense. Never run in hallways or engage in horseplay or any activity that might endanger others.
- DON'T TAKE SAFETY FOR GRANTED. The life you save could be your own.

Remember: Maintaining a safe work environment is a continuous endeavor requiring the common sense and cooperation of all employees, regardless of position or location.

Signetics safety and environmental training

Signetics policy and Federal and State legislation dictate that employees in specific work environments receive additional training regarding safety precautions and proper work procedures in those areas. Dependent upon your job function, you may be required to participate in training classes provided by the Safety/Environmental Training Department. Your function may require job-specific training. If you have a question, ask your supervisor or call the Safety and Environmental Training Department. Many of the classes offered have open enrollment, and you are encouraged to attend any that you may find beneficial. For scheduling see the Safety/Environmental Training Department Class Schedule located in any lobby or call the Safety/Environmental Training Department.

Medical facilities

The Company has made arrangements, via Health Services, to provide treatment and care or referral, as appropriate, to employees who are injured or ill. In the event of a medical emergency dial the EMERGENCY extension number for assistance.

If you are hurt while at work, report your injury, no matter how slight, to your supervisor and Health Services at once. Prompt reporting is a must to avoid loss or delay of benefits.

Workers' compensation

Coverage

Workers' Compensation covers injuries and illnesses that arise out of and in the course of employment.

Benefits begin at the onset of any work related injury or illness, without delay, providing you do the following:

- Immediately report the injury or illness to Health Services.
- Complete an Incident Report the day of the injury or illness.
- Immediately report an injury or illness to Health Services. If occurring on the weekend or offshift, report the incident to Security, then to Health Services on the next business day. (Health Services is open Monday through Friday 6:30 a.m. to 12:00 a.m.)
- Off-site employees are also to follow the above guidelines.

The law provides three types of benefits, if a physician orders them, for your specific injury or illness.

1. Medical benefits are provided to relieve or cure the effects of the work-related injury or illness.
2. You may be referred by Health Services to a physician, dentist, or chiropractor who specializes in industrial medicine, when appropriate. These physicians are not contracted by Signetics Company, but they are familiar with our technology and Company policies. After 30 days from the date of injury, you have the right by law to select your own personal physician or medical facility within a reasonable geographical area. However, if an employee has notified Health Services in writing before the date of injury that he/she has a personal physician, the employee shall have the right to be treated by such physicians from the date of injury.

   You are responsible for submitting the physician's name, address and phone number. It is your physician's obligation to submit periodic medical reports stating your present condition and any progress. Forms are available in Health Services.

You may not be entitled to payment for medical treatment you obtain on your own.

Rehabilitation, such as physical therapy, is an extension of medical treatment. If the injury or illness keeps you from returning to your usual occupation, you may qualify for vocational rehabilitation on a voluntary basis. However, rehabilitation must be approved by the Rehabilitation Bureau before implementing.

3. If you are unable to work due to a work related injury or illness, you may qualify for temporary disability benefits. There is a three-day waiting period prior to receiving these benefits. You have the option of taking sick time or vacation time, whichever you have accrued. Temporary disability benefits are payable beginning the fourth day of disability unless you have been hospitalized or authorized off work for more than 21 days, in which case benefits are payable on the first day of injury. If your injury has caused some permanent disability, you may be entitled to permanent disability indemnity once your condition becomes stable. In the event of an employment-related death, your dependents may be entitled to benefits.

What's Not Covered?

Injuries or illnesses not arising out of or in the course of employment, such as:

Common colds and flu
Self-inflicted injuries
Intoxication and drug abuse

Special Notes

Industrial leaves may be granted for the period of disability certified in writing by the treating physician. It is solely your responsibility to keep Health Services informed of your medical status and provide any and all documentation to support your on-going disability. An absence of more than 3 days without notifying Health Services is grounds for termination.

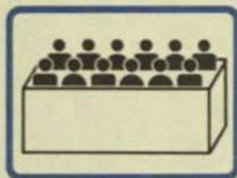
When returning to work, present your return to work status release in person to Health Services. Reasonable efforts will be made to place an employee who is authorized to return to work with restrictions. Health Services will notify the supervisor and make arrangements.

It is Signetics policy to extend an industrial leave of absence for a maximum of 12 months. Successive leaves for the same or related cause, not separated by a return to work of 90 days, will be considered one leave and subject to the 12-month maximum. If your disability continues and you are not able to return to work within that time, your employment will terminate. Upon release from your doctor, you may apply for rehire.

Incidental absences

Your absence from work for personal or other reasons may be necessary from time to time. In recognition of this, the Company provides time off with pay to exempt employees for certain kinds of absences.

- **Illness**—If you are absent from your job as a result of illness, you must notify your supervisor at the start of each day on which you are out.
- **Personal Emergencies**—On occasion, personal emergencies may require time off during the normal work week. If you have such an emergency, be sure to contact your immediate supervisor at the earliest possible moment.



- **Jury Duty**—Your Company encourages you to accept your responsibility as a citizen. Therefore, if you should receive a "Juror's Summons," notify your supervisor immediately. When required, you will be granted time off to serve on jury duty. So as not to cause a financial burden, the Company will reimburse you for time lost on the job. You will receive the difference between jury duty pay and your regular salary.
- **Military Leave (short-term)**—If you are in an organized reserve unit, and must fulfill two weeks of active duty, you will receive the difference between service pay and regular salary while on reserve duty. As soon as you are notified of training dates, furnish copies of your orders to your supervisor and to the Payroll Department.
- **Death in Family**—If you suffer a death in your immediate family (mother, father, wife, husband, daughter, son, sister, brother, mother-in-law, father-in-law, grandmother, grandfather, stepmother or stepfather), you will be permitted up to three days of **Bereavement Time** at your regular rate of pay, including the day of the funeral. Notify your supervisor as soon as possible.

Leaves of absence

If you need extended time off from work, you may apply for a leave of absence. Leaves may be granted for medical or personal reasons, for military or jury duty, or to continue your education. Leaves must be approved by your supervisor.

Medical Leave

If you cannot work because of an illness or injury, you may qualify for a medical leave of absence. If you are absent for more than five consecutive days, you or your supervisor must notify Health Services of your absence not later than the sixth day. Medical leaves must be certified by a physician. Exempt employees receive their regular salaries while disabled, less any benefits available from the Short Term Disability plan. Your salary can continue for a maximum of six months. Health Services will send you the appropriate forms to file for Short Term Disability, if applicable. Medical leaves may continue for a maximum of one year.

Maternity Leave

Maternity leaves are handled in the same way as other medical leaves. As with all medical leaves, your maternity leave must be certified by a physician. You should notify Health Services as soon as you are aware you are pregnant.

Industrial Leave

If you cannot work because of an injury or illness that is work related, you may qualify for an industrial leave of absence. Industrial leaves are handled in the same way as other medical leaves. You may be eligible for Workers' Compensation benefits. See the Workers' Compensation section of this handbook for more information.

All of the above leaves must be coordinated through Health Services.

Personal Leaves

If you need extended time off for compelling personal reasons, such as a family illness or to settle an estate, you may apply for a personal leave. Personal leaves are granted at the discretion of your supervisor and are limited to a maximum of 30 days. Personal leaves are unpaid.

Other company benefits

Educational Assistance

To help you prepare for greater responsibility or improved job qualifications, the Company has established a tuition refund plan.

Under the plan, expenses for courses relating to your areas of responsibility as well as degree-oriented courses at accredited colleges and universities will be refunded at a rate of 100% provided you complete the course with a "C" or better grade. A maximum of two courses per semester will be considered for tuition aid.

To be eligible, you must be a full-time salaried employee before beginning and after completing the course(s). You must complete a tuition reimbursement form and have it approved by your manager **before the course starts.** You can obtain the reimbursement form from your Human Resources Manager.

NAPC Scholarship Program

Under this program, North American Philips awards four-year college scholarships to children of employees and retirees. Awards are made to college-bound high school seniors on the basis of their academic and personal achievements as well as financial need. The special Pieter C. Vink Award gives $10,000 ($2,500 a year for four years) each to the most outstanding male and female scholarship applicant, regardless of financial need. Application forms and a booklet describing the program in detail are available from your Human Resources Manager.

Signetics Scholarship Program for Children of Deceased Employees

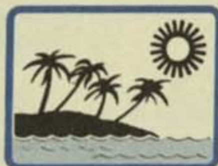
Signetics' Education Scholarship Program provides financial assistance toward high school and college expenses for your children's education if you die or become permanently disabled while you are employed, provided you have completed five years of service.

Matching Gift Program

When you contribute money to a U.S. college, university or independent secondary school, NAPC will match your contribution. Matching gifts can range from a minimum of $10 to a maximum of $1,000 a year for any one employee. To find out how to have your gift matched, obtain a brochure from your Human Resources Manager.

Employee Store

Employees can purchase North American Philips products at considerable savings from suggested retail prices. Catalogs for Magnavox, Sylvania, Philco, Norelco and others are available. Orders are handled by your Employee Store representative.



Vacation

To provide you with a period of relaxation and change from the normal work routine, vacation benefits have been established.

You earn vacation on a day-by-day basis. The amount of vacation you earn increases with your Company service as follows. The amount of vacation you can accumulate is capped at two times your annual accrual amount.

Company Service	Rate of Accrual (hours/month)	Days/Year	Vacation Cap Amount
less than 5 years	6⅔	10	160 hours
5 to 15 years	10	15	240 hours
15 years or more	13⅓	20	320 hours

You may take your earned vacation at any time during the year, subject to your supervisor's prior approval. Vacation is normally taken in weekly increments. Signetics encourages you to take your vacation each year. If you are unable to use all of your vacation by year end, it will carry over to the next year. However, you can accumulate vacations hours only up to your cap amount. If you reach the cap amount, vacation accrual will be suspended. You will not be eligible for pay in lieu of vacation.

When you leave the Company, you will be paid for any unused earned vacation.

Anniversary bonus

Upon completion of each five years of service, you will receive an Anniversary Bonus, consisting of time off with pay and extra pay. You have 12 months from your anniversary date to use your Anniversary bonus. Schedule your Anniversary Bonus Time Off with your supervisor.

Holidays

The Company observes 10 paid holidays each year. At the beginning of each year a schedule will be distributed reflecting the actual days observed by the Company. The schedule may vary from year to year but a typical recent schedule included:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

In addition to the holidays listed above, three "floating" holidays are scheduled by management each year.

Flexible time off

In the Albuquerque plant, the vacation and holiday programs have been combined into Flexible Time Off (FTO). Instead of observing holidays, the plant has certain "plant shutdown" days. Employees may use FTO time to cover these shutdown days, as well as to provide time for rest and relaxation throughout the year.

Our compensation policy

It is the policy of Signetics to compensate all employees based on performance and the value of their contribution within our Company and our industry.

Performance reviews

Signetics uses a formal review system to evaluate your performance and growth annually. In addition, periodic reviews will be conducted with your supervisor to discuss your performance to job objectives. Your supervisor can tell you more about our performance review system.

Merit increases

Merit increases are based on employee and Company performance, as well as the Company's goal to pay competitive salaries. Merit increases are delivered through a process called Focal Point. In the Focal Point process, all employees are considered for merit increases at the same time.

Automatic deposit- "Sure Pay"

Signetics offers a convenient "Sure Pay" service that automatically deposits your pay into your Signetics' Credit Union account or into a bank of your choice. You may arrange for this service through the Payroll Department.

Payroll deductions

Federal and state laws require the following deductions from your pay:

- Federal income tax withholding,
- Social Security (FICA),
- State income tax withholding if applicable,
- Disability insurance premiums (for employees living in CA, NY, NJ, RI, HI, or Puerto Rico),
- Garnishments as required by law.

Also, you may authorize additional deductions for taxes, insurance, ESP and FLEX, savings bonds, United Way contributions and credit union accounts.

Work schedules

Work schedules vary within Signetics but most employees work eight hours per day, Monday through Friday, for a 40-hour week. Office and administrative personnel usually work from 8:00 a.m. to 5:00 p.m. Work hours for employees in manufacturing areas vary depending upon production requirements; however, the most common work hours are:

1st Shift (days)	7:00 a.m. – 3:30 p.m.
2nd Shift (swing)	3:30 p.m. – Midnight
3rd Shift (grave)	Midnight – 7:00 a.m.

Shift differentials

You are eligible for a shift differential if you are regularly scheduled to work at least 6.5 hours or more per day on a second or third shift. The differential, which varies by shift, is applied to your base pay. If you are working a standard shift the differentials are as follows:

2nd Shift (swing) = 10%
3rd Shift (grave) = 12%

If you work a nonstandard shift, your supervisor will tell you if a shift differential applies to your shift.

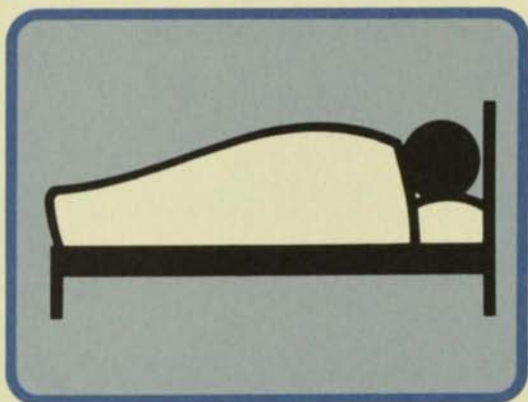
Extended work week

Employees in Salary Grades 44 through 47, with prior approval, may be paid additional compensation if they are required to work on a day(s) that is in addition to the regular schedule. This additional time is considered extended work and will be paid at the equivalent straight time rate.

Additional compensation

Signetics offers an annual incentive program to selected employees to reward their outstanding contributions. Your supervisor can tell you if you are eligible to participate in the Key Employee Compensation Program.

HEALTH PLAN



HEALTH

Your health plan

Superseded by new Health Plan SPD.

Section	Page
Why A Health Plan?	1
Some Special Features	1
How This Section Is Organized	2
Highlights Of The Plan	3
Who Is Eligible?	4
How To Enroll	5
Changes In Family Status	
New Dependents	5
Other Changes In Family Status	5
Delayed Enrollment	6
How The Plan Works	6
Reasonable And Customary/ Medically Necessary	6
Your Cost	7
Before-Tax Contributions	7
The Deductible	8
Family Accident	8
What The Plan Pays	9
Special Full Payment Feature	9
Covered Charges	9
Hospital Care	10
Pre-Admission Testing	12
Friday/Saturday Admissions	12
Home Health Care/Extended Care	13
Home Health Care Benefits	14
Extended Care Facility Benefits	15
Hospice Care	16
When Benefits Are Payable	16
What Is Covered	16
What The Plan Pays	17
What Is Not Covered	17
Alcoholism/Drug Abuse Rehabilitation	18
Surgery	19
Voluntary Second Surgical Opinion	19
Same-Day Surgery	22
Doctors Charges: Psychiatric Services, Alcoholism and Drug Abuse Treatment	23
Mental Health Providers	23
Mail Service Prescription Drug Program	24
How To Use This Program	25
Emergency Situations	26
Refills	26

Your health plan (continued)

Section	Page

Other Covered Charges 27
What's Not Covered 29
An Example 30
MET-ELECT PREFERRED PROVIDER PROGRAM 31
HEALTH MAINTENANCE ORGANIZATIONS 32
  The Cost 32
OTHER IMPORTANT FACTS 33
Coordination Of Benefits 33
  Credit Reserve 34
How To File A Claim 36
  Procedure For Appealing Claims 39
If You Become Disabled 40
  Medicare Coverage 41
  If Your Dependent Becomes Disabled 41
  Total Disability 41
If You Should Die 42
When Coverage Ends 43
  If The Group Insurance Policy Terminates .. 43
Optional Continuation Of Coverage 44
  When You May Continue Coverage 44
  Eligibility Requirements 44
  How Long Optional Continuation of Coverage Lasts ... 45
Post-65 Coverage – Active Employees 46
Conversion Privilege 47
Future Of The Plan 48
Plan Administration 48
  Insurance Company 48
  Agent For Service Of Legal Process 48
  Plan Year 48
  Employer And Plan Number 48
  Plan Cost 48
  Effective Date 48
Your Rights Under Law 49

Why a health plan?

