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**THE VANGUARD GROUP, INC.  
BENEFIT PLAN**

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**2007**

# The Vanguard Group, Inc. Benefit Plan

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# Introduction

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This Plan Document and Summary Plan Description (SPD) for the Vanguard Group Benefit Plan (the “Plan”) contains important information regarding the medical, dental, vision, prescription drug, life insurance, legal services, purchased vacation, reimbursement accounts, academic assistance, adoption assistance and crew assistance plan benefits provided by The Vanguard Group, Inc. to eligible crew members under the Plan. For convenience and clarity, this Plan Document and Summary Plan Description shall hereafter be referred to as the “SPD”.

This SPD reflects the Plan as amended and restated effective January 1, 2007. This SPD describes the basic features of these benefits and how they operate. As used in this document, “crew member” means any individual who performs services for Vanguard and is treated by Vanguard as an employee for purposes of income and employment tax purposes.

The document is separated into two sections - benefits for which Vanguard pays the full cost and benefits for which you contribute through the FlexCare program. In cases where a particular benefit has an automatic and optional component, such as life insurance/AD&D and long-term disability, the benefit is described under Section II.

## *Section I – Automatic Benefit*

Short-Term Disability  
Business Travel Accident

## *Section II – FlexCare Benefits*

Health Benefits  
    Medical  
    Prescription Drug  
    Dental  
    Vision  
Life Insurance and AD&D  
    Crew Member Life Insurance  
    Spousal Life Insurance  
    Dependent Life Insurance  
Reimbursement Accounts  
    Health Care Reimbursement Account  
    Dependent Care Reimbursement Account  
Long-Term Disability  
Legal Services  
Purchased Paid Time Off

## *Section III – Optional Benefits*

Academic Assistance  
Adoption Assistance  
Crew Assistance

## *Section IV – Benefits for Retirees*

*Section V – When You Have a Claim for Benefits*

*Section VI – Administrative Information*

**Please Note...**

Neither this SPD, nor any of the benefit programs described herein, is to be considered an employment contract or a limit on Vanguard's right to terminate the employment of any crew member.

It is the intention of Vanguard that certain benefits payable under the Plan shall be eligible for exclusion from the gross income of participating crew members under the applicable sections of the Internal Revenue Code of 1986, as amended (the "Code"), including but not limited to sections 79, 105, 106 and 125. Moreover, the Plan is intended to qualify as a cafeteria plan under section 125 of the Code and this instrument is intended to satisfy the writing requirements of Department of Treasury Regulation section 1.125-1(Q&A-3), with respect to crew members who are determined to be eligible to participate in such cafeteria plan. Benefits which are subject to ERISA but which are not Code section 125 benefits are incorporated herein for purposes of satisfying the written instrument requirements of section 402 of ERISA, and shall not be construed as part of the Code section 125 plan that is part of the Plan. Similarly, benefits which are section 125 benefits but which are not subject to ERISA are incorporated herein solely for purposes of satisfying the written instrument requirements of section 125 of the Code, and shall not be construed to be subject to ERISA. Any benefits incorporated herein that are not subject to Code section 125 or ERISA are included solely as an administrative convenience to Vanguard, and shall not be construed as part of the Code section 125 cafeteria plan that is part of this Plan, or as subject to ERISA, as the case may be.

This SPD, along with the benefit booklets for certain benefits (appearing in electronic form as attached links), describes the health and welfare benefit plans provided by Vanguard to eligible crew members and serves as the summary plan description required by The Employee Retirement Income Security Act of 1974, as amended ("ERISA") for certain of the plans. Every effort has been made to report correct information. To the extent there are any differences between this SPD and the benefit booklets or insurance contracts that govern the benefit programs, the terms of those benefit booklets or insurance contracts will prevail.

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

As used here and throughout this SPD, the word "spouse" means an individual who is your "spouse" as defined under Federal law. The rights of Domestic Partners under the Plan are addressed in Section II.H.

This SPD is being provided electronically to crew members with ready access to Vanguard's *CrewNet*. You may request a paper copy of the SPD or any part thereof free of charge by calling Benefits (1-800-407-8576 or 34BEN).

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## Whom To Call . . .

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If you have questions about benefits or coverage under any of the programs described in this SPD, please call the following phone numbers.

<b>Benefit Program</b>	<b>Whom To Call</b>
Short-Term Disability	VPA, Inc. 1-800-495-2310
Long-Term Disability	Met-Life 1-800-300-4296
Business Travel Accident	AIG Life Insurance Company 34BEN
Prescription Drug	Caremark 1-866-559-6903
Medical	Aetna Health Plans 1-800-938-0512
Dental	Aetna Health Plans 1-800-938-0512
Vision	Davis Vision 1-888-393-2583
Life Insurance and AD&D	1-800-938-0512
Reimbursement Accounts	Aetna Health Plans 1-800-938-0512
Legal Services	Hyatt Legal Plans 1-800-821-6400
Purchased Paid Time Off	(34BEN)
Academic Assistance	(34BEN)
Adoption Assistance	(34BEN)
Crew Assistance	(34BEN)
Retiree Medical	(34BEN)

## Section I – Automatic Benefits

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### A. Short-Term Disability

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Vanguard provides Short-Term Disability (STD) income benefits administered by VPA Insurance Company (VPA). See Section II.E for an explanation of Long Term Disability (LTD) benefits.

#### ***Short-Term Disability***

Short-Term Disability benefits are provided for crew members who are totally disabled as set forth in the Vanguard Short-Term Disability Policy available on *CrewNet*. You are totally disabled if you are unable to work due to an illness or injury.

#### ***Eligibility***

If you are an active full-time crew member (scheduled to work at least 37.5 hours per week) or an active part-time crew member (scheduled to work at least 25 hours per week) immediately before becoming totally disabled, you are eligible to receive STD benefits. Crew members classified as interns and seasonal crew members are not eligible for STD benefits. Your eligibility for STD benefits begins on your first day of employment in an eligible class.

#### ***Cost***

Vanguard pays the full cost of your STD benefits.

#### ***Termination of STD Benefits***

STD benefits will end on the earliest of the following:

- the date on which the crew member is not totally disabled;
- the date the crew member reaches the maximum benefit period payable under the STD program;
- the date on which the crew member fails to provide required proof of disability;
- the date on which the crew member fails to comply with any of the requirements under the program, including a refusal to allow an independent medical examination;
- the date that the crew member dies; or
- the date on which the crew member begins a leave of absence other than a disability absence.

#### ***Termination of STD Coverage***

A crew member's coverage terminates under this program at the earliest of the following:

- when the crew member's employment ends;
- when the crew member is no longer eligible; or
- when this program terminates.

#### ***For More Information***

Refer to the Vanguard Short Term Disability Leave Policy, which is set forth in Appendix A to this SPD and is incorporated herein by reference, for complete information regarding the STD benefit, including the following topics:

- ◆ Leave entitlements
- ◆ Light and limited duty

- ◆ How to request a leave
- ◆ Return to work requirements
- ◆ Claim Evaluation Process
- ◆ Exclusions
- ◆ How STD Benefits are paid
- ◆ What is the impact of short-term disability leave on Partnership, bonuses, merit increases and other Vanguard benefit programs
- ◆ Coordination of short-term disability leave with Family Medical Leave
- ◆ Employment continuation rights and limits on those rights

The Vanguard Short-Term Disability Leave Policy is available on *CrewNet*. Vanguard Benefits (34BEN or 800-407-8576) is also available to answer any questions about your STD coverage.

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## B. Business Travel Accident

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### ***Eligibility***

If you are an active full-time crew member (scheduled to work at least 37.5 hours per week) or an active part-time crew member (scheduled to work at least 25 hours per week) at the time a business travel accident occurs, you are eligible for Business Travel Accident coverage. Crew members classified as interns and seasonal crew members are not eligible for Business Travel Accident benefits. Your eligibility for Business Travel Accident benefits begins on your first day of employment in an eligible class.

### ***Cost***

Vanguard pays the full cost of your Business Travel Accident benefits.

### ***Benefit Amount***

This Business Travel Accident benefit program pays a benefit if you die or become dismembered as a result of an accident while traveling on company business. You are eligible for a benefit up to five (5) times your basic annual salary.

Regardless of your pay, you will not get less than \$100,000 of benefit or more than the maximum benefit amount of \$500,000.

Benefits will be paid to you (or your beneficiary if you die) if you suffer any of the losses described below:

<b>For Loss of...*</b>	<b>Benefit is...</b>
Life	5 times your direct pay
Two hands, two feet, the sight of both eyes, speech, or hearing, or any combination thereof	5 times your direct pay
One hand, one foot, or sight of one eye, speech, or hearing	2.5 times your direct pay
Thumb and index finger on same hand	1.25 times your direct pay

\* Loss of hand or foot means the severance of such at or above the wrist or ankle joint. Loss of sight means total loss that cannot be recovered.

Your "direct pay" includes your annual base salary as of September 30 of the year of the most recent open enrollment period (or your date of hire, if later) plus that year's Partnership Plan distribution plus your bonus from the prior year (if applicable). For example, if you experience a business travel accident in 2007, your direct pay would be your annual base salary as of September 30, 2006 plus your 2006 Partnership Plan distributions plus your 2005-year bonus.

### ***Exclusions***

This benefit program does not cover loss caused by or resulting from any one or more of the following:

- ◆ Intentionally self-inflicted injuries - suicide or any attempt - while sane or insane.
- ◆ Declared or undeclared war or any act thereof.

- ◆ While you are serving on full-time duty in the armed forces of any country or international authority.
- ◆ Illness, disease, pregnancy, childbirth, miscarriage, or any bacterial infection other than bacterial infection occurring as a consequence of an accidental cut or wound.
- ◆ Riding as a pilot or crew member in any vehicle or device for aerial navigation.
- ◆ Riding in any aircraft owned, operated or leased by or on behalf of Vanguard.
- ◆ While under the influence of drugs or intoxicants, unless taken under advice of physician.
- ◆ Your commission of or attempt to commit a felony.

### ***Termination of Coverage***

A crew member's coverage will terminate on the earliest of:

- the date Vanguard's policy with the insurer is terminated,
- the premium due date if Vanguard fails to pay the required premium to the insurer other than on account of an inadvertent error,
- the date the crew member is no longer eligible for the benefit; or
- the date the crew member terminates employment.

### ***For More Information***

Contact Benefits at 1-800-407-8576 or 34BEN, internally for answers to any questions about your Business Travel Accident coverage.

## Section II – FlexCare Benefits

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### A. Introduction

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The Plan allows you to create a personal benefits portfolio from a menu of FlexCare benefits that fits the needs of you and your family. You can choose benefit coverage from the following benefit programs:

#### *Health*

- ♦ Medical
- ♦ Prescription Drug
- ♦ Dental
- ♦ Vision

#### *Life Insurance and Accidental Death & Dismemberment (AD&D)*

- ♦ Crew Member Life and AD&D
- ♦ Spousal Life
- ♦ Dependent Life

#### *Reimbursement Accounts*

- ♦ Health Care Reimbursement Account
- ♦ Dependent Care Reimbursement Account

#### *Long Term Disability (LTD)*

#### *Legal Services*

#### *Purchased Paid Time Off*

### ***Eligibility and Enrollment***

If you are an active, regular full-time crew member (scheduled to work at least 37.5 hours per week) or a regular part-time crew member (scheduled to work at least 25 hours per week), you are eligible to elect FlexCare Benefits as of your first day of employment. Crew members classified as interns and seasonal crew members are not eligible for FlexCare benefits.

You may elect your FlexCare benefits using the on-line system through Crew Self Service or any other procedure approved by the Plan Administrator. If you fail to enroll for medical benefits at new hire orientation, default elections will be made on your behalf and you will automatically receive:

- ♦ Single health coverage (Standard Medical Option).
- ♦ Life and Accidental Death and Dismemberment coverage each equal to \$10,000 plus 2 times your Direct Pay.
- ♦ LTD coverage with premium deductions to be made on a pre-tax basis.

***Please Note:*** You, your spouse, or your eligible dependents will not be entitled to payment of any FlexCare benefits unless you have made a valid election (which includes the default elections noted above) and have made any required contribution, except as may otherwise be permitted by the Plan Administrator.

Your online enrollment form will list your biweekly contribution for each benefit option and coverage level. The online enrollment form will indicate if your biweekly contribution will be deducted from your paycheck on a pre-tax or after-tax basis.

***Flex Credits:*** You receive flex credits, which you use towards the cost of the Basic Life and Long-Term Disability (LTD) coverage. If you waive medical coverage and certify that you have alternative coverage available elsewhere, you will receive \$39 per pay as taxable compensation.

You'll receive a confirmation statement of your elections. Use this statement to confirm your elections and also as a check against your e-paystub. It is extremely important that you make sure your elections are accurate. If you find any errors, contact the Plan Administrator immediately. If you fail to report any errors within 7 business days, you will be unable to make any changes to your Flex Care benefit choices until the next open enrollment period or under special circumstances as described below "Enrollment Changes".

**Important note for crew members who are married to another crew member:**

There is a special rule that applies in the situation where two crew members are married to each other. In this case, either crew member may choose medical coverage under the Plan by electing family coverage (the "electing crew member"). The non-electing crew member must elect to waive medical coverage and receive a medical waiver payment as described above. Also, the electing crew member will make all elections under the Plan for the family unit, except for purchased paid time off, long-term disability, health care spending account and individual life insurance election which can be made separately by the non-electing crew member. Married crew members are not eligible to elect the Spousal Life option.

***Enrollment Changes***

You will have the opportunity to change your FlexCare benefit elections during the annual open enrollment period.

During the year, you cannot stop, start, increase, or decrease your level of your elected FlexCare benefits unless you have a "change in status." If you experience a change in status, you may be permitted to change your benefit election for the balance of the Plan Year after the change, provided the change in your election is on account of and consistent with a change in status that affects eligibility, and is permitted under the terms of the Plan.

According to the IRS, the following events are among those that may be treated as constituting a change in status:

- ◆ A change in your legal marital status;
- ◆ A change in the number of your dependents;
- ◆ Termination or commencement of employment, by you, your spouse, or your dependent;
- ◆ A change in work hours or employment status for you, your spouse or your dependent (such as commencement of or return from unpaid leave) that results in a change in eligibility for you, your spouse or your dependent for benefits under this Plan or another plan;
- ◆ Your dependent satisfies or ceases to satisfy the eligibility requirement for a particular benefit;
- ◆ A change in place of residence or work for you, your spouse or your dependent that affects benefits coverage;
- ◆ You, your spouse or your dependent become entitled to a special enrollment right under a group health plan;
- ◆ A change in coverage attributable to your spouse's or your dependent's employment;
- ◆ A significant increase in the cost or coverage of a Vanguard plan;
- ◆ You, your spouse or dependent becomes enrolled under Medicare; or
- ◆ A qualified judgment, decree or order requires health coverage for a dependent child.