Probably nothing in life holds more importance for you and your family than good health. A serious illness can make all other problems seem insignificant.

This section describes your health insurance plan. It has been carefully designed to protect you and your family against the financial burden that sickness or accidents can impose.

Health insurance through a Health Maintenance Organization (HMO) may be available as an alternative to the Company-provided plan. Please see page 32 for an overview of HMO's.

Some special features

Your health plan is comprehensive and it includes special features that are designed to

- **encourage** wise use of medical resources (for example: whenever possible, use a same-day surgical facility in favor of surgery while a hospital inpatient)
- **help** you become an informed consumer when it comes to your own health (for example: get a voluntary second opinion for certain surgical procedures)
- **prevent** hospitals from filling their beds when not medically necessary (for example: use the Pre Admission Review program (PAR) to get authorization for your hospitalization; opt for medical care at home — in a comfortable, supportive atmosphere)
- **enlist** your help in controlling runaway health care costs that have become a major national concern.

What's your incentive to help meet these goals? First and foremost, your incentive is to gain *quality medical care* that's most appropriate for your needs. There is also a dollar incentive: In a selected number of situations, you receive *more money* from the plan if you follow certain procedures — and *less money* if you don't.

For example, say you are considering cataract surgery. Since this delicate surgery can be performed in one day without hospitalization, the first incentive is minimizing your hospital stay. If you elect outpatient surgery (in a doctor's office or other same day surgical facility), the Plan pays considerably more than if done in the hospital. If you do not have surgery done on a same day basis, the Plan pays substantially less. In other words, by being an informed consumer you gain the reassurance that your operation is being performed under the best possible conditions in the right atmosphere, and you *save money too!*

$ $ SAVE $ $

We want to make sure you always get the most appropriate, quality medical care *and* the highest benefit available. So those situations where you can make decisions in your best interest, and save money besides, are highlighted in **$ $ SAVE $ $** boxes like this one. Please read those areas with care.

How this section is organized

On the next page, you'll find a chart designed to give an overview of the main features at a glance. But remember: To fully understand the plan and to get maximum benefit from it, *there's no substitute for reading the full plan description.*

Following the chart is a complete description of your health plan.

Then, starting on page 10, you'll find a description of a very important health plan feature: Pre Admission Review.

HIGHLIGHTS OF THE PLAN

Feature	Plan Provisions
Covered Charges	Hospital room, board and miscellaneous charges; surgery; diagnostic tests; and a broad range of outpatient medical services and supplies.
Your Cost	You pay nothing for individual coverage. For family coverage, you pay $20.00/month.
The Deductible	• $200 ind. coverage • $400 family coverage } applies to most covered charges
What the Plan Pays (Assuming any hospitalization is authorized through Pre Admission Review)	After deductible, Plan pays 85% of most *covered* charges. (You pay remaining 15% "co-insurance.")
Stop-Loss (Full Payment Protection)	Plan pays 100% of a calendar year's *covered* charges after your deductible plus 15% co-insurance reaches • $1,500 if individual coverage • $3,000 if family coverage

Special Features

Subject to Plan rules, pre-admission hospital tests, home health/extended care, voluntary second surgical opinion consultation and outpatient surgery MAY BE COVERED AT 100%, WITH NO DEDUCTIBLE.

EXAMPLE 1—Outpatient

(Assuming individual coverage)

You experience stomach problems. As a result, in one calendar year, you

• See a doctor 5 times:	$300
• Take diagnostic tests:	$130
• Require prescription drugs:	$110
Total Covered Charges:	$540

Covered Charges Are:	$540
You Pay Deductible:	−200
	$340
	× 85%
Plan Pays 85%:	$289
You Pay 15%	$ 51
IN TOTAL: Plan Pays	$289

EXAMPLE 2—Inpatient (Assuming individual coverage and Pre-Admission Review requirement is met, if applicable.)

You are hospitalized for an operation. Your covered charges are

• Hospital room, board and miscellaneous expenses:	$4,200
• Surgeon's fee:	1,100
• Private duty nursing:	620
• Prescription drugs after release:	100
• Doctor's fees after release:	300
Total Covered Charges:	$6,320

Covered Charges Are:	$6,320
You Pay Deductible:	− 200
	$6,120
	× 85%
Plan Pays 85%:	$5,202
You Pay 15%	$ 918
IN TOTAL: Plan Pays	$5,202

Who is eligible?

If you are an active, full-time employee, you are eligible for health insurance on your date of employment. ("Full-time" means that you are regularly scheduled to work at least 30 hours per week.) Your husband or wife (unless legally separated or divorced) and unmarried children from birth up to their 19th birthday can also be covered as your "dependents" under the health plan.

- **Children** — Children eligible for coverage include . . .
  - —your own children
  - —stepchildren,
  - —adopted children, or
  - —any children permanently residing in your household in a parent-child relationship

  . . . provided that they are primarily dependent upon you for support.
- **Students** — Coverage will be provided for your unmarried children up to their 25th birthday while they are attending school as full-time students and are primarily dependent upon you for support.
- **Handicapped Child** — If you have a mentally retarded or physically handicapped child, coverage will be provided for as long as he or she remains handicapped and dependent upon you. When you enroll for family coverage upon employment, a form must be completed providing satisfactory evidence of your child's handicap. This form will be forwarded to the insurance company for approval or denial of handicapped child coverage. If your child is mentally retarded or physically handicapped at age 19 but before age 25, or at age 25, his or her coverage may continue for as long as he or she remains handicapped and dependent upon you. To have coverage continued, you must provide satisfactory evidence of the handicap to the insurance company. Contact your Personnel or Employee Relations Office at least 90 days before the handicapped child's normal coverage termination date.

If your husband or wife is also an employee of the Company, you may both enroll for individual coverage or you may include each other as a dependent under family coverage. Both of you may cover your children. However, the coordination of benefits provision explained on page 34 will apply.

How to enroll

Coverage for you and your eligible dependents will take effect on your employment date.

If you do not elect any coverage in writing, you will be covered automatically for individual coverage as of your employment date. However, your medical claims (incurred on or after the date you become covered) will be reimbursed only after you have completed and submitted an enrollment form.

You and your eligible dependents will be covered as of your date of employment *only* if you complete and submit an enrollment form electing family coverage within your first month of employment.

Changes in family status

New Dependents

If you have individual coverage and you later gain an eligible dependent, e.g., you get married or you have a child, you must enroll for dependent coverage within 31 days of the date he or she became your dependent. Coverage will be retroactive from the date you acquired the dependent(s).

If you do not enroll for family coverage within 31 days after gaining a dependent, your dependent(s) will not be covered unless you submit evidence of the dependent's good health to the insurance company. If the insurance company approves your application, coverage would take effect on the January 1 following your application.

Other Changes in Family Status

If you have individual coverage and your spouse becomes unemployed (thereby losing group insurance coverage), you can immediately enroll for family coverage. If you enroll within 31 days after your spouse becomes unemployed, there is no need to provide evidence of good health. However, you will have to provide proof satisfactory to the Company that your spouse terminated employment.

If you have a *change in family status* (for example, you become divorced or your child reaches the limiting age under the plan), and wish to switch from family to individual coverage, you may do so by filing a group insurance change form within 30 days of the change.

How to enroll (continued)

Delayed Enrollment

If you are absent from work because of injury or illness on the day your insurance would otherwise become effective, the effective date of coverage for you and your family will be postponed until the date you return to work.

If a member of your family is in the hospital on the date dependent coverage is to take effect, coverage will be postponed until the date he or she is discharged from the hospital. This limitation does not apply to newborn children, who are covered from birth, provided you enroll for family coverage.

How the plan works

- Each calendar year, you pay a "deductible."
- Then, the plan pays 85% of remaining covered eligible charges for the rest of the calendar year (except outpatient psychiatric/drug abuse charges, as explained on page 23).

However, certain covered charges are paid at 100% with no deductible. These opportunities for higher than usual coverage are clearly marked in **$ $ SAVE $ $** boxes.

Reasonable And Customary/Medically Necessary

The *kinds* of services and supplies for which plan benefits are payable are called "covered charges." Covered charges are reimbursed to the extent they are "reasonable and customary."

To determine whether charges are reasonable and customary, the insurance company considers such things as the nature and complexity of the medical services, the usual range of fees charged by most doctors who perform these services in the same location, and whether any of the charges were for the unnecessary repetition of tests.

The plan will not cover any services or supplies which are not medically necessary. This means services or supplies that are not needed for diagnosis or treatment under generally accepted health care practice — even if ordered by a doctor. For example, repeated tests or treatments which are not needed or days in the hospital when not medically necessary will not be covered by the plan. The insurance company has the final say in determining if a service or supply is *reasonable and customary* and *medically necessary*.

Your cost

Individual coverage — for yourself only — is free. Family coverage — for yourself and all your eligible dependents — costs $20 a month. Your contributions are made through convenient pretax payroll deductions.

Before-Tax Contributions

By signing up for family coverage, you agree to make contributions through a reduction in your salary *before taxes are taken out.* As a result, the actual bite out of your take-home pay will be *less* than $20 a month.

Here are some other important points about before-tax contributions:

- "Taxes" means federal income tax, most states' income tax and Social Security (FICA) tax. Because your before-tax contributions reduce your earnings for Social Security purposes, making such contributions may slightly decrease your Social Security benefit.
- Before-tax contributions for health insurance are allowed under current tax law. Should the tax law change, you will have to contribute in after-tax dollars, without the special savings just described.

$200 Deductible

The deductible

Before you can receive plan benefits, you must pay a certain dollar amount of covered charges. This is called a "deductible." The deductible must be met each calendar year. You can satisfy the deductible with expenses from more than one illness or injury.

Individual Coverage. If you have individual coverage, you must meet a $200 deductible each calendar year.

Family Coverage. If you have family coverage, the $200 deductible applies separately to each covered person. However, a special rule can limit your family's deductible expenses.

If, during a calendar year, two or more family members incur a total of $400 in covered charges (but not counting more than $200 on account of any one individual), you meet the "family deductible." This means all covered family members become eligible for medical benefits for the rest of the calendar year.

Here's an example of how this special rule helped to limit one family's deductible expenses in one calendar year.

Family Member	Covered Charges
Spouse	$150
Child	$120
Employee	$130
Total Deductibles:	$400

FAMILY DEDUCTIBLE MET

At this point, all covered family members are eligible for medical benefits. No further deductible expenses need be met for the rest of the calendar year.

In determining when the deductible is met, bills are considered in chronological order — based on the date the service is performed.

Family Accident

If, while insured, more than one member of your family is injured in the same accident, only a single $200 deductible applies.

85%
15%

What the plan pays

After you have satisfied the deductible for the calendar year, the plan pays 85% of reasonable and customary covered charges. You pay the remaining 15%. Because you share a portion of the expense, this coverage is called *co-insurance.*

There is *no lifetime maximum* on how much the plan will pay.

Special Full Payment Feature

Generally, the 15% share of covered charges comes to an amount most people can handle comfortably. However, in cases of serious or prolonged illness, that 15% share could seriously threaten income or savings.

So the plan has this valuable full payment provision, commonly called a "stop-loss." If in any calendar year, your out-of-pocket expenses reach $1,500 (or $3,000 if you have family coverage), the plan pays 100% of covered charges for the rest of the calendar year. Out-of-pocket expenses include the deductible and your expenses at the 15% rate.

IMPORTANT: Charges for psychiatric services, alcoholism and drug abuse treatment, the $3.00 co-payment for non-generic mail-order prescription drugs, charges above the reasonable and customary amount, or charges not considered medically necessary, *will not be used* to satisfy the stop-loss, and won't be subject to the 100% reimbursement. This also pertains to charges incurred if you did not use the Pre Admission Review program (PAR) to get authorization for hospitalization (see page 10).

Hospital care

$ $ SAVE $ $

PRE ADMISSION REVIEW (PAR)

To ensure the quality of care and appropriateness of any hospital stay, the health plan includes a Pre Admission Review program — called PAR, for short. Under this program, all non-emergency hospitalizations (including childbirth) must be approved *before admission*. In case of an emergency, approval can be obtained within 48 hours *after admission* (or within 72 hours on weekends or holidays). If you don't get proper approval, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%. This reduction applies to the time you are not in compliance.**

For example, say you're admitted to a hospital and your covered hospital charges (after the deductible) come to $4,000.

- If you used PAR, the plan would pay $3,400 ($4,000 x 85%).
- If you did *not* use PAR, the plan would only pay $2,720 (regular $3,400 benefit x 20% = a $680 reduction in benefits).

As you can see, it is extremely important that you understand how PAR works and use it each and every time you or a dependent is hospitalized. So please be sure to read about required Pre Admission Review by reading the section in your guidebook behind the red tab.

Hospital Benefits. Whenever you are confined in a legally constituted and operated hospital, the plan pays 85% of the semi-private or ward charges for the first 365 days of each continuous confinement. A hospital confinement is considered continuous if you are readmitted for the same cause within two months of discharge. *After a continuous hospital confinement of 365 days, no further hospital benefits are payable for that confinement.*

Covered hospital charges include miscellaneous charges for such services as X-rays, drugs, laboratory exams, operating room and anesthesia as well as room and board charges. Charges incurred for inpatient psychiatric, and mental/nervous disorders are paid differently, as explained on page 23.

Hospital care (continued)

Private Room. If you stay in a private room, the plan pays 85% of the hospital's most common *semi-private* room charges during the first 365 days. However, there are a few important exceptions to this private room limitation:

- If your hospital has no semi-private rooms, 90% of the private room charge will be covered at the usual 85% rate.
- If your condition requires a sterile environment to keep you from contracting or spreading an infection, the full private room rate will be covered at 85%. There must be medical documentation satisfactory to the insurance company to prove medical necessity for the isolation room.

Intensive Care. If you are confined in the hospital's intensive care unit (that is, one that provides care for critically ill patients other than normal post-operative recovery care), the hospital's intensive care room rate will be covered at 85%.

Mental/Nervous Disorders. If you are admitted to a legally constituted and operated hospital for the treatment of a mental nervous disorder, the plan pays 85% of the semi-private or ward charges for 180 days in a 12 month period.

Hospital Defined. Hospital charges are only covered when you're confined in a legally constituted and operated institution which has, on its premises, organized facilities for the care and treatment of sick or injured people. These facilities must be supervised by a staff of legally qualified physicians and must have a registered professional nurse on duty at all times. Charges *will not* be considered covered hospital charges if treatment takes place in any institution — or any part of an institution — that

- is used principally as a rest or nursing facility
- is used principally for care of the aged, chronically ill, convalescents, drug addicts or alcoholics (except as described on page 18), or
- primarily provides educational or custodial care.