(Please refer to Section II.H for eligible Domestic Partner status changes.)

IRS rules also provide that any change to the benefit elections must be on account of and consistent with the underlying change in status. For example, if you are married and covering your spouse under the Plan and your spouse obtained a new job with his/her own coverage; it would be a consistent benefit election change to drop coverage under the Plan and be covered under your spouse's plan. In that event, you will be asked to certify that you will be added to your spouse's plan.

***If you want to change your benefit election during the year because of a status change, you must submit the necessary changes via eBenefits - the online benefits enrollment system - within 30 days of the change.*** You must also provide acceptable proof of your change in status. If you do not submit the forms within 30 days of the event, you will have to wait until the next annual open enrollment period to make benefit election changes.

The Plan Administrator will determine whether a requested change is on account of and consistent with a change in status and thus permitted under the terms of the Plan. The ability to make a status change may vary by benefit. For example, special limitations apply with respect to Purchased Paid Time Off and benefits under the Legal Plan, as described in Sections IIE and IIF. The effective date for any change made due to a change in status will be prospective only, unless otherwise permitted by the Plan and applicable law.

NOTE: Generally, any contribution change related to your new status election will be deducted from your next scheduled pay. Any status changes elected after December 15 in a particular calendar year may not be funded in that same year depending upon Vanguard's payroll processing schedule. You should consider this if you are participating in a Reimbursement Account.

If you have a question concerning the status change rules, please contact Benefits at 1-800-407-8576 or 34BEN.

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## B. Health Benefits

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### *Eligibility*

The Plan offers comprehensive health benefits including prescription drug, medical, dental and vision benefits (collectively referred to as the health plan). If you meet the eligibility requirements set forth in Section IIA, you are eligible to elect these benefits as of your first day of employment.

### *Your Dependents*

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

- ✓ Your legally married spouse. As used here and throughout this SPD, the word “spouse” means an individual who is your “spouse” as defined under Federal law.
- ✓ Any unmarried child(ren) under age 19 (or up to age 25 if a full-time student\*) who rely on you for support and maintenance, including:
  - Natural children, legally adopted children (including a child who you are legally obligated to support in anticipation of adopting such child, even if the adoption is not yet final), and stepchildren. (*Application must be made within 30 days of birth or adoption to add a child as a dependent.*)
  - Any child for whom you are required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree, or order (including a settlement agreement or administrative notice), issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process under state law that has the force and effect of law in that state, which creates or recognizes the existence of the right of a child to, or assigns to such child the right to, receive benefits for which a participant is eligible under the plan, and which the Plan Administrator determines meets the requirements of ERISA. The effective date of coverage for the child shall be the date specified in the QMCSO, or if none, the date of the QMCSO. (You can request a copy of Vanguard’s QMCSO Procedures from the Plan Administrator without charge.)
  - Unmarried child(ren) age 19 and older who remain continuously mentally or physically disabled, primarily dependent upon you for support, and who were covered prior to age 19. A full-time student between the ages of 19 and 25, who became permanently disabled while covered under the plan, would remain a covered dependent. A dependent child who meets the above eligibility requirements will continue to be eligible until the day he or she reaches the limiting age, unless he or she is disabled as described above. Application for continued coverage for a disabled child must be made within 31 days of the child’s 19<sup>th</sup> birthday. Proof may be required to support the continuation of the disability. Coverage will stop at the earlier of: the end of the child’s disability, failure to give proof that the disability continues, failure to have any required examination, or the end of the child’s status as your dependent.

Dependent children will **not** be eligible if they are:

- ❖ In the armed forces of any country.
- ❖ Covered as a crew member under the Vanguard health plan.
- ❖ Are employed on a full-time basis.

\*You will be required to submit proof of full-time student status for eligible dependents ages 19 to 25 annually prior to the student’s birthday (Please refer to Section II.H for Domestic Partner eligibility)

**Cost of Coverage**

Your contributions toward the cost of health care coverage (medical, prescription drug, dental, and vision) will be deducted from your pay on a pre-tax basis. The amount of these contributions will be provided in the annual FlexCare enrollment materials and is subject to change. In addition to your share of premiums, you may also be required to pay a co-pay or co-insurance at the time services are provided. The amount of the co-pays or co-insurance for each benefit will be provided in the annual FlexCare enrollment materials and is subject to change.

**Coverage Category Options**

You may elect one of the following coverage categories:

Crew Member Only	Option 1
Crew Member plus Spouse	Option 2
Crew Member plus Child	Option 3
Crew Member plus Family	Option 4
Waive Medical Coverage	Option 9

If you waive medical coverage, you must verify that you have, and will maintain throughout the Plan Year, medical coverage for you and your dependents in the eBenefits online enrollment worksheet. If you are on a leave of absence and unable to make your FlexCare elections using the eBenefits online enrollment worksheet, complete and submit a copy of the Medical Waiver Form with your Status Change paperwork.

(Please see Section II.H for Domestic Partner levels of coverage.)

**Provider Networks**

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

Standard Medical Option, Enhanced Medical Option, Aetna HealthFund, Aetna HMO and Dental	<a href="http://custom.aetna.com/VANGUARD/">http://custom.aetna.com/VANGUARD/</a>
Vision	<a href="http://www.ibx.com/vanguard">www.ibx.com/vanguard</a>
Prescription Drug	<a href="http://www.caremark.com">www.caremark.com</a>

If you’d like a hard copy of the directory, you can call Benefits at 1-800-407-8576 or 34BEN. While the provider directories are believed to be accurate as of the print date, they are subject to change without notice. Participating providers are independent contractors in private practice and are not employees or agents of the plans of their affiliates.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directories may be accepting new patients. Although the third-party administrators may have identified providers who were not accepting patients as known at the time the directory was created, the

status of a provider's practice may have changed. For the most current information, you should call the plan's number on the back of your I.D. card for that plan.

### ***Special Enrollment Rights***

You may enroll yourself and your dependents in the Plan during the first 30 days after you become eligible, or during the annual open enrollment period. If you do not enroll during either of these enrollment periods, and if you have declined enrollment for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(Please refer to Section II.H for special enrollment rights regarding Domestic Partners)

### ***Coverage Certifications***

When you or your dependents' coverage ends, the third-party administrator will give you and/or your dependent(s) a "coverage certification," a written record of the health coverage you received under the Plan and under COBRA, if applicable. You and/or your dependent(s) will receive a coverage certification when your coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new medical plan. For example, if you obtain new employment and your new employer's plan has a preexisting condition limitation, the employer may be required to reduce the duration of the limit by one day for each day of your prior coverage (subject to certain requirements). If you are purchasing individual coverage you may need to present the coverage certification to your insurer at that time as well.

### ***Termination of Coverage***

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

- ▶ your employment terminates;
- ▶ the Plan or the offered benefit terminates;
- ▶ you are no longer in an eligible class; or
- ▶ you fail to make any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.7

## 1. Medical Benefits

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### *Eligibility*

Vanguard offers medical benefits to all crew members and their dependents who meet the eligibility requirements in Section II.A or Section II.H.