Pre-Admission Testing

Hospitals routinely require a number of tests before they will start any treatment. But it's usually not medically necessary to perform these pre-admission tests while you're an inpatient. So, whenever possible, arrange to do your pre-admission testing (PAT) as an outpatient or through an approved independent laboratory.

By using PAT, you can shorten your hospital stay by one or two days — allowing you to carry on with your normal routine at home or at work.

All reasonable and customary PAT charges will be paid at the special 100% rate with no deductible provided

- you are hospitalized within 7 days after the tests are performed, and
- the tests are normally required and accepted by the hospital in place of tests that would otherwise have been performed after admission.

$ $ SAVE $ $

> Pre-admission testing can let you stay comfortably at home until hospital admission is medically necessary. The plan will pay *100%* of reasonable and customary PAT charges, *with no deductible.*
>
> Plus, if PAT keeps you out of the hospital for a day or so, you avoid the 15% co-insurance for hospital charges during those days.

Friday/Saturday Admissions

In many cases, hospital admissions on a Friday or Saturday are good for filling empty hospital beds — and not much else. That's because tests and other medical procedures generally are not performed on those days.

Therefore, the plan will not pay hospital charges for a Friday or Saturday admission *unless*

- you're admitted for childbirth or a medical emergency,
- you're admitted to an approved alcohol or drug rehabilitation facility as defined on page 18, or
- treatment is actually performed on the Friday or Saturday, as certified by the hospital and attending physician.

$ $ SAVE $ $

> If you're admitted on a Friday or Saturday, you get *no* hospital benefits for those days (except in the three circumstances described on page 12). You will, however, receive the regular 85% benefit for the remainder of your confinement.
>
> If you're admitted on any other day, you get *regular plan benefits.*
>
> *Remember, you must obtain approval for any hospital confinement through Pre Admission Review (PAR). Otherwise, your hospital benefits will be reduced as described on page 10.*

Home health care/extended care

The previous pages describe the benefits available while you're in the hospital. However, there may come a time when you're well enough to leave the hospital, but not well enough to go without some continued care. In this case you may be entitled to home health care or extended care.

- Home health care benefits are available if your need for home health care is medically necessary and certified by the licensed physician in charge of your case. Home health care may be covered if used in place of hospitalization — even if you were not a hospital inpatient before home health care begins.
- Extended care facility benefits are available if you were a hospital inpatient due to the same medical condition for at least three days during the 14 days right before extended care begins, and your need for extended care is medically necessary and certified by the licensed physician in charge of your case.

Home health care/ extended care facility (continued)

Home Health Care Benefits

Home health care benefits are available when you are essentially confined to your home and require intermittent nursing, therapy or other services. Services must be provided by an approved Home Health Care Agency and performed by or under the direct supervision of a registered or licensed practical nurse in accordance with a plan or treatment established and periodically reviewed by your physician. A Home Health Care Agency is "approved" if it meets standards set by Medicare.

Covered charges include • services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) • medical and surgical supplies and rental or purchase of durable medical equipment • physical, occupational, speech and respiratory therapy • home health aid services • nutritional guidance • diagnostic services • oxygen and its administration • hemodialysis.

Be sure to check with the insurance company to determine if the durable medical equipment you need will be covered and if it should be rented or purchased.

$ $ SAVE $ $

The plan pays 100% of covered reasonable and customary home health care charges. Plus, there is no deductible. The maximum benefit per illness is $3,000.

In other words, if home health care keeps you out of the hospital, you save the deductible and 15% co-insurance charges associated with a hospital confinement.

Exclusions. Home health care benefits *do not* cover • custodial care or care of the aged • meals • physician's services • housekeeping services • drugs and biologicals • services performed by relatives or members of your household • care for alcoholism or drug addiction care for senility, mental deficiency or retardation • non-medical personal care services.

(Physicians' services, drugs and biologicals, and care for alcoholism or drug addiction may be covered at the usual 85% rate.)

Home health care/ extended care facility (continued)

Extended Care Facility Benefits

When you're released from the hospital, benefits for extended care facility charges may be payable. If you still require professional and practical nursing care after a hospital confinement of at least 3 days and you enter an approved Extended Care Facility under the active medical supervision of a licensed physician, your benefits can continue as specified below. An Extended Care Facility is "approved" if it meets standards set by Medicare.

$ $ SAVE $ $

Your plan pays

- 100% of the Extended Care Facility's room and board charges for up to 31 days per confinement — to the extent the charge does not exceed one-half of your hospital's semi-private room rate, and
- 100% of reasonable and customary charges for other medically necessary covered services and supplies during your confinement.

If you were in a hospital instead of an Extended Care Facility, you would have to pay the usual deductible and 15% co-insurance charge. So, by leaving the hospital as soon as medically possible, you can save many co-insurance dollars. And there's no deductible.

If you leave an Extended Care Facility and are later readmitted to the hospital, you'll be entitled to another 31 days of Extended Care Facility benefits *only* if

- at least two months have passed since you last left an Extended Care Facility, or
- the medical condition that causes readmission is unrelated to the condition that caused your earlier confinement.

Exclusions. Extended care benefits are *not* payable for • confinement which is principally for custodial care or care of the aged • care for alcoholism, or drug addiction • care for senility, mental deficiency or retardation.

Hospice care

Nothing causes more physical, emotional and financial stress than having to deal with terminal illness. For this reason, your health plan includes special benefits for "hospice services." Hospice services are designed to meet the exceptional needs of a terminally ill patient and his or her family.

When Benefits Are Payable

Hospice benefits are payable when

- the patient's attending physician certifies that you or a dependent covered under the plan is expected to live less than six months, and
- the patient enters an approved hospice program. A hospice program is "approved" if it meets standards set by the insurance company.

If you're considering a hospice program, be sure to check with the insurance company to see if the program is approved.

What Is Covered

Care through a hospice program may be provided on an inpatient or outpatient basis. For example, care in a specialized hospice facility, hospital or at home may all be covered.

During The Patient's Lifetime. The following services are covered during the patient's lifetime — if considered medically necessary by the patient's attending physician, approved by the insurance company, and billed through a hospice program:

- Room and board expenses in:
  - —a hospice facility located within a hospital, up to the hospital's most common semi-private room and board rate
  - —an approved free-standing, inpatient hospice facility, up to the most common semi-private room and board rate for hospitals in the general area
- Skilled nursing and home health aid, if performed by a registered graduate nurse or licensed practical nurse.
- Counseling for the patient and other family members who are enrolled in the health plan, if administered by a psychiatrist, psychologist or a member of a state-licensed social services organization. The patient's primary physician must determine that the terminal illness is the direct cause of the need for counseling.

Hospice care (continued)

- Homemaker services, if the patient's family is unable to attend to the patient's needs.
- Local ambulance or special transport between the patient's home and the hospice facility.
- Miscellaneous services, such as: medical supplies, drugs and medication, physicians' services and rental or purchase of durable equipment.

During Bereavement. If a patient was receiving care through a hospice program and dies, during the six months following the patient's death, the plan covers up to 12 out-patient counseling sessions for covered family members by a mental health provider as described on page 23.

> **Employee Assistance Program**
>
> If you are experiencing personal problems, the Employee Assistance Program (EAP) may be able to help. For further information, please refer to the EAP section of this guidebook.

What The Plan Pays

The plan pays 85% of the reasonable and customary covered charges explained above — after the patient's deductible has been met.

The maximum benefit payable for all covered hospice charges, including the 12 out-patient counseling sessions, is $10,000.

What Is Not Covered

The plan does not pay benefits for the following services or treatments under the hospice care program:

- Volunteer services or other services that would normally be provided free of charge.
- Legal and/or financial advice services (such as preparation and execution of a will, estate planning and liquidation, financial investment).
- Counseling by the clergy or any volunteer group.
- Services of a person who ordinarily resides in the home of the patient or a member of his or her family or spouse's family.
- Services not provided and billed through the hospice program and not approved by the patient's attending physician and the insurance company.

Alcoholism/drug abuse rehabilitation

If you are admitted to an inpatient institution for the treatment of alcoholism or drug abuse, the plan pays benefits just as it would for treatment in a hospital. These benefits are available to you and your dependents and will only be paid for 45 days per person in a calendar year. Treatment must take place while the patient's health insurance is in effect.

> Inpatient treatment for alcoholism or drug abuse must be approved *before admission* through the Pre Admission Review program (PAR). **FAILURE TO GET PAR APPROVAL WILL RESULT IN A 20% REDUCTION IN BENEFITS. This reduction applies to the time you are not in compliance.** (See the example on page 10). For details on how PAR works, please read the special guidebook section marked "PAR."

The benefits will only be paid for two periods of confinement in one person's lifetime. Successive periods of confinement will be considered as one confinement if they are separated by less than two months.

For this benefit, an inpatient institution means a legally constituted, operated and approved rehabilitation unit licensed by the state or approved by the insurance company. Such facilities provide medical treatment for patients who require inpatient care and have specified medical conditions. They have permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time registered professional nurse (R.N.), and they maintain daily medical records on all patients. **Before admission, please check with the insurance company to make sure the services of the facility you are considering will be covered.**

The Friday/Saturday admission exclusion (see page 12) does *not* apply to admission for treatment of alcoholism or drug abuse.

Employee Assistance Program

If you are experiencing personal problems or problems associated with alcoholism or drug abuse, the Employee Assistance Program (EAP) may be able to help. For further information, please refer to the EAP section in this guidebook.

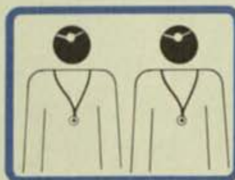
Surgery

The plan also covers surgery performed by a legally qualified doctor. Benefits are payable when the operation is performed in:

- a hospital (remember, any hospitalization must be authorized through Pre Admission Review, or PAR)
- a doctor's office
- an outpatient department of a hospital
- an approved ambulatory surgical facility (sometimes called a "Surgicenter")

The plan usually pays up to 85% of reasonable and customary charges for each operation. But you can receive more, as explained later under "Same-Day Surgery."

If you have more than one operation performed through the same incision, or in the same operative area, or if during one operation two or more surgical procedures are performed in different operative areas with separate incisions, you will receive 85% of the reasonable and customary charge for the major procedure and 50% of the reasonable and customary charges for the other procedure(s).



Voluntary Second Surgical Opinion

Medical studies show that certain surgical procedures often do not need to be performed. In other words, in many cases, the surgical risks outweigh the benefits — or an alternative treatment would be just as effective. If your doctor recommends any of the following surgical procedures, *you may obtain a second surgical opinion* as described on page 21.

Surgery (continued)

- Breast surgery (excluding biopsy)
- Bunionectomy/surgery involving bones of the feet
- Cataract extraction
- Coronary bypass surgery
- Gallbladder surgery
- Hemorrhoidectomy
- Hernia repair
- Hip joint replacement
- Hysterectomy (excluding D&C)
- Knee surgery
- Laparotomy (exploratory abdominal surgery)
- Nasal surgery (submucous resection, excision of polyps, sinusotomy)
- Osteotomy
- Oophorectomy (removal of ovaries)
- Prostatectomy (removal of prostate)
- Spinal disc surgery
- Strabotomy (correction of crossed eyes)
- Tonsillectomy and/or adenoidectomy
- Varicose vein ligation and/or stripping

If your doctor recommends one of the above surgical procedures, **you may obtain a second surgical opinion through the insurance company's Medical Action Center (MAC). The insurance company is Metropolitan Life. Details on how to get a voluntary second surgical opinion begin on page 21.**

Surgery (continued)

REMEMBER: Any doctor, even the best, can recommend surgery that's not really necessary — especially when dealing with a procedure that's not his or her specialty. So be sure to take advantage of the second surgical opinion. It's your guarantee that the surgery you elect is medically appropriate.

You pay nothing for any Second Surgical Opinion charges incurred for one of the above procedures. The plan pays the entire cost. What's more, if the second doctor doesn't agree with your first doctor's recommendation, the plan will even pay for a third opinion.

By understanding how the voluntary second surgical opinion feature works and using it properly, you will:

- **know the risks and alternatives:** Any surgery involves a degree of risk. A second opinion ensures complete, impartial information on what the risks are and what alternative treatment might be available.
- **make the best decision:** If your doctor's recommendation for surgery is backed up by a specialist, you can be confident that you're doing the best thing for your good health.

Best of all, the Company pays the full cost of voluntary second surgical opinion.

How To Get A Voluntary Second Opinion. Two simple steps are all it takes to get a second opinion.

- First, call the Medical Action Center (MAC). **Their toll free number is 1-800-225-5481.** The MAC reviewer will schedule an appointment for you with a physician in your area with the necessary credentials capable of performing the second opinion.
- If your reviewer recommends a second opinion, tell your original doctor that. Then ask him or her to forward your records and test results (lab, X-ray, etc.) to the second opinion consultant. This is becoming a common request, and your doctor will be happy to cooperate.

If you must cancel or change an appointment that MAC has arranged for you, you will need to reschedule your own appointment.

Surgery (continued)

REMINDER: If you intend to be hospitalized for your surgery, be sure to get authorization for your admission through the Pre Admission Review program (PAR).

What About Other Surgery? If you're considering surgery that's not on the previous list, we highly recommend that you still get a second opinion — because it may help you avoid unnecessary risks and costs.

To do so, you must arrange to see a specialist of your choice (you cannot use MAC for a referral). Reasonable and customary charges for the second opinion consultation will be covered at the usual 85% rate, after the deductible.

Same-Day Surgery

Many people, and especially children, deal with surgery best when they can get back home to a comfortable, supportive atmosphere as soon as possible.

Therefore, it's fortunate that a great number of all surgical procedures — from simple tonsillectomies to delicate cataract surgery — can be performed in one day *without* hospitalization.

You're encouraged to seek same-day surgery whenever possible, either in a doctor's office, outpatient department of a hospital or an independent facility that specializes in outpatient surgery.

$ $ SAVE $ $

If you elect outpatient surgery (in a doctor's office or other same-day surgical facility), the plan pays 100% of reasonable and customary surgery charges, with no deductible. Related services and supplies provided by the facility or a physician on the day of surgery (such as anesthesia or biologicals) are also covered at 100%.

If you elected hospitalization instead, the plan would pay at the usual 85% rate provided that your admission is approved through Pre Admission Review. You would have to pay the deductible and 15% co-insurance.

Doctor's charges:
psychiatric services, alcoholism and drug abuse treatment

- **Inpatient Care:** For treatment of alcoholism, drug addiction, or mental and nervous disorders by a legally qualified physician (M.D.), psychiatrist (M.D.), or licensed clinical psychologist (Ph.D.) while confined in a hospital, the plan pays at the regular 85% level for covered expenses after the deductible. (Benefits for *facility* charges related to inpatient alcohol and drug rehabilitation are payable for up to 45 days per person per calendar year with a lifetime maximum of 2 confinements.) Benefits for facility charges related to inpatient mental/nervous disorders are payable up to 180 days per person in a 12 month period.
- **Outpatient Care:** For outpatient treatment of alcoholism, drug addiction, or mental and nervous disorders (when not confined to a hospital or approved rehabilitation facility) you will be reimbursed 50% of reasonable and customary charges — up to a maximum covered benefit of $3,000 per year for professional mental health visits if provided by
  - — a legally qualified physician (M.D.),
  - — psychiatrist (M.D.),
  - — licensed clinical psychologist (Ph.D.),
  - — psychiatric social worker as described below,
  - — agencies licensed by the Council on Accreditation of Services for Families and Children, Inc.,
  - — Masters level clinician in the psychiatric or mental health field, as described below.