### *Medical Coverage Options*

Crew members may choose from the following medical benefit options:

- ❖ Standard Medical Option
- ❖ Enhanced Medical Option
- ❖ Aetna Health Fund
- ❖ Aetna HMO

### *Managed Care – non-HMO, Enhanced Medical Option (POS II), Standard Medical Option (POS II), and Aetna Health Fund (POS II)*

The Standard Medical Option, the Enhanced Medical Option, and the Aetna Health Fund are self-insured plans that are administered by Aetna. This means that Vanguard's costs for these benefits include the amount of actual claims paid plus administrative and network access fees. Appendix B is the Aetna booklet for the Standard Medical Option, Appendix C is the Aetna booklet for the Enhanced Medical Option and Appendix D is the Aetna booklet for the Aetna Health Fund. Those booklets, which are incorporated herein by reference, constitute the plan provisions, including all benefits, limitations and exclusions, for these Aetna benefit options. Aetna uses these plan booklets to make determinations on claims for benefits under the self-insured plans. **In the event of any discrepancy between this SPD and the plan booklets, the provisions of the plan booklets will control.**

### *HMO Coverage*

The Aetna HMO is a fully insured plan. Appendix E is the Aetna booklet for the Aetna HMO, and that booklet, which is incorporated herein by reference, constitutes the plan provisions, including all benefits, limitations and exclusions, for the Aetna HMO. The booklet includes information concerning (i) the nature of services provided to members; (ii) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which services may be denied; (iii) the procedures to be followed in obtaining such services; and (iv) the procedures available for the review of claims for services which are denied in whole or in part.

### *Termination of Coverage*

When your eligibility for coverage terminates, all medical benefits will end. Termination of your coverage (and that of a spouse, domestic partner or dependent) under a medical plan occurs at the earliest of the following events:

- ❖ your employment terminates;
- ❖ the Plan or the offered benefit terminates;
- ❖ you are no longer in an eligible class; or
- ❖ you fail to make any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.7

## 2. Prescription Drug Benefits

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### ***Eligibility***

Vanguard offers two prescription drug benefit options to crew members and their dependents who meet the eligibility requirements in Section II.A or Section II.H.

### ***Prescription Coverage Under Caremark***

The Plan provides prescription drug benefits through Caremark – the Standard Prescription Plan and the Enhanced Prescription Plan. These plans are available regardless of your choice of medical coverage. Prescription coverage is not automatic; you must elect it.

**With Caremark, you can purchase prescription drugs** through a nationwide network of participating pharmacies and/or a mail service program. Over 50,000 pharmacies - all major chains - and more than 20,000 independent pharmacies participate in the Caremark network.

Appendix F is the Caremark prescription plan summary of coverage. This summary of coverage, which is incorporated herein by reference, constitutes the plan provisions, including all benefits, limitations and exclusions, for the Plan's prescription drug benefits.

### ***Termination of Coverage***

Termination of your coverage (and that of a spouse, domestic partner or dependent) under the prescription drug plan occurs at the earliest of the following events:

- ♦ your employment terminates;
- ♦ the Plan or the offered benefit terminates; or
- ♦ you are no longer in an eligible class; or
- ♦ you fail to make any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.7

### ***For More Information***

You may call Caremark at 1-866-559-6903 or Benefit at 1-800-407-8576 or 34BEN if you have any questions about your prescription drug benefits, or to get a complete list of what is covered and what is not covered under the program.

### 3. Dental Benefits

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#### ***Eligibility***

Vanguard offers dental benefits to all crew members who meet the eligibility requirements in Section II.A or Section II.H, regardless of whether they elect or waive medical coverage. Dental coverage is not automatic; you must elect it.

#### ***Dental Coverage***

There are two dental benefit options provided through Aetna – Standard Dental and Enhanced Dental. The options differ in the dental services that are covered as well as the percentage of established Reasonable and Customary (R&C) charges that are paid (see the attached links for the definition of Reasonable and Customary).

Under both of these options, crew members and dependents may choose to receive services from either a Preferred Provider Organization (PPO) participating dentist or any non-participating dentist at the time of service. PPO participating dentists have agreed to provide care in accordance with a negotiated fee schedule and may not bill patients for amounts in excess of this fee schedule. However, PPO dentists may balance bill patients for services not approved by Aetna. Non-PPO dentists may balance bill patients for amounts over the Reasonable and Customary charge paid by Aetna. For a list of participating PPO providers, please access the Aetna web site at [www.aetna.com](http://www.aetna.com).

Appendix G is the summary of coverage booklet for Standard Dental, Appendix H is the summary of coverage booklet for Enhanced Dental, and Appendix I is the Standard and Enhanced Dental Policy Provisions booklet... Those booklets, which are incorporated herein by reference, constitute the plan provisions, including all benefits, limitations and exclusions, for the Dental benefit options. In the event of any discrepancy between this SPD and the summary of coverage booklets, the summary of coverage booklet controls.

#### ***Termination of Coverage***

Your coverage (and that of a spouse, domestic partner or dependent) terminates under this plan at the earliest of the following events:

- ♦ your employment terminates;
- ♦ the Plan or the offered benefit terminates;
- ♦ you are no longer in an eligible class; or
- ♦ you fail to make any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.7 of this SPD.

## 4. Vision Benefits

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### ***Eligibility***

Vanguard offers Enhanced Vision Option through Pennsylvania Blue Cross/Blue Shield to all crew members and their dependents who meet the eligibility requirements in Section IIA or Section II.H, regardless of whether they elect or waive medical coverage. However, if a crew member elects medical coverage under an HMO, he or she is automatically provided with the corresponding HMO vision assistance plan.

### ***Vision Coverage***

All services and supplies must be furnished or prescribed by a licensed ophthalmologist, optometrist, physician, or an optician.

Vision benefits under the Plan are fully insured. Appendix J is the Blue Cross/Blue Shield Vision booklet. This booklet, which is incorporated herein by reference, constitutes the plan provisions, including all benefits, limitations and exclusions, for the Plan's vision benefits.

### ***Termination of Coverage***

When your eligibility for coverage terminates, all benefits under the vision plan will end. A crew member's coverage (and that of a spouse, domestic partner or dependent) terminates under this program at the earliest of the following events:

- your employment terminates;
- the Plan or the offered benefit terminates;
- you are no longer in an eligible class; or
- you fail to make any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.7

## 5. Coordination of Benefits

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

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

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

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

### ***Which Plan Pays?***

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

□ ***Plans Without COB Provision***

If the other group plan does not include a provision to coordinate benefits, it will be the primary payor.

□ ***Plans Covering Employees***

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

□ ***Plans Covering Dependents***

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

□ ***Plans Covering Same Dependent***

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

□ ***Divorce or Legal Separation***

Unless otherwise required by a court order, the primary payor of benefits for a dependent child whose parents are divorced or legally separated is determined as follows:

- The plan covering the parent with custody of the child is primary.
- If the parent with custody of the child has remarried, the stepparent's plan is primary over the plan of the parent without custody.
- The birthday and gender rules apply where the parents have joint custody.

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

□ ***Responsibility Not Determined***

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

□ ***Continuation Coverage***

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

### ***Coordination with Medicare***

The Plan, or other group plan, will generally be primary over Medicare for those services that would otherwise have been provided by Medicare where:

- You are an active employee, age 65 or older, and are entitled to Medicare benefits.
- If required by law, a disabled individual (under age 65) is covered under the Plan by reason of his/her spouse's or parent's current employment and is entitled to Medicare benefits.
- A dependent, who is covered under the Plan, is also entitled to Medicare (other than because of disability) and has not waived his/her right to Plan benefits.
- You or your dependent is entitled to Medicare benefits solely on the basis of having end-stage renal disease. (The Plan pays as primary during the first 30 months of Medicare coverage).

### ***Plan's Rights***

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

## 6. Coverage During Certain Leaves

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### *Family and Medical Leave and Other Leaves of Absence*

If you go on an approved leave of absence, including a leave that qualifies under the Family and Medical Leave Act of 1993 (an “FMLA leave”), coverage for you and your dependents will continue in accordance with Vanguard’s leave policies, including its family and medical leave policy. Please refer to these policies on *CrewNet* or contact Benefits at 1-800-407-8576 or 34BEN.

**If you lose coverage during your leave because you fail to make your required contributions, you may re-enroll in the Plan when you return from the leave. Your coverage will start again on the first day after you return to work and make your required contributions.**

### *Uniformed Services Leave*

If you take uniformed services leave, whether for active duty or for training, your health care coverage will continue in accordance with Vanguard’s uniformed services leave policy. In accordance with the Uniformed Services Employment and Reemployment Rights Act (“USERRA”), as amended by the Veterans Benefits Improvement Act of 2004, coverage will continue for up to 24 months of uniformed services leave (18 months if the election of continuation coverage occurs before December 10, 2004) as long as you continue to pay your portion of the cost, provided that your total leave, when added to any prior periods of uniformed services leave from Vanguard, does not exceed five years (with certain exceptions). Upon expiration of any entitlement to continuation of coverage due to uniformed services leave, you may have a right to further continued coverage under COBRA. As permitted by federal law, however, any additional right you may have to continuation coverage under USERRA, as amended by the Veterans Benefits Improvement Act of 2004, shall run concurrently with and be satisfied by your continuation of coverage under COBRA. Please refer to Vanguard’s uniformed services leave policy on *CrewNet* for more details on continuing health coverage during uniformed services leave.

### *COBRA Continuation Coverage after your Leave Ends*

If you do not return to work at the end of your FMLA or Uniformed Services Leave, you may be entitled to purchase COBRA continuation coverage as described in this SPD.

## 7. Continuing Coverage under COBRA

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

For purposes of this section, the phrase “group health plan” includes health, prescription drug, dental, crew assistance, and vision coverage as well as coverage under a healthcare reimbursement account.

### *What is COBRA Continuation Coverage*

COBRA continuation coverage is a continuation of group health plan coverage, which would otherwise end because of a life event known as a “qualifying event”. Specific qualifying events are described below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

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

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

### *Who is Covered?*

If you are a crew member covered by a group health plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (except for gross misconduct).

If you are the legally married **spouse** of a crew member covered by a group health plan, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under the plan for any of the following four qualifying events:

- ♦ the death of your spouse;
- ♦ the termination of your spouse's employment (except for gross misconduct) or a reduction in your spouse's hours of employment with Vanguard;
- ♦ divorce or legal separation from your spouse; or
- ♦ your spouse becoming entitled to Medicare.

A **dependent child** of a crew member covered by a group health plan is also a qualified beneficiary and has the right to continuation coverage if group health coverage under the plan is lost for any of the following five qualifying events:

- ♦ the death of the crew member;
- ♦ the termination of the crew member's employment (except for gross misconduct) or reduction in the crew member's hours of employment;
- ♦ the crew member's divorce or legal separation;
- ♦ the crew member becoming entitled to Medicare; or
- ♦ the dependent ceasing to be a "dependent child" under the group health plan.

(Please refer to Section II.H of the document for information on Domestic Partner COBRA eligibility.)

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

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

### ***Your Duties Under The Law***

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

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

### ***Vanguard's Duties Under The Law***

Vanguard has the responsibility to notify the COBRA Administrator of the employee's death, termination of employment (other than for gross misconduct) or reduction in hours, or Medicare entitlement. Notice must be given to the COBRA Administrator within 30 days of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will notify you that you have the right to elect continuation coverage.

### ***Electing COBRA Continuation Coverage***

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

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

### ***Duration of Coverage***

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

Reason For Termination Under Plan	Period
Voluntary termination of crew member	18 months
Involuntary termination of crew member (except for gross misconduct)	18 months
Reduction in work hours of crew member	18 months
Death of crew member	36 months
Divorce or legal separation	36 months
Crew member becomes entitled to Medicare	36 months
Dependent child no longer qualifies as a dependent under the group health plan	36 months

There are circumstances under which continuation coverage may be extended. When the qualifying event is the end of employment or reduction of the crew member's hours of employment, and the crew member became entitled to Medicare benefits less than 18 months before the qualifying event, continuation coverage for qualified beneficiaries other than the crew member lasts until 36 months after the date of Medicare entitlement. For example, if a crew member becomes entitled to Medicare 8 months before the date on which his or her employment terminates, continuation coverage for the crew member's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

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

### ***Early Termination of Continued Coverage***

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

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

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

### ***Premium Payments***

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

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

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

Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the month to make your periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that month. However, if you pay a periodic payment later than the first day of the month, but before the end of the grace period for that month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

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

### ***For More Information***

Additional information about COBRA can be obtained by calling Ceridian/CobraServ at 1-888-588-6852 or by contacting Benefits at 1-800-407-8576 or 34BEN. If you have changed your marital status, if you or your spouse have changed addresses, or if a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you are responsible for promptly notifying Ceridian/CobraServ or the Benefit information Center.

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

### ***COBRA and the Family and Medical Leave Act (FMLA)***

An FMLA leave does not make you eligible for COBRA coverage. However, whether or not you continue health coverage during an FMLA leave, you may be eligible for COBRA as of the earliest of the following events:

- ❖ when you inform Vanguard that you are not returning at the end of the leave;
- ❖ the end of the leave, assuming you do not return; and
- ❖ when the FMLA entitlement ends.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- ❖ you or your dependent is covered by the plan on the day before the leave commences (or becomes covered during the FMLA leave); and
- ❖ you do not return to employment at the end of the FMLA leave; and
- ❖ you or your dependent loses coverage under the plan before the end of what would be the maximum COBRA continuation period.

## 8. Other Continuation of Coverage

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Health benefits may be continued for a period of time, other than under COBRA, under the following circumstances:

<b>Reason for Continuation Coverage</b>	<b>Eligible for Coverage</b>	<b>Maximum Coverage Period</b>
Long-Term Disability	Crew member and covered dependents	12 months from crewmember's Long-Term Disability effective date
Death of a Crew Member	Covered dependents	12 months from the date of crew member's death

Contributions for coverage that were being made by the crew member prior to the occurrence of an event noted above will continue to be required to be made by the crew member or covered dependents, as applicable.