Mental Health Providers

To be covered under the plan, a Clinical Social Worker (M.S.W.) or equivalent Master's level mental health clinician must be certified or registered in the state in which he or she practices. If a state does not require certification or registration, a mental health provider must have three (3) years experience in psychotherapy and/or substance abuse treatment and at least a Master's degree in social work, psychology, or an equivalent clinical psychiatric/mental health degree from an accredited program.

Employee Assistance Program

If you are experiencing personal problems or problems associated with alcoholism or drug abuse, the Employee Assistance Program (EAP) may be able to help. For further information, please refer to the EAP section in this guidebook.

Mail service prescription drug program

Included in your health plan is a mail service prescription drug program. This program is an expansion of the plan's regular reimbursement provisions for prescription drugs.

The mail service program is designed primarily for maintenance drug use and to encourage the use of generic drugs. The main features of the program are that you:

- have no cost for up to a 90-day supply of generically prescribed medication;
- pay only $3.00 per prescription for up to a 90-day supply of non-generic medication;
- receive your medication by convenient home delivery, postage paid;
- do not wait for reimbursement.

Your health plan's mail service drug program covers prescription medication presently covered under the health plan's covered charges. You have no co-payment if your doctor prescribes your medication generically. Your cost for non-generic drugs is only $3.00 per prescription. Your $3.00 co-payment is not a covered medical expense under the health plan. Therefore, you cannot make a claim for it and it does not apply to the full payment provision as referred to on page 9.

Mail service prescription drug program (continued)

How To Use This Program

- Ask your physician to prescribe needed medications for up to a 90-day supply plus refills. Your doctor must prescribe a 90-day supply for you to receive that quantity. If you are presently taking medication, ask your doctor for a new prescription. Please discuss with your doctor the possibility of writing your prescriptions generically.
- Complete the Enrollment Order/Confidential Patient Profile form for each eligible family member with your first order *only*. Completion of this form is necessary so that Express Pharmacy Services can check potentially harmful drug interactions when you have prescriptions filled through Express Pharmacy Services. Be sure to answer all questions, for yourself and your eligible dependents, and make certain you include your (employee's) Social Security Number on the form and on the back of each prescription.
- After your first order, you only need send a Prescription Drug Mail Order Form with your prescription order. You should complete all information in the employee section. Send the completed form, your original prescription(s) and a $3.00 co-payment for each non-generic prescription to Express Pharmacy Services, using a postage paid envelope. Postage paid envelopes and prescription drug order forms are available where you usually pick up your medical claim form. The co-payment can be in the form of a check, money order or credit card charge to Mastercard, Visa or American Express. Remember that there is no co-payment for generic prescription drugs.
- Express Pharmacy Services will process your order and return your medications to you via First Class Mail or UPS, along with an order form for future prescriptions and/or refills and a postage paid envelope. Please allow 14 days for delivery.

Mail service prescription drug program (continued)

Emergency Situations

When you need a prescription immediately, you should have your prescription filled at a local pharmacy and submit a claim for reimbursement, subject to the health plan's usual deductible and co-payment provisions.

If you need medication immediately *but will be taking it on an ongoing basis,* ask your doctor for two prescriptions; the first should be for a 14-day supply that you can have filled at a local pharmacy; the second prescription should be for the balance, up to a 90-day supply. Send the larger prescription with your $3.00 co-payment (if your prescription is not filled generically) and a prescription order form to Express Pharmacy Services immediately.

Refills

The law requires that pharmacies dispense no more than the quantity prescribed by the physician. If your doctor authorizes refills, they can only be dispensed when your initial order has nearly expired.

When you need a refill, place your order three weeks prior to the time your current supply of medication runs out to allow for mail delivery. Follow the instructions on the Prescription Drug Order Form, making sure that the Refill portion on the back of the form is completed. Send your form to Express Pharmacy Services in your postage paid envelope.

If you have any questions or problems concerning your prescription order, you should contact Express Pharmacy Services toll-free. You should receive your medication within 14 days. If a replacement is necessary, it will be filled promptly and sent to you at no additional charge.

Express Pharmacy Services
Toll Free Number: 1-800-826-8850
Hours: Monday – Friday 8:00 a.m. to 10:00 p.m. EST
Saturday 8:00 a.m. – 4:30 p.m. EST

Other covered charges

In addition to the services and supplies already described, the plan covers *reasonable and customary charges* for all of the services and supplies listed below that are medically necessary and prescribed by a legally qualified doctor.

- Doctors' charges in connection with hospital confinements and office visits which are not related to hospital confinements (other than routine physicals)
- Outpatient medical services and supplies at a hospital and doctor's treatment in the hospital or elsewhere — when needed in connection with an accident or illness
- Assistant surgeon's charges of up to 20% of the reasonable and customary charges for the surgical procedure
- Anesthesiologist's charges — up to the reasonable and customary charge

- The services of a registered nurse (R.N.) — or licensed practical nurse, if an R.N. is not available — except one who is a member of your family or who ordinarily lives in your home
- Medications which require a physician's written prescription and which must be dispensed by a licensed pharmacist or physician.
- Diagnostic X-ray and laboratory services
- X-ray, radium and radioactive isotope therapy
- Anesthesia and oxygen
- Rental or purchase of a wheelchair, hospital-type bed, iron lung and certain other durable medical equipment. **Be sure to check with the insurance company beforehand if the equipment you need will be covered and if it should be rented or purchased.**
- Initial cost of braces, artificial limbs or eyes. (Replacement costs will only be paid when the replacement is medically required.)
- Local professional ambulance service, when medically necessary, and air ambulance service to the nearest facility equipped to provide medically necessary treatment

Other covered charges (continued)

- Public transportation to a specialized hospital or clinic and back to your home when a local hospital cannot provide the necessary care recommended by a physician
- Cardiac rehabilitation and occupational therapy rendered by a provider covered under the health plan. **Be sure to check with the insurance company to make sure that the program you are considering will be covered.**
- Dental work or cosmetic surgery required as a result of accidental bodily injury which occurs while you are covered under the plan.
- The following oral surgery procedures will be covered by the health plan:
  - removal of cysts of the jaw
  - stomatoplasty
  - osteotomy

  If you have any questions about coverage of oral surgery under this plan, contact your Personnel or Employee Relations Office.
- Treatment of temporomandibular joint dysfunction (TMJ) pain syndrome, or craniomandibular disorders, up to a lifetime maximum of $1,500 per person. Related services and supplies include:
  - initial consultation and diagnostic exam
  - temporomandibular repositioning appliance and adjustment
  - injections and prescription drugs
  - physical therapy
- Speech therapy by a qualified speech therapist for speech loss or impairment which results from an injury or sickness — not from a functional nervous disorder or congenital defect
- Physical therapy services falling within the guidelines established by the insurance company
- Chiropractic services, up to 36 visits in a 12 month period

What's not covered

The plan does not cover expenses for any of the following:

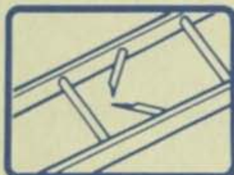
- Sickness or injury that is not treated by a legally qualified and licensed physician or surgeon
- Routine physical examinations
- Immunizations and innoculations
- Private nursing care by a member of your family
- If you occupy a private hospital room, charges in excess of the hospital's most common semi-private room charge (except as described on page 11)
- Care or treatment in a Veteran's Administration Hospital for an insured person with a military disability

- Expenses that you are not legally required to pay
- Sickness or injury resulting from war or an act of war, or incurred while in the armed forces
- Any days of hospital confinement or any medical services which are not medically necessary
- Hospital charges after the first 365 days of a continuous confinement
- Hospital charges after 180 days in a 12 month period for mental/nervous disorders
- Experimental medical treatment, therapy or surgery
- Drugs and medicines not approved by the FDA (Federal Drug Administration)
- Non-prescription ("over-the-counter") drugs, prescribed vitamins (including B-12 injections) and food supplements
- Any charges resulting from injury or sickness connected with employment with any employer
- Eye refractions, radial keratotomy (incision of the cornea to correct eye refractions), optic training, eyeglasses, contact lenses, hearing aids or examinations for their prescription or fitting
- Care or treatment in other than a legally constituted and operated hospital as defined on page 11
- Care or treatment in any institution or part of an institution which is primarily a rest facility, nursing facility or facility for the aged, chronically ill, convalescents, drug addicts or alcoholics; also, one primarily engaged in educational or custodial care — except as defined on page 18
- Drainage of an intraoral alveolar abscess, acute with cellulitis

What's not covered (continued)

- Dental work, treatment or appliances other than required as a result of accidental bodily injury, certain oral surgical procedures and treatment of temporomandibular joint dysfunction (TMJ)
- Exercise bicycles, whirlpools, treadmill joggers, environmental control equipment or other non-medical equipment

IMPORTANT: See "Other Important Facts" on page 33 for other conditions that may affect coverage.



An example

You are injured in an accident, and are confined in a hospital for 10 days requiring surgery and private duty nursing as well as extensive treatment after you are discharged. You obtained authorization for your hospitalization through the Pre Admission Review program (PAR) within the required time after emergency admission. Here's how the plan pays benefits:

	Total Charges
Hospital Semi-Private Charges — 10 Days at $150 per Day	$1,500
Miscellaneous Hospital Charges	$1,800
Surgeon's Fee	$ 750
Anesthetist's Fee	$ 150
Private Duty Nursing	$ 750
Drugs and Medicines After Discharge From Hospital	$ 120
Doctor's Fees After Discharge From Hospital	$ 230
TOTAL	$5,300
First you pay the $200 deductible:	– 200
	$5,100
	x 85%
Then the plan pays 85% of reasonable and customary covered charges:	$4,335
You pay the 15% co-insurance:	$ 765

Remember: The plan *limits* how much you ever have to pay in covered out-of-pocket expenses in any calendar year to $1,500 per individual or $3,000 per family. ("Out-of-pocket expenses" means the deductible plus your 15% co-insurance amount.)

An example (continued)

Once out-of-pocket expenses in a calendar year reach $1,500 for a covered individual ($3,000 for family coverage), the plan pays 100% of reasonable and customary covered charges for the rest of the calendar year.

For more important facts about the plan, please be sure to read pages 33 through 50.

Met-Elect Preferred Provider Program

This program is available only in certain plant locations. Check with Human Resources for availability in your area.

Met-Elect makes quality health care benefits available to you and your covered dependents while working to contain health care costs for everyone involved.

Preferred Providers are physicians and hospitals who, after careful review of the services they offer, have been invited to join Met-Elect. We believe they provide efficient quality care at reasonable costs. As part of the Met-Elect program these physicians and hospitals have agreed to charge preferential rates to Met-Elect participants like you and your covered dependents.

Here's How It Works:

When you or a covered dependent use a "Preferred Provider" (either physician or hospital) the Plan pays 95% of covered charges, instead of the regular 85%.

Check your directory of Met-Elect providers to identify the hospitals and physicians that are part of Met-Elect. With Met-Elect, the choice is yours. You are never "locked into" specific providers. You and your covered dependents can use non Met-Elect providers and regular plan benefits will apply. But using Met-Elect has several advantages. It will save you money because the providers charge a lower rate and the plan pays more. Here is an example:

	Met-Elect Provider	Other Provider
Covered Expenses	$3,000	$3,000
Deductible	– 200	– 200
	$2,800	$2,800
Plan Reimbursement Rate	x 95%	x 85%
Plan Benefit	$2,600	$2,380
You Pay	$ 340	$ 620

Met-Elect providers accept assignment of benefits. This means that they will handle claims filing for you and bill you for your balance after Metropolitan has paid. Also, these providers agree to never charge more than Metropolitan allows as a "reasonable and customary charge" (see page 6).

HEALTH MAINTENANCE ORGANIZATIONS

If there are Health Maintenance Organizations (HMOs) in your community, one or more may be offered to you as a substitute for the Company's health plan.

HMOs coordinate the services of physicians and specialists in an attempt to provide a wide range of medical care services economically.

Some HMOs operate as *group practices*. In these instances, several doctors are grouped together in one clinic or medical center, and the doctors share common laboratory, diagnostic and surgical facilities. Other HMOs are *individual practices*. In these cases, several doctors are associated with each other and/or with a hospital, but each doctor has a separate office.

Generally, an HMO requires that you visit only local HMO-approved doctors and hospitals to obtain medical treatment, except in certain emergency situations. This restriction may be an important factor to consider in deciding whether or not to join an HMO.

The Cost

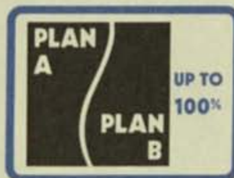
Most HMOs provide services for a fixed monthly fee, which is paid in advance. If you and your family members are eligible to participate in the Company's health plan, you can enroll in any HMO offered to you. If you do, the Company will contribute toward the monthly cost of HMO coverage. If the monthly HMO charge is greater than the Company contribution, you will automatically make up the difference through payroll deductions.

If you decide to participate in an HMO and later decide to join the Company's health plan, you will have to wait for an open enrollment period. There is one open enrollment period each year.

Only you can decide if enrollment in a particular HMO is worthwhile. When you are offered the HMO option, the Company will give you a detailed comparison outlining the differences between HMO coverage and coverage under the Company's health plan. You should study this comparison carefully and, if possible, visit the HMO to ask questions. Think seriously about your health care needs before you make your decision. This will help you determine which coverage is most appropriate for you.

OTHER IMPORTANT FACTS

The following important facts apply to your health plan.



Coordination of benefits

The coordination of benefits features explained in this section apply to active employees.

Since many companies make health insurance benefits available to their employees, some of you may now be covered by more than one group plan. This situation often arises when both you and your spouse are employed, and are covered under the group plans sponsored by each employer. As a result, you could receive payments in excess of your actual expenses.

To avoid such duplicate payments, our plans contain what is known as a "coordination of benefits" (COB) provision. If you or one of your family members is covered by other group insurance or similar coverage, your Company health plan will coordinate its benefit payments with your other coverage — including no-fault motor vehicle coverage and school insurance — so that you will receive no more than 100% payment for the allowable medical charges.

Here is how COB works. If you or a dependent is covered under more than one group plan, you should determine which plan pays benefits first (this is called the "primary" plan). Claims should be submitted to the primary plan first. After the primary plan has paid benefits within its limits, a claim can be submitted to the other plan. The other plan will then determine what remaining charges it will cover.

Here are the general rules used by most insurance companies to determine which plan is primary.

If you are covered by another plan that doesn't have a coordination of benefits provision, the other plan has the primary responsibility for paying claims. If both plans under which you're covered have a coordination of benefits provision, the following factors determine which plan pays first:

- A plan which insures the person as an employee pays before a plan which insures the person as a dependent

Coordination of benefits (continued)

- For children, the plan of the parent whose birthday is earlier in the year will pay first. (NOTE: A parent's year of birth is *not* considered.) For example, in the case of a child whose mother's birthday is March 5 and whose father's birthday is June 12, the mother's plan pays first. If both parents have the same birthday, the plan which covered the parent longer pays first. However, if one of the coordinating plans has a provision requiring that the order of payment be determined by the sex of the parents, the plan which insures the father pays first.
- A plan which insures the person as an active employee (or a dependent of an active employee) pays before a plan which insures the person as a retiree (or a dependent of a retiree).