### ***Conversion Option***

Certain of the group health plan options may provide you and your family members with the opportunity to enroll under a conversion health plan during the 180-day period preceding the date that continuation coverage expires. Also, if you cease to be eligible for benefits under the group health plan because of layoff, disability, leave of absence, or termination of employment, you may be eligible for arrangements for health care (medical, dental, and vision) coverage under an individual contract available from the group health plan. Conversion coverage may be available for your surviving spouse and child(ren) when appropriate. Children who reach the maximum age limit specified in this SPD also may have the privilege of converting to an individual contract. Call Benefits at 1-800-407-8576 or 34BEN for more details on available conversion options.

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## C. Life Insurance and Accidental Death & Dismemberment Insurance

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Vanguard provides eligible crew members with Automatic Life Insurance and Automatic Accidental Death and Dismemberment (AD&D) Insurance. This automatic coverage is paid for entirely by Vanguard. You may also purchase additional Life and AD&D Insurance under the Plan.

### ***Eligibility***

Vanguard offers life insurance and AD&D insurance to all crew members who meet the eligibility requirements in Section II.A.

### ***Benefit Amount***

Vanguard provides you with life insurance coverage equal to \$10,000 plus two times your direct pay as well as an equal amount of AD&D coverage for "free" - this means that your flex credits will equal the price of this coverage. You can purchase supplemental life insurance to increase this coverage to three, four, or five times your direct pay. Your AD&D coverage amount will mirror your life insurance coverage amount, but you will not pay for any additional AD&D coverage.

You also have the option to elect a flat \$50,000 coverage option instead of a multiple of your direct pay. If you elect this option, you will not be subject to imputed income taxes (see below). If your credits exceed the cost of the \$50,000 coverage, you can use them to purchase other benefits. If the price of the \$50,000 option exceeds your flex credits, you will pay the difference with pre-tax dollars.

<b>Basic Life Options</b>	<b>Coverage</b>	<b>Credits/Costs</b>
Option 1 Option 2	\$50,000 2 times your pay plus \$10,000	Credits equal 2 times your pay plus \$10,000 for all options.
<b>Supplemental Life Options</b>	<b>Coverage</b>	<b>Cost</b>
Option 1 Option 2 Option 3	1 times your pay 2 times your pay 3 times your pay	Costs are based on coverage amount and age and are calculated on your online enrollment form. See below for supplemental life rates.

**Cost**

Your costs for the Basic and Supplemental life insurance options that you are eligible for are shown on your online enrollment form. The maximum life insurance coverage limit is the lesser of five times your direct pay or \$1,000,000. Costs for supplemental life insurance will be based on your age as of December 31 of the plan year for which you are enrolling. The table below shows the rate per \$1,000 of coverage for each age bracket for the 2007 Plan Year. Your online enrollment form will calculate the cost of supplemental life insurance for you. You pay the full cost of supplemental life insurance on a pre-tax basis.

<b>Age As of December 31, 2007</b>	<b>Cost for Supplemental Life Per \$1,000 of Coverage Per Pay</b>
Under 25	\$ .013
25 to 29	\$ .016
30 to 34	\$ .018
35 to 39	\$ .023
40 to 44	\$ .033
45 to 49	\$ .066
50 to 54	\$ .106
55 to 59	\$ .175
60 to 64	\$ .273
65 to 69	\$ .457
70 and older	\$ .951

**Imputed Income Information**

Under current tax regulations, if your group life insurance coverage exceeds \$50,000, the federal government taxes the value of the employer's cost of providing that excess coverage as "imputed income," with the amount of the "income" set by an IRS formula. The following table shows how much taxable income per \$1,000 of coverage above \$50,000 will be reflected on your year-end W-2 Tax and Earnings Form as imputed income.

**W-2 Life Insurance Imputed Income**

<b>Age As of 12/31/2007</b>	<b>Taxable Income Per \$1,000 Of Coverage Per Year (Over \$50,000)</b>
Under 25	\$ .60
25 to 29	\$ .72
30 to 34	\$ .96
35 to 39	\$ 1.08
40 to 44	\$ 1.20
45 to 49	\$ 1.80
50 to 54	\$ 2.76
55 to 59	\$ 5.16
60 to 64	\$ 7.92
65 to 69	\$15.24
70 and older	\$24.72

### ***Important Life Insurance Considerations...***

Your "direct pay" includes your annual base salary as of September 30 of the year during which open enrollment takes place (or your date of hire, if later) plus that year's Partnership Plan distribution plus your bonus from the prior year (if applicable). For example, for the 2007 plan year, your direct pay would be your annual base salary as of September 30, 2006 plus your 2006 Partnership Plan distributions plus your 2005 year bonus.

During open enrollment each year, you can increase your previous election by **one** times your salary, up to the limit of five times your direct pay or \$1,000,000, without restrictions. You may also reduce your previous election without restrictions at open enrollment.

You will be required by Aetna to complete an **Evidence of Insurability Form (EOI)** if you elect an amount of supplemental life insurance in excess of \$500,000. When you receive the form from the Benefits Unit, complete it and mail it to Aetna. Aetna will notify you directly if your new coverage amount has been approved or denied. The EOI form must be approved by Aetna before the elected amount is effective.

If you are married to another crew member each of you should elect your own life insurance coverage and waive spousal life coverage.

### ***Spousal Life Insurance***

Under the Plan, you can purchase life insurance for your spouse up to the following limits:

- ♦ Option 1 - \$10,000
- ♦ Option 2 - \$20,000
- ♦ Option 3 - \$40,000
- ♦ Option 4 - \$60,000
- ♦ Option 5 - \$80,000
- ♦ Option 6 - \$100,000
- ♦ Option 9 - Waive coverage

You will be required by Aetna to complete and Evidence of Insurability Form (EOI) if you elect an amount of spousal life insurance in excess of \$60,000. This EOI form must be approved by Aetna before the elected amount is effective.

If both you and your spouse are Vanguard crew members, neither crew member is able to purchase Spousal Life Insurance.

(Please refer to Section II.H of the document for Domestic Partner eligibility.)

### ***Cost***

You pay the full cost of your spousal life insurance on an after-tax basis.

### ***Beneficiary***

You are automatically the beneficiary for your spousal life insurance election.

### ***Dependent Child Life Insurance***

Under the Plan, you can purchase life insurance for your dependent child(ren) up to age 19 (age 25 if a full-time student), as follows:

<b>Option 1</b>	\$2,500 per child covered
<b>Option 2</b>	\$5,000 per child covered
<b>Option 3</b>	\$10,000 per child covered
<b>Option 9</b>	Waive coverage

If both you and your spouse are Vanguard crew members, only one of you may elect Dependent Child Life Insurance.

(Please refer to Section II.H of the document for eligibility pertaining to children of a Domestic Partner.)

### ***Cost***

You pay the full cost of your Dependent Child Life Insurance on an after-tax basis.

### ***Beneficiary***

You are automatically the beneficiary for your Dependent Child Life Insurance election.

### ***For More Information***

Appendix K is the Aetna summary of coverage booklet and Appendix L is the Aetna Life Insurance Policy Provisions. This summary of coverage booklet, which is incorporated herein by reference, constitutes the plan provisions, including all benefits, limitations and exclusions, for the Plan's life insurance and accidental death and dismemberment benefits. In the event of any discrepancy between this SPD and the summary of coverage booklets, the summary of coverage booklet controls. In addition, Benefits is available at 1-800-407-8576 or 34BEN from 8 a.m to 5 p.m. Monday – Friday..

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## D. Reimbursement Accounts

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### *Eligibility*

Crew members who meet the eligibility requirements in Section II.A may participate in these accounts.

### *Highlights of the Reimbursement Accounts*

There are two reimbursement accounts available under the Plan:

- ❖ the Health Care Reimbursement Account; and
- ❖ the Dependent Care Reimbursement Account

Participation in these accounts is optional. You may enroll in one or both reimbursement accounts. Participation will continue until the later of:

- 1) The last day of the calendar year for which you filed a valid enrollment election and made all required contributions.
- 2) In the event of a family status change during the year of the date you stopped making contributions to your reimbursement accounts.

These accounts offer you an opportunity to pay for your eligible out-of-pocket health care and dependent care expenses with money that is deducted from your paycheck before Federal and Social Security taxes, and in some cases state taxes, are taken out. This is referred to throughout this section as “pre-tax” money.

Here’s how the accounts work:

- ❖ You estimate your eligible expenses and decide how much money you want to put into each account via payroll deduction.
- ❖ Your automatic payroll deductions are credited to an account in your name.
- ❖ After you incur an eligible expense, you will be reimbursed through Aetna’s Streamline processing or you can submit a paper claim along with receipts to Aetna.
- ❖ You receive your reimbursement check via direct deposit.
- ❖ Unused funds are forfeited at the end of the calendar year.

You will receive statements from Aetna in November and January that lists the account transactions and account balance. You can check on the status of your account throughout the year by calling Aetna’s customer service department at 1-800-938-0512 or by viewing the Aetna Navigator website ([www.aetna.com](http://www.aetna.com)).

### *Enrolling in the Reimbursement Accounts*

You can enroll in one of the reimbursement accounts or both. If you don’t enroll when you are first eligible, you will have to wait until the next annual open enrollment period or may enroll based on a change in family status. See Introduction to Flex Care in this SPD under “Enrollment Changes” for examples of a change in family status.

NOTE: Generally, your eligibility in the reimbursement accounts must be renewed by a new election to participate during the annual open enrollment period. Unless you have a family status change during the year and stop making contributions to the Reimbursement Account, you will be considered a participant in your selected Reimbursement Accounts for the entire calendar year. If you stop contributing to your Reimbursement Account during the year, you are no longer considered a participant in those accounts as of such date. Eligible expenses incurred prior to the date you stopped contributions may still be covered as described below.

## **1. The Health Care Reimbursement Account**

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The Health Care Reimbursement Account lets you use pre-tax dollars to pay for certain health care expenses. This saves you money because you do not pay Federal or Social Security taxes, and in some cases state taxes, on the dollars when they go into the account or upon reimbursement.

Because you pay less Social Security tax when you participate in the Health Care Reimbursement Account, it is possible that your future Social Security benefit might be slightly reduced, but for most people that possible loss is more than offset by current tax savings.

Throughout this section, reference is made to the Plan Year. The Plan Year runs from January 1 to December 31.

### ***Eligible Dependents***

You can use the Health Care Reimbursement Account to pay eligible expenses for the following individuals (regardless of whether they are covered by the Vanguard health plan):

- ✓ yourself;
- ✓ your legally married spouse;
- ✓ your dependent children; and
- ✓ anyone else you can claim as a dependent for income tax purposes for the Plan Year, including a qualified domestic partner or children of a qualified domestic partner. (Please refer to Section II.H for discussion qualified domestic partners).

### ***Eligible Expenses***

The Health Care Reimbursement Account lets you pay for eligible “out-of-pocket” expenses with pre-tax dollars. Examples of eligible expenses include:

- ✓ Deductibles, co-payments and other out-of-pocket costs for non reimbursed medical, dental, vision, or hearing expenses; and
- ✓ Medical, dental, vision, or hearing expenses beyond the limits of the Plan or those that are above reasonable and customary charges.

### ***Expenses the Health Care Reimbursement Account May Cover***

Call Aetna (1-800-938-0512 for a decision as to whether the following items are reimbursable:

- ♦ Attendant to accompany blind or deaf student;
- ♦ Capital expenditures for home modifications to accommodate a handicapped person;
- ♦ Cosmetic surgery needed to ameliorate a deformity arising from a congenital abnormality, personal injury, or disfiguring disease;
- ♦ Disposable diapers needed because of a severe neurological disorder;
- ♦ Elevator needed to alleviate a cardiac condition;
- ♦ Halfway house, with continuing psychiatric supervision, to adjust to a community after a stay in a mental hospital;
- ♦ Health club dues for activities prescribed by a Physician for a medical condition, excluding weight control, fitness, and general good health;
- ♦ Laetrile as prescribed by a doctor and legally used;
- ♦ Lead-based paint removal;
- ♦ Lifetime medical care in a retirement home;
- ♦ Lodging, while away from home, primarily for and essential to medical care, limited to \$50 per night per individual;
- ♦ Medically necessary nursing home services;
- ♦ Nursing services;
- ♦ Sanitarium rest home for medical, educational, or rehabilitative reasons;
- ♦ Tooth veneers applied for preventive reasons;
- ♦ Tuition for learning disabled or mentally retarded persons and tuition paid to a special school or for a specially trained teacher, if prescribed by doctor and
- ♦ Smoking cessation programs and related prescription drugs.
- ♦ Over the Counter Drugs, such as allergy medicine, cold medicine, diabetic supplies, pain reliever and items that used to be prescribed drugs but now are available over the counter.

### ***Expenses Not Eligible for Reimbursement***

You cannot use the Health Care Reimbursement Account for expenses such as:

- fees for exercise, athletic, or health club membership where there is no specific medical reason for membership;
- weight loss programs that are not medically necessary;
- contributions you make for health care coverage at Vanguard and contributions your family makes for healthcare coverage through your spouse's employer;
- cosmetic surgery (unless necessary to correct a deformity that is congenital or that resulted from an injury or a disfiguring disease);
- expenses incurred before you enroll in the Account (or increase an election due to a status change) or after you have terminated participation in the Account;
- long term care expenses;
- amounts reimbursed or reimbursable by Vanguard's plans or any other source, such as insurance companies, or Medicare; or
- expenses for which a Federal itemized tax deduction is taken.

Call Aetna at 1-800-938-0512 if you have questions about whether an expense is reimbursable or view a full list on [www.irs.gov](http://www.irs.gov).

### ***Annual Deposit Amounts***

You can deposit up to \$3,000 per Plan Year. The dollars you deposit will automatically be deducted in equal amounts from your paycheck each pay period and credited to an account in your name. The payroll

deductions will stop at the end of the year. You must make a new election each Open Enrollment period in order to continue your participation in the Health Care Reimbursement Account.

To comply with Internal Revenue Service regulations, the plan will be tested to ensure it meets nondiscrimination rules. If the plan does not pass the test, certain crew members may not be able to contribute up to the full amount on a before-tax basis. You will be contacted if this affects you.

### ***Reimbursement From Your Account***

The expenses that can be reimbursed through the account are only for health care expenses incurred during the Plan Year and while you were an active participant in the Health Care Reimbursement Account. Expenses are treated as having been incurred when the medical care that gives rise to the medical expenses is provided, and not when you are formally billed or charged for, or pay for the medical care.

NOTE: If you stop participating during the Plan Year based on a family status change, any health care expenses you incur in that Plan Year after you stopped participating will not be eligible for reimbursement.