If a person has two coverages through two jobs, the plan which has insured the person for a longer period of time pays first.

If you're divorced or legally separated, other factors are considered. The plan of the parent who has custody of the children pays first, a step-parent's plan pays second and the plan of a natural parent who doesn't have custody pays third. If a court decision has established financial responsibility for the children, the plan of the parent with financial responsibility pays first, the step-parent's plan pays second and the other natural parent's plan pays third.

No-fault motor vehicle coverage will be the primary payor of benefits regardless of the above guidelines — except in those states which require otherwise.

These coordination of benefits provisions do not apply to any *individual* policy you may have.

If you or a dependent has dual coverage, the person who handles medical claims at your location can help you determine which plan is primary. This will help speed up processing of your claim.

Credit Reserve

Through coordination of benefits, your plan sometimes pays less than it would have if you had no other coverage. In such cases, the difference between what your plan actually paid and what it would have paid becomes your *credit reserve.* The insurance company will use the credit toward any additional covered expenses that you incur during the year. However, the credit will not carry over to the next year.

Coordination of benefits (continued)

Example. Suppose that your wife is a covered dependent under your health plan. She is hospitalized and required surgery for some knee damage after a fall. She is also employed and covered by group insurance where she works. Her plan pays first in this case.

	Total Charges	If No Other Insurance, Our Plan Would Pay	Since the Other Plan Paid	Our Plan Only Paid
Hospital Semi-Private Charges — 5 Days at $160 per Day	$ 800	$ 680	$ 350	$450
Miscellaneous Hospital Charges	$ 440	$ 374	$ 275	$165
Surgeon's Fee	$ 400	$ 340	$ 150	$250
Anesthetist's Fee	$ 100	$ 85	$ 40	$ 60
Other Doctors' Charges	$ 60	$ 51	$ 20	$ 40
	$1,800	$1,530	$ 835	$965

The example assumes that the deductible has already been met.

As you can see, with total charges of $1,800, you and your wife would have had NO OUT-OF-POCKET EXPENSES for this claim. Since your wife's group insurance plan paid $835, our plan then paid the difference of $965. In addition, you have a credit reserve under your plan ($1,530 — $965 = $565).

How to file a claim

When you have a medical claim, you may obtain a claim form from your Personnel or Employee Relations Office.

Completing a Claim Form. You should file your first claim each calendar year after you've accumulated enough bills to meet the deductible. As you continue reading this section, you may refer to the sample claim form shown on page 38.

To ensure proper payment of your claim please read and follow these instructions. Incomplete or incorrect claim forms and bills will be returned to you and will delay processing. *Each time you submit a claim for yourself or a covered dependent a newly completed claim form is required.* On the form . . .

Part 1. — Employee Information — Fill in all items in this section. Please note:

EMPLOYEE'S SOCIAL SECURITY NUMBER — must always be entered even if the claim is for your spouse or child. Your claim cannot be processed without your (employee's) correct Social Security Number.

Part 2. — Patient Information — Complete this section if the patient is your spouse or child.

If the claim is for a child over age 19, provide all applicable information.

Part 3. — Other Coverage Information — Complete this section if patient is covered by any other group insurance plan.

- Provide plan name, policy number and address of any other group insurance plan.
- If the claim is for a dependent child who has school insurance, provide the plan name, policy number and address.
- You must *always* give your spouse's Social Security Number and date of birth if your spouse has other coverage.
- If the other plan pays first, attach its "Explanation of Benefits" Statement to this claim.

Please refer to the "Coordination of Benefits" section beginning on page 33 for details on how to determine which plan is the primary payor.

Part 4. — Medicare Information — If Medicare is the primary payor, provide Medicare effective date and attach the Medicare "Explanation of Benefits" Statement. Please refer to page 41 to determine when Medicare is the primary payor.

How to file a claim (continued)

Part 5. — Accident or Occupational Illness/Injury — Fill in all items in this section and describe the accident, if applicable.

Part 6. — Employee's/Patient's Signature, Release and Assignment of Benefits — Always sign and date this section. Your claim cannot be processed without your signature. Your dependent must also sign the form, if he or she is the patient and not a minor.

Check the "Yes" box if you want benefits paid directly to the provider. Check the "No" box if you want benefits paid to you.

HOSPITAL BILL

The hospital must attach an itemized bill to the claim form.

PHYSICIAN'S/SURGEON'S STATEMENT

Your physician must complete this section or attach a fully completed HCFA 1500 form or an itemized bill.

A physician's ITEMIZED BILL must show:

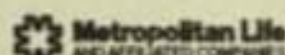
- Name of patient
- Diagnosis*
- Service(s) provided*
- Date of each service
- Charge for each service
- Name, addess, phone number and Social Security/tax identification number of provider of service

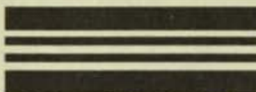
*ICD-9 code and/or CPT-4 code should be used.

PRESCRIPTION DRUG BILLS

Bills for prescription drugs must include:

- Name of patient
- Prescribing doctor
- Prescription number
- Name of drug and/or code
- Date of purchase
- Pharmacy's name
- Separate charge for each prescription





NORTH AMERICAN PHILIPS CORPORATION

Medical Claim Form

INPATIENT HOSPITAL CHARGES WILL BE PAID TO HOSPITAL.
ALL OTHER BENEFITS WILL BE PAID TO EMPLOYEE UNLESS ASSIGNED.

Mail Completed Form To ▶ Metropolitan Life Insurance Company
North American Phillips Medical Unit
Post Office Box 1267
Pittsburgh, PA 15230-1267
For Claim Inquires Call: 1-800-638-0035

Employee's Statement — See instructions on reverse side.

Part 1. Employee Information — Please print and provide all required information. Incomplete or incorrect forms will be returned to you and delay processing.

Employee's Name First / Middle Initial / Last | Social Security Number | ☐ Male ☐ Female | Date of Birth

Mailing Address: Street | Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Legally Separated | Telephone No. ( ) Area Code

City | State | Zip Code | Check If New Address: ☐

Part 2. Patient Information — (Complete if patient is not the employee.)

Patient's Name: First / Middle Initial / Last | Sex ☐ M ☐ F | ☐ Spouse ☐ Child | Birthdate

If for child 19 or older, is he or she:
☐ Employed?
☐ Student Full-time?
☐ Handicapped?

Name/Mailing Address of Child's Employer/School Street | City | State | Zip

Part 3. Other Coverage Information — Are you or any family member covered by another group plan? ☐ Yes ☐ No
Are you or any family member covered by another NAPC medical plan? ☐ Yes ☐ No
If yes to either, the following section must be completed.
If another insurer is primary, attach a copy of the other plan's Explanation of Benefits Statement.

Name of Plan | Plan's Policy Number

Name/Address of Other Carrier: Street | City | State | Zip

Dependent's Name | Relationship | Social Security No. | Birth Date

Name/ Address of Dependent's Employer: Street | City | State | Zip | Employer's Phone ( )

Part 4. Medicare

If Medicare is the primary payor, attach "Explanation of Benefits" statement and provide Medicare effective date. Mo. Day Yr.

Part 5. Accident or Occupational Illness/Injury Information — Complete this section only if claim is result of accidental injury.

Date of Accident | Time of Accident A.M. P.M. | Where did the accident occur? (City/State) | Is claim due to occupational illness/injury? ☐ Yes ☐ No

Describe Accident

Part 6. Employee's/Patient's Signature Release and Assignment of Benefits — Claim cannot be processed without employee's signature and social security number.

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this claim and the expenses reported. I agree to reimburse the insurance company any payment made to me in excess of the amount payable under the group policy. I also understand that the false statements may be cause for disciplinary action, including discharge.

It is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I understand that I am financially responsible to the provider for charges not covered by my benefits plan.

ASSIGNMENT OF BENEFITS:
EXCEPT WHERE MY PLAN PROVIDES FOR AUTOMATIC PAYMENT OF BENEFITS TO THE PROVIDER, I AUTHORIZE PAYMENT OF BENEFITS, OTHERWISE PAYABLE TO ME, TO THE PHYSICIANS OR PROVIDERS OF SERVICES RENDERED AS DESCRIBED ON THE REVERSE SIDE OF THIS FORM AND/OR AS INDICATED ON THE ENCLOSED BILL. I UNDERSTAND THAT PAYMENT WILL AUTOMATICALLY BE PAID TO THE HOSPITAL FOR INPATIENT CHARGES.

☐ YES. I WANT BENEFITS PAID DIRECTLY TO THE PROVIDER.
☐ NO. (Benefits will be paid directly to you.)

Signed (Employee or Surviving Spouse) Date | Signed (Dependent patient, not minor) Date

MM2332 GRN (12/88)

How to file a claim (continued)

Important Tips: Here are some other important points about filing claims:

1. Don't submit cancelled checks, cash register receipts, balance due statements, non-itemized bills or photocopies. THEY ARE NOT ACCEPTABLE AS PROOF OF EXPENSES. (Exception: a photocopy is OK if your insurer is the secondary payor of benefits.)
2. Part of a dependent's claim may be paid first by his or her own group insurance. If so, you must attach the other insurer's "Explanation of Benefits" to your secondary claim.
3. If the insurance company requests additional information to consider payment of a claim, it is *your* responsibility to obtain and submit the requested information.
4. The more detail provided with claim forms/bills, the better. Details (especially operative notes for surgery and a full report on chiropractic services) allow the insurer to process claims quickly and accurately.
5. Claims submitted more than two years after the date of treatment WILL NOT BE PAID.
6. Keep a copy of *everything* for your personal files.
7. Send your claims to the insurance company at the address on the claim form.
8. Questions about claims should be directed to Metropolitan Life at (800) 638-0035.

Procedure For Appealing Claims

If your claim is denied, in whole or in part, the insurance company will provide you with a written notice within 90 days from the date they received your claim (or 180 days if they notified you that there would be a delay). The notice will explain the reason(s) for the denial, point out the part of the plan on which the denial is based, and outline the steps you must take to appeal the denial. If you've made an error in your claim, the notice will list ways you can correct it.

You are entitled to appeal a claim that is denied within 60 days of the date you received the denial notice. To do so, write to the person who sent you the denial notice. Be sure to state why you believe the claim should not have been denied, and submit any additional information you feel may be relevant.

You will receive a written decision on your appeal within 60 days of the time the insurance company received your request. Under special circumstances (e.g., to hold a hearing), it may take longer than 60 days to reach a decision. In that case, you'll receive written notification of the delay within 60 days.

If you become disabled

If you become totally disabled, your health insurance will continue for up to 2½ years. If you had family coverage at the time of your disability, your dependents may also be covered during the first 2½ years of your disability, provided they meet the definition of eligible dependent. You pay nothing for this extra protection unless you're receiving full pay from a Company-provided salary continuance program in which case deductions for family coverage would continue.

Extended Protection. If you are still totally disabled after 2½ years, coverage for you and any eligible dependents will continue under the plan if

- you have at least 15 years of service which will never be less than your years of eligibility service as defined in the pension section (counting your first 2½ years of disability) and
- you are receiving benefits under the *Company's* Long-Term Disability Plan.

Coverage under the plan will continue until you recover or retire—whichever happens first. At retirement, you may be eligible for retiree health coverage.

A different rule applies if you have been totally disabled for 2½ years and do not meet the two eligibility requirements for the extended protection described above. In that case, your regular coverage for yourself and your dependents will cease. You may choose "limited coverage" under the plan at no cost to you or purchase health insurance for yourself and dependents for a limited time as described under "Optional Continuation of Coverage" on page 44. "Limited coverage" means the plan will only pay benefits for covered charges that are incurred directly because of the disabling illness or injury. Therefore, if you choose limited coverage you may want to convert to an individual policy as described under Conversion Privilege on page 47. You may also want to convert your dependent insurance to an individual policy or your dependents may wish to purchase health insurance for themselves for a limited time as described under "Optional Continuation of Coverage" on page 44.

If you become disabled (continued)

Medicare Coverage

Generally, if you become eligible for Medicare while your active health plan coverage continues *and you are not* receiving a company pension, your health plan will be the primary payor (pay benefits first) and Medicare will be secondary. When you retire, Medicare will become the primary payor of benefits.

If Your Dependent Becomes Disabled

If a dependent becomes totally disabled, his or her regular coverage continues until your coverage ends—or until he or she no longer meets the definition of an eligible dependent. However, if a dependent is totally disabled when regular coverage ends, your dependent may choose "limited coverage" under the plan at no cost to your dependent or purchase health insurance for himself or herself for a limited time as described under "Optional Continuation of Coverage" on page 44.

"Limited Coverage" means the plan will only pay benefits for covered charges that are incurred directly because of the disabling illness or injury. Therefore, if your dependent chooses limited coverage, he or she may want to convert to an individual policy as described under Conversion Privilege on page 47.

Here are a few important things you and your dependents should know:

- "Limited coverage" is provided until the end of the calendar year following the year in which your regular plan benefit coverage ended.
- "Limited coverage" ends immediately if you or a dependent recover or become eligible for similar coverage under another group plan.

Generally, if a disabled dependent becomes eligible for Medicare while coverage under a Company health plan continues (and you are not receiving a Company pension), the Company health plan will be the primary payor (pay benefits first) and Medicare will be secondary. When you retire, Medicare will become the primary payor of benefits.

Total Disability

For purposes of determining continued health coverage during disability, a person is considered "totally disabled" if he or she is unable to engage in any occupation for compensation or profit, or perform any activities which are usual for his or her age.

If you should die

If you die while actively employed, your eligible enrolled dependents' coverage will continue under the plan for three months.

There is no charge for this extra protection. However, coverage may continue longer than three months in the following situation:

If You Die After Age 65. If you die in active service after your normal retirement age and you . . .

- would have been eligible for retiree medical benefits
- were in the pension plan
- were enrolled for family health coverage

. . . coverage for your spouse under the Company-sponsored plan will continue for his or her lifetime. Your eligible dependent children's coverage will continue until they are no longer eligible dependents.

If health coverage ends for your surviving dependents and they are not eligible for the extended protection described above (or their health insurance ends because they are no longer eligible dependents under the plan), group health insurance may be purchased for a limited time as described under "Optional Continuation of Coverage" on page 44.

When coverage ends

Your insurance coverage ends when you leave the Company, become ineligible or the group policy terminates, whichever happens first. Your dependents' coverage ends when yours does or when a dependent is no longer eligible.

Your health insurance also ends when you are laid off or begin an approved leave of absence. You and your covered dependents may be able to purchase health insurance for a limited time after your Company-provided group coverage ends. For more details, please refer to "Optional Continuation of Coverage" described on page 44.

If The Group Insurance Policy Terminates

If the group insurance policy terminates, or if it is amended to end coverage for the group of employees that you belong to, you won't receive benefits for any expenses that you incur on or after the termination date. This includes the limited coverage provided in case of disability as described on pages 40-41 and optional continuation of group health coverage described below.

Optional continuation of coverage

If group health coverage ends for certain reasons, you and your covered dependents may be able to continue coverage beyond the normal termination date.

If you become eligible to elect continuation of health coverage, you may purchase the coverage you had before it ended, including participation in a Health Maintenance Organization (HMO). Of course, you will be required to pay the full cost of coverage (which is 102% of your group rate).

When You May Continue Coverage

You may continue coverage for yourself and any covered dependent if coverage ends because your employment ends, either voluntarily or involuntarily, or your work status changes. If, in either case, you do not elect to continue coverage, a covered dependent may individually elect to continue coverage. Covered dependents may also elect to continue coverage, if they lose coverage due to:

- your death, divorce or legal separation
- loss of dependent status (such as reaching the limiting age) under the plan.

Eligibility Requirements

If your coverage stops because your employment ends or your work status changes, you will be notified by the Company within 14 days of your last day of coverage if you are eligible to continue coverage.

If you become divorced or legally separated and your local Personnel or Employee Relations Office is notified within 60 days of either event, your covered dependents may be eligible to elect optional continuation of coverage. If a dependent child reaches the age when he or she is no longer covered under the plan and your local Personnel or Employee Relations Office is notified within 60 days of termination of coverage, your dependent child may be eligible to elect optional continuation of coverage.

Within 14 days after informing the Company of a divorce, legal separation or a child reaching the limiting age (as described in the preceding paragraph), your covered dependent(s) will be notified by the Company of their eligibility to continue coverage.

If optional continuation of coverage is not elected within 60 days after receiving notification from the Company, eligibility for this option ceases.

Optional continuation of coverage (continued)

Optional continuation of coverage is not available to anyone who is covered under Medicare, if you were terminated for gross misconduct, or if the Company isn't notified within the specified time limit.

How Long Optional Continuation of Coverage Lasts

If group health coverage ends because your employment ends or your work status changes, optional continuation of coverage may be purchased for up to 18 months. In the case of your death, divorce, or legal separation, or loss of dependent status, covered dependents may continue coverage for up to 36 months.

Optional continuation of coverage will end *before* the expiration of the time periods described above, if:

- you (or your covered dependent) fail to pay the required premium
- you (or your covered dependent) become covered under Medicare
- the group policy terminates.

Please see your Personnel or Employee Relations Office for further information on optional continuation of coverage.

Post-65 coverage—active employees

If you remain in active service beyond age 65 (the age when Medicare coverage starts), your health insurance will automatically continue under the plan as your *primary coverage*. In other words, you will be covered the same as any other active employee under age 65. Medicare will provide limited supplementary coverage. However, the Company *will not* reimburse you for your participation in Part B of Medicare. This arrangement will continue until you retire.

If your spouse is age 65 or older, he or she will also have primary coverage under the Company plan (with Medicare for supplementary coverage).

Conversion privilege

If your insurance or optional continuation of coverage ends (as just described) and you have been insured for at least three months, you can convert your health insurance to an available individual policy (including family coverage). You need not undergo a medical examination, provided that you apply within 31 days after your insurance terminates. Of course, you will pay the entire premium for this individual policy, and the benefits will be substantially different and generally less than those described in this section.

The conversion privilege is available:

- to your covered family members if coverage ends in the event of your death while you are insured, whether you are retired or not. After your death, the conversion privilege is available to your eligible dependents while covered by the Health Plan;
- to eligible dependent children who reach the maximum age for coverage under this plan while covered by the Health Plan;
- to your spouse upon divorce, provided the spouse was a covered dependent at such time.

In the event the group policy terminates, the conversion privilege would be available to you, your eligible dependents, insured retirees, their eligible dependents and insured dependents of deceased employees. As with any conversion to an individual policy, the person would be responsible for the entire premium but would not have to provide evidence of insurability.

In all cases, when the conversion privilege is available, it will be available whether or not at the time coverage ceases under the plan, you, your spouse or dependent children are disabled. Application must be made within 31 days after coverage ends in order for any of the conversion privileges to apply.

Metropolitan may refuse to issue converted coverage on a person if the coverage would make that person overinsured by Metropolitan's rules.

When your insurance or optional continuation of coverage ends, you should contact your Personnel or Employee Relations Office. They can supply you with conversion information which should include summaries of the terms of the individual health conversion policies. Upon request, the summaries may also be obtained while you are insured.

Future of the plan

The Company necessarily reserves the right to charge for coverage or to end or amend health coverage for you or your dependents at any time.

Plan administration

A plan administrator is responsible for providing participants with information about their benefits, processing payments, implementing plan changes and handling other functions necessary for the plan's operation. The plan administrator for the Plan is North American Philips Corporation, 100 East 42nd Street, New York, N.Y. 10017 (212) 697-3600.

Your Personnel or Employee Relations Office handles plan administration on the local level; they should be your first source for answers to any questions you have about your plan.

Insurance Company

Your benefits are insured by Metropolitan Life Insurance Company, 1 Madison Avenue, New York, New York 10010.

Agent For Service Of Legal Process

For any legal proceedings, the plan's agent is CT Corporation System, 1633 Broadway, New York, N.Y. 10019.

Legal process may also be served on the plan administrator.

Plan Year

Records for the plan are kept on a calendar year basis ending each December 31.

Employer And Plan Number

The Employer Identification Number (EIN) is 13-1895219 and the Plan Number (PN) is 501.

Plan Cost

The health insurance contract is experience-rated. Employees pay a fixed amount. The Company is responsible for the remaining cost after any dividends.

Effective Date

This guidebook section is a summary of health plan provisions in effect as of January 1, 1989.

Your rights under law

As a participant in the group health insurance plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other locations (including worksites), all plan documents including copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. (The administrator may make a reasonable charge for the copies.)
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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," have a duty to do so prudently and in the interest of you and other plan participants. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or 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 federal court.

Your rights under law (continued)

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.

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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

> The benefits description in this booklet does not constitute an express or implied contract of employment.

PRE ADMISSION REVIEW (PAR)

A Most Important Health Plan Feature

Hospital costs represent the single largest portion of the total national health care bill. And those costs continue to rise at an alarming rate. Clearly, the government, the health care delivery system, companies like ours and individuals like you must work together to prevent hospital costs from becoming too heavy to shoulder.

The Company is doing its part through responsible health plan design. For example, in 1984 we introduced incentives to get second surgical opinions, use pre-admission testing, have same-day surgery, and use cost- and care-effective alternatives to hospitalization (such as home health care and extended care). One of the most important steps forward for the cause of quality health care at affordable cost is Pre Admission Review (PAR) which is designed for all hospital admissions.

Basically, each and every time you or a covered dependent is hospitalized, *you must obtain approval for the admission.* In brief, PAR works like this:

- **For non-emergencies,** *including childbirth,* you and your physician must submit a form to PAR (a special division of the health plan's insurer) to get written approval for hospitalization *before admission.* The approval will include the number of hospital days authorized.
- **For urgent admissions,** your physician can call a PAR reviewer to get authorization *before admission* over the phone.
- **For emergencies,** you can receive approval *after admission.* However, your physician or hospital must call PAR for approval within 48 hours after admission (or 72 hours on weekends and holidays).
- **For extensions of stay** beyond the number of hospital days originally authorized, your physician must notify PAR *before the extra days begin.*

The PAR toll-free telephone number is **1-800-225-5481.** You may call weekdays between 8:00 a.m. - 5:00 p.m. Eastern Time.

The Company is convinced that Pre Admission Review is one of the best programs available to promote quality, cost-effective health care. For this reason, we are giving you a *strong dollar incentive* to use PAR:

> If you use PAR, you will receive your regular health plan benefits — as explained in the health plan section of this guidebook. If you don't get proper PAR approval, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%.** This reduction applies to the time you are not in compliance.

Please be sure to read the following pages with care for details on what PAR can do for you.

Pre admission review (PAR)

Section | Page

When You Must Use PAR 1
How To Get PAR Authorization 1
  Non-Emergency Hospitalization 1
  Urgent Admissions 2
  In Case Of Emergency 3
  To Call PAR 3
If You Don't Use PAR 4
How PAR Helps You 5
The PAR Reviewer 5
Two Special PAR Features 6
  Medical Case Management 6
  Psychiatric Case Management 7
Your Health I.D. Card 9
Filing A Claim 9
Sample PAR Form 10

Superseded by new Health Plan SPD -

PAR

When you must use PAR

Pre Admission Review applies to *all hospital admissions for inpatient care.* Every time you are hospitalized, you must get authorization for the admission and length of stay through PAR.

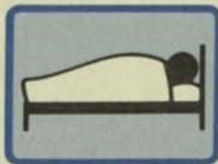
What's more, PAR *applies to all your covered dependents exactly the same way as it applies to you.* So please be sure your family knows about this most important health plan feature.

You do not use PAR for outpatient care, even if provided in a hospital. For example, if you go to a hospital emergency room (with no subsequent admission) or have same-day surgery in a hospital, there is no need to contact PAR.

Other Hospital Pre Admission Review Programs

If a covered dependent obtains approval for a hospital admission through another group plan, the approval will meet this plan's Pre Admission Review requirement. It is not necessary to get an additional approval through PAR; however, when filing a claim under this plan, proof that hospital admission approval was obtained through other coverage must be submitted to ensure maximum benefits under this plan.

If a covered dependent does not obtain approval for a hospital admission through his or her primary group health plan, PAR approval must be obtained to ensure maximum benefits under this plan, which would be the secondary payor.



How to get PAR authorization

PAR has been set up to make the authorization process quick and simple. And you'll never experience a delay in treatment because of the PAR requirement.

Non-Emergency Hospitalization

Usually, you know in advance that you will be hospitalized. So in non-emergency situations, you must get written authorization for inpatient care *before you go into the hospital.* PAR approval is valid for 60 days after the date of authorization, but for childbirth approval is valid

for nine months. You can plan for a non-emergency hospitalization, *including one for childbirth,* in advance by following these simple steps:

- Get a "Pre Admission Review" form from your Personnel or Employee Relations Office. As you can see from the sample form on page 10, it's short and easy to complete.
- Fill out the top part of the form. Have your physician complete the rest, indicating the proposed treatment and length of hospital stay. Your physician should then send the form to Metropolitan Life, to the address on the lower right corner of the form (see page 10). This should all be done about two weeks before your proposed admission.
- A professional PAR reviewer will evaluate the proposed admission plan for medical necessity and length of stay, based on medical norms as well as any special circumstances relating to your case. If surgery is involved, the hospital admission will usually begin the same day that the surgery is scheduled to take place. However, in all cases, a patient's age, general condition and medical complications will all be considered in determining the approved number of hospital days. If the PAR reviewer has questions about the admission or length of stay, he or she will call your doctor. Your doctor can then discuss your case in more detail with the PAR reviewer.

  If admission is approved, the reviewer mails written authorization usually within 24 hours after receiving the request. The approval states the number of authorized hospital days. You, your doctor and hospital will each receive a copy of the PAR approval, which is valid for 60 days after the date of authorization.
- **For childbirth admissions, complete and submit your PAR form well in advance of the delivery date. Authorization is valid for nine months.** Then, as a follow up, be sure to call PAR (1-800-225-5481) on the day of admission so the reviewer can work with your physician on discharge planning.

Urgent Admissions

What if your doctor advises you to be hospitalized immediately? If this happens, you must still get PAR approval *before you are admitted.* But in this case, your doctor should call a PAR reviewer directly to get authorization on-the-spot over the phone. Phone authorization will be confirmed in writing usually within 24 hours of the call.

How to get PAR authorization (continued)

In Case Of Emergency

If you are hospitalized for an emergency, your physician or hospital administrator can get PAR approval by phone *after admission.* However, the call must be made

- within 48 hours of admission on weekdays, or
- within 72 hours of admission on weekends and holidays.

Authorization by phone will be confirmed in writing within 24 hours of the call. This special emergency procedure has been set up to prevent any delay in treatment.

To Call PAR

Remember, obtaining PAR approval is your responsibility. Be sure to check on it yourself. Do not assume your physician or hospital's admitting office will contact PAR. Any administrative fees charged to obtain PAR approval is not a covered expense under the health plan.

If you do not receive a copy of the PAR approval within a week or so after giving the form to your doctor to complete and mail to PAR (or if you want to be sure your doctor submitted the form), you can call PAR directly yourself. Of course, you're also free to call PAR if you have any other questions.

PAR reviewers identify themselves by name, so always note the reviewer's name in your files in case you need to follow up on your phone inquiry at a later date. You will save time by talking to a reviewer who is already familiar with your admission file.

PAR's toll-free telephone number is 1-800-225-5481.

Calls can be made on weekdays between 8:00 a.m. and 5:00 p.m. Eastern Time.

IMPORTANT: If your physician recommends that you stay in the hospital beyond the number of days originally authorized, he or she must notify the PAR reviewer *before those extra days begin.* Unless the extra days are pre-authorized or found to be medically necessary, the 20% cutback in hospital benefits will apply to the extra days.

If you don't use PAR

If you don't get proper PAR approval for any hospitalization, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%.** This reduction applies to the time you are not in compliance.

For example, assume you have individual coverage under the Company-provided health plan and you are admitted to a hospital. Your hospital charges come to $5,000. These numbers will show just how important it is to use PAR.

Benefits Payable

With PAR	**Without PAR**	**Reduction In Benefits Without PAR**
$4,080 (85% of hospital charges, after $200 deductible)	$3,264 ($4,080 reduced by 20%)	$816

PLEASE NOTE: Any benefits lost by not using PAR cannot be regained through your health plan's special full-payment (or "stop-loss") feature. (The health plan's stop-loss provision is explained on page 9/health.) In other words, any hospital charges that are not covered because you failed to use PAR *will not count toward meeting the stop-loss.* And those charges will not be paid *even if you have already met the stop-loss.*

How PAR helps you

The best thing about PAR is that it gives you added assurance that the hospital is the best place to be for your particular condition. And it lets you know *in advance* that your hospital stay is medically necessary.

Also, your PAR reviewer will be familiar with your health plan. This way, he or she can remind you about other important plan features. For example, your reviewer might help you

- **cut down on hospital days** through pre-admission review
- **avoid a Friday or Saturday admission,** which is usually not covered by your health plan
- **consider same-day surgery** for 100% reimbursement
- **opt for medically-sound alternatives to hospitalization** — such as home health care or extended care.
- **arrange a voluntary second surgical opinion.** In fact, your health plan's Managed Second Surgical Opinion program (explained in the health section of this guidebook) is administered by the PAR staff.

In short, the PAR reviewer can help you get quality, cost-effective care. At the same time, his or her advice can help you *save money* on health care costs.

The PAR reviewer

The PAR review is performed by a registered nurse who has years of hands-on hospital experience, as well as specialized training in the review process. The reviewers know the ins and outs of hospital admissions, benefit coverage and review procedures. Also, the reviewers are backed by a network of consulting physicians who offer expert advice whenever needed.

Two special PAR features

There are two more special services through Case Management that come to you as part of PAR.

Medical Case Management

Along with catastrophic illness or injury comes a bewildering array of problems and concerns. Am I getting the best possible care? Is the hospital the right place to be? Where can my family and I turn for counseling and support? Medical Case Management (MCM), a special part of PAR, has been set up to address such questions.

Medical Case Management may step in when you or a covered dependent is affected by one of the following illnesses or injuries:

Illnesses

- Neonatal High Risk Infant
- Cerebral Vascular Accident (CVA, or severe stroke)
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig disease)
- Acquired Immune Deficiency Syndrome (AIDS)
- End Stage Cancer
- Osteomyelitis – infection of bones
- Anorexia
- Bulimia
- Severe Rheumatoid Arthritis
- Substance Abuse
- Certain Psychiatric Conditions
- COPD – Chronic Obstructive Pulmonary Disease
- Chrohn's Disease
- Selected Osteoarthritis

Injuries

- Major Head Trauma
- Spinal Cord Injury
- Amputations
- Multiple Fractures
- Severe Burns

Two special PAR features (continued)

If the insurance company accepts a patient for Medical Case Management, an expert MCM coordinator is assigned to the case. The coordinator works closely with the patient, family and attending physician to

- *assess the patient's condition.* The coordinator prepares a medical evaluation and suggested treatment plan based on input from the attending physician and, if need be, from an outside medical consultant.
- *act as an information resource.* Through a national network of information sources, the coordinator can recommend quality, cost-effective facilities and services that are most appropriate for the particular patient.
- *monitor the patient's progress.* The coordinator follows the patient's progress to assure the appropriateness of care and help the patient achieve greater independence (for example, through home health care).
- *provide ongoing support.* Throughout the treatment period, the coordinator is an important source of information on support services that the patient and family may need — such as community programs and counseling.

Plan deductibles, coinsurance and PAR requirements remain in effect while an individual is covered under MCM. However, at the MCM coordinator's recommendation, the health plan may cover certain medical services and supplies that ordinarily would not be covered.

In short, the MCM coordinator's role is to provide the facts, suggestions and support needed to make the best decisions regarding the patient's care. Of course, any final decision on the actual course of treatment is left up to the patient, family and attending physician.

Psychiatric Case Management (PCM) is the component of Case Management that is designed to ensure quality care for patients with serious mental and nervous disorders or for alcoholism or drug dependence. PCM works alongside the Employee Assistance Program (EAP) and PAR to make sure that the patient's care and treatment site are the most appropriate. However, strict confidentiality is always maintained and EAP will never release information without signed authorization from the individual.

Your health I.D. card

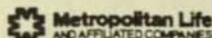
As a new employee, you will receive a health I.D. card with a capsule summary of your health plan. The card also indicates the Pre Admission Review requirement and gives the PAR telephone number. *You should carry the I.D. card with you at all times.* It serves as a valuable reminder about PAR for you, your doctor or hospital. Extra I.D. cards are available for your dependents.

REMEMBER: Since all PAR features apply equally to you and your covered dependents, be sure your family knows all about PAR. That way, you can help remind each other about this most important plan feature when any family member needs to be hospitalized. This can be especially vital in case of an emergency — when the patient may not be able to tell the doctor to call PAR.

Filing a claim

Whenever you file a claim form that includes any hospital charges, you should attach the PAR authorization notice.

The PAR program is designed to assure the medical necessity of hospital admissions and length of stay. A PAR hospital authorization does not constitute verification that the patient is covered by the Company health plan. Nor does it guarantee that all hospital expenses will be covered. Eligibility for coverage and the extent to which medical services and supplies will be covered are determined by health plan provisions.



Metropolitan Life Insurance Company
Pre-Admission Review
(Met Review)

Hospital benefits will only be payable if the medical necessity (according to generally accepted standards of medical practice) of an in-patient hospital admission can be substantiated. If approval is not requested or Metropolitan does not approve in advance, benefits may be paid at a reduced rate in accordance with the Plan provisions.

TO BE COMPLETED BY EMPLOYEE

LAST NAME ______________________ FIRST NAME ______________________

ADDRESS ______________________

CITY ______________________ STATE ______________ ZIP CODE __________

HOME PHONE ______________ SOCIAL SECURITY NO. ____/____/____ GROUP NUMBER __________

SUBDIVISION ______________ BRANCH ______________ PLAN/UNION CODE __________

PATIENT

RELATIONSHIP ______________________ (EMPLOYEE SPOUSE DEPENDENT)

FIRST NAME ______________________ BIRTHDATE ______________ SEX ______

For claim review purposes, I authorize the physician named below to give Metropolitan Life Insurance Company and its consultants, any medical information concerning the condition which is subject to this review. I understand that the duration of this authorization is for the term of coverage under the Plan under which my claim is submitted. I know that I have a right to get a copy of this authorization.

DATE ______________ SIGNATURE OF EMPLOYEE ______________________

DATE ______________ SIGNATURE OF PATIENT ______________________
(Unless Minor)

TO BE COMPLETED BY PHYSICIAN

DIAGNOSIS ______________________ PROCEDURE ______________________

ICD9 __________ ICD9 __________ ICD9 __________

CPT4 __________ CPT4 __________ CPT4 __________

PHYSICIAN'S LAST NAME ______________________ FIRST ______________________

ADDRESS ______________________

CITY ______________________ STATE ______________ ZIP CODE __________

TELEPHONE NUMBER ______________________

FACILITY HOSPITAL NAME ______________________

ADDRESS ______________________

CITY ______________________ STATE ______________ ZIP CODE __________

FACILITY TAX I.D. ______________________ TELEPHONE ______________________

ANTICIPATED LENGTH OF STAY (DAYS) __________ DATE ADMISSION __________ DATE SURGERY __________

SPECIFIC INDICATIONS FOR ADMISSION ______________________

____

____

SIGNATURE OF PHYSICIAN ______________________ M.D. DATE __________

IF THE ADMISSION IS TO BE SCHEDULED WITHIN LESS THAN TEN WORKING DAYS PLEASE HAVE SOMEONE IN YOUR OFFICE CALL METROPOLITAN AT 1-800-225-5481 WITH THE ABOVE INFORMATION. THE CALL SHOULD BE MADE BETWEEN 8:30 A.M. AND 7:00 P.M. EASTERN TIME AND PLACED AT A TIME WHEN THE ADMITTING PHYSICIAN IS AVAILABLE TO DISCUSS THE SPECIFIC INDICATIONS FOR THE ADMISSION IF NECESSARY.

OTHERWISE, THE FORM MAY BE MAILED TO METROPOLITAN LIFE INSURANCE COMPANY AT ADDRESS BELOW. PLEASE INDICATE A CONVENIENT DAY FOR OUR PHONE CALL IN THE EVENT FURTHER DISCUSSION REGARDING THE INDICATIONS FOR ADMISSION IS NECESSARY.

(DATE) ______________ ________ AM ________ PM

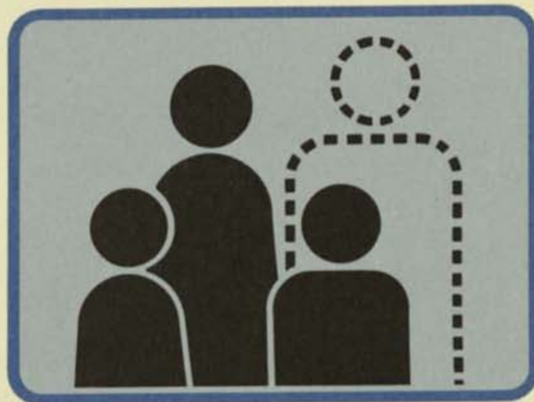
North American Philips Corporation

CALL
1-800-225-5481

MAIL TO:
Metropolitan Life Insurance Company
Westport Medical Action Center
14 Westport Avenue
Norwalk, CT 06851

MD450-22130-NAPC (1-88) Printed in U.S.A. 18000062101 (0188)

LIFE PLAN



LIFE

Group life insurance

Superseded by new Health Plan/Life SOD.

Section | Page

Why Group Life Insurance? 1
Who Is Eligible? 1
Enrollment 1
Amount Of Insurance
  Free Insurance 2
  If You Want Additional Coverage 2
  Your Contributions For Additional Coverage . 2
  Some Examples 3
  Maximum Coverage 3
  Rounding Out Your Benefit Level 3
  Changing Your Additional Coverage 4
  When Your Salary Changes 4
  If You Work Past Age 65 4
Payment Of Life Insurance
  Your Beneficiary 5
  How Your Life Insurance Is Paid 5
  How To File A Claim 5
  Procedure For Appealing Claims 5
Other Important Facts
  Income Tax On Life Insurance 6
  When Coverage Ends 6
  If You Become Disabled 7
  Conversion Privilege 7

DEPENDENT LIFE INSURANCE

Enrollment 8
Amount Of Insurance 8
  Children 8
Cost 9
Payment Of Insurance 9
How To File A Claim 9
When Coverage Ends 10
Conversion Privilege 10
Plan Administration
  Plan Administrator 11
  Insurance Company 11
  Agent For Legal Process 11
  Plan Year 11
  Employer And Plan Number 11
  Effective Date 11
Your Rights Under Law 12

Why group life insurance?

When a wage-earner dies, and income stops, the difficulties can be overwhelming. So during your working years, your family needs the kind of financial security that the Company's group life insurance plan provides. As a plan member, you'll automatically have free life insurance. Plus, you can have extra security by purchasing additional coverage at relatively low cost.

Who is eligible?

You are eligible to participate if you are an active, full-time salaried employee (i.e., you regularly work more than 30 hours a week).

Enrollment

Your free life insurance automatically goes into effect on your date of employment. You don't have to enroll.

You may enroll for additional coverage when you join the Company. If you do, the additional coverage also becomes effective on your date of employment provided you enroll on or before that day. If you enroll within 31 days after your date of employment, your coverage begins on the date you enroll. If you fail to enroll within that time, you must furnish satisfactory evidence of good health to the insurance company before you can be insured. You may be asked to undergo a medical examination at your own expense. *You may never be allowed to enroll if you are unable to provide satisfactory evidence of good health.*

If you are absent from work because of injury or illness on the day your insurance would otherwise become effective, the effective date of your coverage will be postponed until the date you return to work.

Amount of insurance

Free Insurance

You are automatically insured for an amount equal to one times your basic annual earnings rounded up to the next higher $1,000 multiple. This amount of free insurance will never be less than $10,000.

1x or 2x

If You Want Additional Coverage

You have an opportunity to purchase additional life insurance at low group rates. Because individual needs differ, the plan offers you two options: you can choose additional coverage of one or two times the amount of your basic annual earnings. In other words, your total coverage can be as high as three times your basic annual earnings.

The kind of insurance you are buying is called "term" insurance. This means your premiums pay for coverage for a specific period of time; you don't build a cash reserve for the future.

Basic Annual Earnings. Basic annual earnings means your annual rate of pay. Bonuses, overtime payments, or any other forms of additional compensation are not included for life insurance purposes.

If you're a salesperson who earns commissions in addition to salary, basic annual earnings means your base salary in effect on January 1 of the current year, plus your average annual commissions for the two prior calendar years. If you've only completed one prior year of service, earnings include your annual commissions for that year. If you have less than one prior year of service, earnings include your annualized average monthly commissions for your period of employment. For the calendar year in which you're hired, basic annual earnings include only your base salary.

Your Contributions For Additional Coverage

The amount you pay each month for additional coverage depends on your age as of January 1 of the current year, as follows:

If Your Age on January 1 of the Current Year Is	Then Your Contribution For Each $1,000 of Additional Coverage Is
Under 40	10¢
40-54	20¢
55-59	50¢
60 or older	65¢

Amount of insurance (continued)

For example, say you are hired in July 1986 at age 40 and you decide to elect additional life insurance. Your birthday was in May. Throughout 1986, you would contribute 10¢ for each thousand dollars of additional coverage since you were only 39 on January 1, 1986. Then on January 1, 1987, you would start contributing 20¢ for each $1,000 of additional coverage.

Some Examples

Assume Jack Smith's age on January 1, 1986 is 39. His basic annual earnings are $30,000. If Jack decides to elect additional life insurance of one times his basic annual earnings, his monthly contribution is figured like this:

Contribution Rate Based On Age	x	Thousands Of Additional Coverage	=	Monthly Cost
10¢	x	30		$3.00

His total life insurance is $60,000 ($30,000 free plus $30,000 additional). The following year, when Jack's age as of January 1 will be 40, his contribution rate goes up to 20¢ per $1,000 of additional coverage — making his monthly cost $6.00.

June Harris is age 57 and has basic annual earnings of $42,000. If she elects additional coverage of two times basic annual earnings, her contribution is figured like this:

Contribution Rate Based On Age	x	Thousands Of Additional Coverage	=	Monthly Cost
50¢	x	84		$42.00

For $42.00 a month, June has total life insurance coverage of $126,000 ($42,000 free plus $84,000 additional).

Maximum Coverage

The maximum amount of life insurance coverage for any individual is $1,000,000.

$1000 multiples

Rounding Out Your Benefit Level

If your basic annual earnings are not an even $1,000 multiple, your insurance will be rounded up to the next higher $1,000 multiple — as shown in these examples:

Suppose your basic annual earnings are $10,200. This amount would be rounded up to $11,000 in computing your free insurance. If you opt for additional coverage equal to one times earnings, your additional coverage would be $11,000. Add this to your free $11,000 benefit and your total coverage is $22,000.

Amount of insurance (continued)

If you choose additional coverage equal to two times earnings, your $10,200 is doubled to $20,400 and then rounded up to $21,000 of insurance. With your free $11,000 benefit, your total coverage is $32,000.

Changing Your Additional Coverage

You can change the option you chose during your initial enrollment at any time afterward. If you elect additional coverage equal to two times basic annual earnings, you can decrease this amount to one times basic annual earnings. You may also *increase* your additional coverage from one to two times basic annual earnings; *however, you must first submit satisfactory evidence of good health to the insurance company.*

When Your Salary Changes

When you receive a salary increase, and you become eligible for a higher amount of life insurance, the new amount automatically goes into effect on the day your salary increases. If you are absent from work because of injury or illness on the day your insurance is scheduled to change, the new amount will become effective on the day you return to work.

Should your salary decrease, your amount of life insurance will remain the same (unless you're a commissioned salesperson whose earnings are calculated each January 1).

If You Work Past Age 65

If you work past age 65, you may continue to participate in the life insurance plan. However, starting with your 65th birthday the benefit payable upon your death is reduced by 8% a year, as follows:

If You Die On Or After Your	Your Beneficiary Receives This % Of Your Full Insurance Amount
65th birthday	92%
66th birthday	84.64%
67th birthday	77.87%
68th birthday	71.64%
69th birthday	65.91%
70th birthday	60.64%...and so forth

Note, though, that the amount you contribute for any additional coverage is based on your *full* insurance amount.

For example, say you are age 67 and your basic annual earnings are $25,000. You have elected additional life insurance of two times your basic annual earnings ($50,000). Your full insurance amount, then, is $75,000 ($25,000 free plus $50,000 additional).

Amount of insurance (continued)

Your monthly contribution for additional coverage is $32.50 (65¢ per thousand of additional coverage). If you die in active service at age 67, your beneficiary receives $58,402.50 (77.87% of $75,000).

Payment of life insurance

Your Beneficiary

You can select anyone as the beneficiary of your group life insurance. You can name more than one person and you have the right to change your beneficiary at any time. You should contact your Personnel or Employee Relations Office for the appropriate forms.

If you have no designated beneficiary when you die, benefits will be paid to your survivors in the following order of priority: your spouse, children, parents, brothers and sisters, executors or administrators. If your beneficiary is a minor who doesn't have a legal guardian, the benefit may be paid at a rate not exceeding $50 per month to the adult who the insurance company determines has assumed custody of the minor.

How Your Life Insurance Is Paid

Your insurance is paid to your beneficiary should you die from any cause while you are insured. Ordinarily, this benefit is paid in one lump sum, but your beneficiary can make arrangements for monthly installments.

How To File A Claim

The Personnel or Employee Relations Office at your location will assist your beneficiary in filing the appropriate claim form with the insurance company.

Procedure For Appealing Claims

If your beneficiary's claim for your insurance is denied, in whole or in part, the insurance company will provide a written notice within 90 days from the date they received the claim (or 180 days if they notified the beneficiary that there would be a delay). The notice will explain the reason(s) for the denial, point out the part of the plan on which the denial is based, and outline the steps your beneficiary must take to appeal the denial. If your beneficiary has made an error in the claim, the notice will list ways it can be corrected.

Payment of life insurance (continued)

Your beneficiary is entitled to appeal a claim that is denied within 60 days of when he or she received the denial notice. He or she may also review any plan documents that relate to the claim. To appeal, your beneficiary should write to the person who sent the denial notice. The appeal should state why the beneficiary believes the claim should not have been denied and should include any additional information that may be relevant.

Your beneficiary will receive a written decision on the appeal within 60 days of the time the insurance company received the request. Under special circumstances (e.g., to hold a hearing), your beneficiary will receive a decision within 120 days of the appeal.

Other important facts

Income Tax On Life Insurance

If your total life insurance coverage exceeds $50,000, a portion of your insurance may count as income for income tax purposes. The taxable amount (if any) is determined by an IRS formula based on your age and the premiums you pay. Any taxable amount will be included in your income on your W-2 form.

When Coverage Ends

Your group life insurance terminates on the earliest of the following dates:

- the date the group policy terminates
- the date you are no longer eligible
- your last day of active service with the Company, or the end of the period for which the last payroll deduction was made, whichever date is later
- the date you retire

Coverage will continue during temporary layoffs or leaves of absence, up to the end of the third month following the month that you left active service — provided that you pay the premium for coverage. In no event will coverage extend beyond the third month after your layoff or leave of absence began.

If You Become Disabled

Your coverage will continue as long as you remain disabled. There is no cost to you unless you're receiving full pay from a Company-provided salary continuance program. Your insurance amount will be reduced by 8% for each year starting with your 65th birthday. If you retire while disabled, your life insurance coverage will terminate on the date of your retirement.

Conversion Privilege

You can convert your group life insurance to a permanent individual policy, without a medical examination, if you apply within 31 days after the date your group life insurance terminates because you've left the Company or transferred to an employment status not covered by this plan. Special conditions apply to conversion if the group policy is terminated. Contact your local Personnel or Employee Relations Office for conversion information.

The rates for an individual life insurance policy are based on your age at the time you convert your group life insurance, and the amount of insurance you convert.

If you die within the 31-day period allowed for conversion, your beneficiary will receive payments under the *group* policy. And any premiums you may have paid toward an individual policy will be refunded. If your individual policy beneficiary is someone other than the beneficiary you'd named under the group policy, the benefits payable from the group policy will be paid to the beneficiary you named for the individual policy.

The insurance company may refuse to issue a converted policy if doing so would result in overinsurance or duplication of coverage.

DEPENDENT LIFE INSURANCE

Enrollment

When you join the Company, you'll receive an enrollment form for dependent life insurance which you must complete and return to the Personnel or Employee Relations Office. If you indicate that you want to participate, this form authorizes the Company to deduct the required plan contributions from your paycheck.

If you enroll when you first join the Company, your dependents' life insurance will go into effect after you have been employed for one month. If you enroll your dependents within 31 days after the end of your first month, their coverage begins on the date you enroll them. If you do not have dependents when first hired, but acquire them later through marriage or birth, you have 31 days from the date of marriage or birth to enroll your new dependents. If you do not enroll your dependents when first eligible, you must furnish the insurance company with satisfactory evidence of your dependents' good health before they can be insured. They may be asked to undergo a medical examination at your expense. Should your dependents be unable to furnish satisfactory evidence, you will not be able to get dependent life insurance coverage.

If you are absent from work because of injury or illness on the day your dependents' life insurance would otherwise take effect, the effective date of coverage will be postponed until the date you return to work.

Amount of insurance

You may insure your "dependents," — that is, your spouse (unless legally separated or divorced) and eligible children. Your spouse can be insured for $5,000 and each eligible child for $1,000.

Children

- **Children** — Children eligible for dependent life insurance include unmarried children from 14 days of age to their 19th birthday. They can be . . .
  - — your own children,
  - — stepchildren,
  - — adopted children, or

Amount of insurance (continued)

— any children permanently residing in your household in a parent-child relationship

. . . provided that they are primarily dependent upon you for support.

- **Students** — Coverage will be continued until age 25 for your unmarried children while they are attending school as full-time students and are primarily dependent upon you for support.

Cost

Your cost for dependent life insurance coverage is $1.25 per month, no matter how many dependents you have.

Payment of insurance

Upon the death of an insured dependent, you receive the full benefit in one lump sum.

These special payment rules apply if you are not alive when dependent life insurance becomes payable:

- if your spouse dies — payment goes to your spouse's executors or administrators
- if a child dies — payment goes to the first surviving class of the following beneficiaries (1) surviving parent (2) surviving brothers and sisters (3) executors or administrators. (Should a beneficiary be a minor with no legal guardian, the benefit may be paid at a rate not exceeding $50 a month to the adult who the insurance company determines has assumed custody and principal support.)

How to file a claim

Notify the Company immediately of the death of a covered dependent. The Personnel or Employee Relations Office will assist you in filing the appropriate claim form with the insurance company.

The procedure for appealing claims, explained on page 5, also applies to any dependent life insurance claim.

When coverage ends

Your dependent life insurance terminates on the earliest of the following dates:

- the date the group policy terminates
- the date you are no longer eligible
- the last day of active service with the Company or the end of the period for which the last payroll deduction was made, whichever is later
- the day your dependent is no longer eligible
- when you retire
- the end of the third month following the month you become totally disabled.

Coverage will continue during temporary layoffs or leaves of absence, up to the end of the third month following the month that you left active service — provided that you pay the premium for coverage. In no event will coverage extend beyond the third month after your lay-off or leave of absence began.

Conversion privilege

You can convert your dependent's life insurance to a permanent individual policy, without a medical examination, if you apply within 31 days after the date your dependent's life insurance terminates because you or your dependent are no longer eligible, or you stop contributing to the plan. Special conditions apply to conversion if the policy is terminated. See your local Personnel or Employee Relations Office for conversion information.

The rates for an individual life insurance policy are based on your dependent's age at the time you convert the insurance, and the amount of insurance you convert.

If your dependent dies within the 31-day conversion period, you will receive the amount payable under the group policy (even if you had requested conversion to an individual policy). Any premiums you may have paid under the individual policy will be returned to you.

The insurance company may refuse to issue a converted policy if doing so would result in overinsurance or duplication of coverage.

Plan administration

Plan Administrator

A plan administrator is responsible for providing participants with information about their benefits, processing payments, implementing plan changes and handling any other functions necessary for the plan's operation. The plan administrator of the group life insurance plan for salaried employees is:

North American Philips Corporation
100 East 42nd Street
New York, N.Y. 10017
(212) 697-3600

Your Personnel or Employee Relations Office handles plan administration on the local level; they should be your first source for answers to any questions you have about the plan.

Insurance Company

Your benefits are insured by Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N.Y. 10010.

Agent For Legal Process

For all legal procedures, the designated agent for service of process is:

CT Corporation System
1633 Broadway
New York, N.Y. 10019

Legal process may also be served on the plan administrator.

Plan Year

Records for the plan are kept on a calendar year basis ending each December 31.

Employer And Plan Number

The Employer Identification Number (EIN) is 13-1895219 and the plan number is 501.

Effective Date

This guidebook section summarizes life insurance benefits in effect as of January 1, 1989.

Your rights under law

As a participant in the group life insurance plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other locations (including worksites), all plan documents including copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. (The administrator may make a reasonable charge for the copies.)
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or 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 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.

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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

The benefits description in this guidebook section does not constitute an express or implied contract of employment.

TRAVEL ACCIDENT INSURANCE

TRAVEL ACCIDENT

Your Business Travel Accident Insurance

Section	Page
WHY BUSINESS TRAVEL ACCIDENT INSURANCE?	1
ELIGIBILITY	1
NO ENROLLMENT	1
WHEN YOU ARE COVERED	1
YOUR BENEFITS	
Benefit Amount	2
When Benefits Are Paid	2
Who Receives Benefits	3
Medical Benefits	3
WHAT'S NOT COVERED	3
Benefit Limit	3
Definition of Losses	4
When Coverage Ends	4
HOW TO FILE A CLAIM	4
Procedure for Appealing Claims	4
PLAN ADMINISTRATION	5
Insurance Company	5
Agent for Legal Process	5
Plan Year	5
Employer and Plan Number	5
Effective Date	5
YOUR RIGHTS UNDER LAW	5

Why business travel accident insurance?

Any time you travel, you're subject to certain risks. When you travel on Company business, the Company insures you for those risks through the Business Travel Accident Insurance Plan. The Company pays the entire cost for this valuable protection.

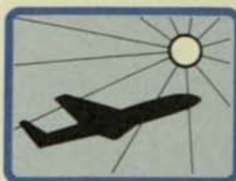
Eligibility

You're eligible for business travel accident coverage if you are an active, full-time employee. ("Full-time" means you are regularly scheduled to work at least 30 hours a week.)

Your spouse and dependent children are eligible when they accompany you on a business trip or relocation travel. (Salespeople are also eligible.) You're ineligible if you are a part-time or temporary employee.

No enrollment

You don't enroll for this plan; your coverage automatically goes into effect on your first regular day of employment.



When you are covered

You are covered while you are on any authorized business trip for the Company, anywhere in the world. Your protection starts when you leave on the business trip from either your home or office, whichever you leave last. It ends when you return to your home or office, whichever you return to first.

Except as specifically excluded on page 3, travel accident coverage is provided on an all-risk basis for accidental death or injury.

You are covered on any civilian aircraft which has a current and valid airworthiness certificate and is piloted by a properly certified pilot who is authorized to pilot the

When you are covered (continued)

aircraft. (This includes any transport-type aircraft operated by the Military Airlift Command of the U.S. or similar authority.)

In addition, you are covered if you are injured:

- while leaving your place of work because of a bomb scare or bomb explosion
- in an assault during business hours by someone other than another employee or a member of your family
- as a result of a highjacking or skyjacking while you are on Company business (whether or not it is an act of war)

Your benefits

Benefit Amount

Your benefit under this plan is six times your basic annual earnings, with a minimum of $100,000 and a maximum of $2,000,000. Earnings refer to your annual base salary at the time of your death.

If you're a salesperson who earns commissions in addition to your salary, earnings mean your base salary in effect on January 1 of the current year, plus your average annual commissions for the two prior calendar years. If you've only completed one prior year of service, earnings include your base salary plus annual commissions for that year. If you have less than one prior year of service, earnings include your base salary and your annualized average monthly commissions for your period of employment. For the calendar year in which you're hired, earnings include only your base salary.

Your spouse's benefit is $50,000; a $25,000 benefit applies to each dependent child.

When Benefits Are Paid

The full benefit is payable in the event of your or your dependent's accidental death within one year of the date of the accident, or the loss of any *two* of the following:

- hands
- feet
- eyes
- speech
- hearing

One-half the benefit is payable if you or a dependent loses *one* of the above. One-quarter of the benefit is payable for the loss of a thumb and index finger of the same hand. Only one benefit, the largest, will be paid for any one accident.

Your benefits (continued)

You must be eligible under the plan when the accident occurs, and the accident must directly cause your loss independent of any other causes.

Who Receives Benefits

In the event of your accidental death, payment will be made to the beneficiary you have designated under the Company's group life insurance plan, unless you have specifically designated a different beneficiary in writing for the business travel accident plan. If neither of these applies, the accidental death benefit will be paid to your estate. Payment for any other loss covered under the plan will be made directly to you.

Medical Benefits

If you are injured while on a business trip, you are covered for up to $5,000, *in excess of the amount paid or payable by Worker's Compensation,* for reasonable medical charges that you incur in connection with the accident.

What's not covered

The plan doesn't cover losses which result from the following:

- commuting — regular travel between home and work. However, you will be covered if you are directly affected by a transit strike or major breakdown of a public transportation system.
- travel during vacation time or leave of absence
- flying in any aircraft that is not used solely for the transportation of passengers.* (Corporate pilots are covered while flying on Company business.)
- suicide or self-inflicted injuries
- war or act of war within the U.S. or Canada
- service in the military, naval or air service of any country
- travel by truck drivers and their helpers while performing their normal duties

Benefit Limit

For any single aircraft accident which involves more than one insured person, the plan will pay up to a total of $17,500,000. If the total benefits payable exceed that amount, you will share the benefits in proportional amounts.

*Except for employees authorized to test equipment aboard an aircraft.

What's not covered (continued)

Definition of Losses
Benefits will only be paid for the various accidental losses listed on page 2 if the losses meet the following definitions:

- loss of hand or foot means actual severance at or above the wrist or ankle joint
- loss of sight, speech or hearing must be entire and irrecoverable
- loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints

When Coverage Ends
Your coverage ends on the date your full-time employment with the Company ends.

How to file a claim

Your Personnel or Employee Relations Office will assist you or your beneficiary in filing the appropriate claim form with the insurance company. To expedite processing of your claim, follow the instructions on the claim form carefully. Be sure to fully answer all questions.

Procedure for Appealing Claims
If your or your beneficiary's claim is denied, in whole or in part, the insurance company will provide you with a written notice within 90 days from the date they receive the claim (or 180 days if they notify you that there will be a delay). The notice will explain the reason(s) for the denial, point out the part of the plan on which the denial is based, and outline the steps you must take to appeal the denial. If you've made an error in your claim, the notice will list ways you can correct it.

You are entitled to appeal a claim that is denied within 60 days of when you received the denial notice. Be sure to state why you believe the claim should not have been denied, and submit any additional information you feel may be relevant. You may review any plan documents that relate to your claim.

You will receive a written decision on your appeal from the insurance company within 60 days of the time the insurance company receives your request. Under special circumstances (e.g., to hold a hearing), it may take longer than 60 days to reach a decision. In that case, you will receive written notification of the delay within 60 days.

Plan administration

The plan administrator of the Business Travel Accident Insurance Plan is:

North American Philips Corporation
100 East 42nd Street
New York, N.Y. 10017
(212) 697-3600

Your local Personnel or Employee Relations Office handles plan administration on the local level; they should be your first source for answers to any questions you have about the plan.

Insurance Company

Your business travel accident benefits are fully insured by American Home Assurance Company, 102 Maiden Lane, New York, N.Y.

Agent for Legal Process

For disputes arising under the plan, the designated agent for service of legal process is CT Corporation System, 1633 Broadway, New York, N.Y. 10019.

Legal process may also be served on the plan administrator.

Plan Year

The plan runs on a fiscal year: from June 30 through June 29 of the next year. All employee records which relate to the plan are maintained on a plan-year basis.

Employer and Plan Number

The Employer Identification Number (EIN) is 13-1895219 and the Plan Number is 541.

Effective Date

This guidebook section is a summary of Business Travel Accident Insurance Plan benefits in effect as of January 1, 1987.

Your rights under law

As a participant in the Business Travel Accident Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other locations (including worksites), all plan documents including copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

Your rights under law (continued)

- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. (The administrator may make a reasonable charge for the copies.)
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or 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 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.

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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

The benefits description in this section does not constitute an express or implied contract of employment.