Effective January 1, 2007, there will be three ways to access the funds in your Health Care Reimbursement Account:

- ✓ Streamline Processing
- ✓ FSA Debit Card
- ✓ File a paper claim

### ***Streamline Processing***

Crew members who are enrolled in the Aetna Medical benefit options and have elected the Health Care FSA will have their claims processed through Streamline processing. With Streamline processing, when you incur a medical expense, you will provide your id card to your provider and pay the out-of-pocket copay expense. Aetna will process and pay your claim according to your medical plan coverage and will automatically reimburse you for your copay under the FSA plan through direct deposit. The streamline processing will also work for eligible Aetna Dental out-of-pocket expenses, such as deductibles and coinsurance. You will automatically be enrolled in the Streamline processing, but you may opt out if you would like to control when you receive reimbursement from your FSA. If you opt out of Streamline processing, you will be required to submit paper claims.

### ***FSA Debit Card***

Crew members who enroll in the Health Care FSA will receive a debit card to be used to pay for prescription drug expenses. The debit card can also be used at Walgreen's and Drugstore.com for eligible over-the-counter expenses.

### ***Filing a Paper Claim***

After you have incurred an eligible expense, fill out a reimbursement claim form and send it to Aetna with a written statement (such as an Explanation of Benefits) from the provider stating that the medical expense has been incurred, the date the expense was incurred, and the amount of such expense. You will be reimbursed up to the full amount elected for the Plan Year. You will receive your reimbursement check via direct deposit to the same account that your paycheck is deposited. Reimbursement forms can be downloaded from *CrewNet* or Aetna's website ([www.aetna.com](http://www.aetna.com)).

### ***If you Have A Leftover Balance***

Each year you have until May 31 to submit claims for the prior Plan Year's expenses. Any leftover amounts in your account will be forfeited. Forfeited funds will be used to offset the cost of administering the plan.

*As required under Internal Revenue Service regulations, you will forfeit the unused money remaining in your accounts at the end of the year. A "use it or lose it" rule applies. As permitted by IRS Notice 2005-42, a grace period of two-and-one-half months is now permitted for incurring expenses, so that any money contributed to an account in a given year must be used for expenses incurred by March 15 of the following year. The Plan then permits a "run-out" period during which documentation necessary to substantiate a claim may be submitted. In light of the grace period, the run-out period for substantiation now ends on May 31 of the year following the year in which the contributions are made. Any contributions remaining in the account at the close of the grace period and for which necessary substantiation is not submitted by the end of the run out period will not be available to you as a refund; so it is important for you to estimate your expenses carefully.*

### ***If you Leave Vanguard***

If you leave Vanguard, you may be reimbursed for expenses as long as they are incurred after you enrolled in the Account for the Plan Year and prior to the date you terminated participation in the Account. You may submit claims for reimbursement until May 31 following the end of the Plan Year in which your employment terminated.

You may continue to submit paper claim reimbursements to Aetna. Only the expenses that are incurred while you were an active participant in the plan will be eligible for reimbursement from the account.

### ***If you Die***

If you die, your surviving dependents may be reimbursed for expenses incurred during your period of participation during the Plan Year until your date of death. Your surviving dependents may submit claims for reimbursement until May 31 following the end of the Plan Year in which you died.

### ***COBRA***

Certain Health Care Reimbursement Account participants may be eligible for COBRA continuation coverage if they have a positive Health Care Reimbursement Account balance at the time of the "qualifying event" (taking into account all claims submitted prior to the qualifying event date). The Human Resources Department will notify you of your COBRA rights, if any, under the Health Care Reimbursement Account. However, even if COBRA coverage is elected for the Health Care Reimbursement Account, COBRA coverage for the Health Care Reimbursement Account will end at the end of the year in which the qualifying event occurred and cannot be continued into the next calendar year. See the COBRA section of this SPD for more information on COBRA continuation coverage.

## **2. The Dependent Care Reimbursement Account**

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The Dependent Care Reimbursement Account provides you with a way to save money while paying for eligible dependent care expenses. You make contributions to your account through payroll deductions before Federal and Social Security taxes, and in some cases, state taxes, are taken out of your paycheck. Your eligible dependent care expenses are reimbursed directly from your account and the money is not taxed upon reimbursement.

Because you pay less Social Security tax when you participate in the Dependent Care Reimbursement Account, it is possible that your Social Security benefit might be slightly reduced, but for most people that possible loss is more than offset by current tax savings.

Throughout this section, reference is made to Plan Year. The Plan Year runs from January 1 to December 31.

### ***Eligible Dependents***

The Dependent Care Reimbursement Account can be used to pay for the care of the following dependents:

- ❖ children or other dependents under the age of 13;
- ❖ a spouse who is physically or mentally incapable of self-care; or
- ❖ any other dependent (regardless of age) who lives with you and is physically or mentally incapable of self-care, such as an elderly parent.

Generally, the care must be provided for someone who qualifies as your dependent for Federal income tax purposes. Also, qualified dependents age 13 or older must live with you (i.e., spend at least eight hours a day in your home).

### ***Eligible Expenses***

You can use the Dependent Care Reimbursement Account to pay for dependent care expenses so that you and your spouse can work or look for work. You can also use the account to pay for dependent care if your spouse attends school full-time for at least five months of the year or if your spouse is disabled.

#### ***Eligible expenses include:***

- ❖ a qualified child care or adult day care center (must meet all state and local regulations if it provides care for more than six individuals);
- ❖ a housekeeper whose duties include dependent care;
- ❖ preschool tuition;
- ❖ before and after-school programs;
- ❖ summer day camps (not for educational or overnight purposes);
- ❖ a relative who cares for your dependents (the relative cannot be your dependent for Federal income tax purposes or your child under the age of 19); and
- ❖ a person who cares for an eligible child or an elderly or disabled dependent in your home.

### ***Annual Deposit Amounts***

Each Plan Year, you may deposit a maximum of \$5,000 in your account subject to certain limits described below. The money will be deducted in equal before-tax amounts from each paycheck until the end of the year. You must make a new election for each Plan Year you participate in the Dependent Care Reimbursement Account.

Federal law requires that the amount excluded from your gross income for deposit in a Dependent Care Spending Account cannot exceed the lesser of:

- ❖ \$5,000 (\$2,500 if you are married and filing separate federal income tax returns)
- ❖ Your annual income; or
- ❖ Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either \$200 (if you claim expenses for one dependent) or \$400 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income and these assumed monthly income amounts of either \$200 or \$400.

If your spouse also participates in a dependent care reimbursement account at work, each of you can deposit up to \$2,500 in an account (if you file separately) or up to \$5,000 combined in both accounts (if you file jointly). By making an election under the Plan, you are representing to Vanguard that your contributions to your Dependent Care Spending Account are not expected to exceed the federal legal limits.

If you are married and filing separate federal income tax returns, the \$2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent's primary residence for more than six (6) months during the year, and you paid more than half of the expenses of that household.

To comply with Internal Revenue Service regulations, the Plan will be tested to ensure it meets nondiscrimination rules. If the Plan does not pass the test, certain highly compensated crew members may not be able to contribute up to the full amount on a before-tax basis. You will be contacted if this affects you.

### ***Dependent Care Subsidy Program***

Vanguard may provide a subsidy to help pay for your dependent care expenses if you are eligible to participate in the Dependent Care Subsidy Program (i.e., crew members whose household income is below \$56,800 annually). For those crew members eligible for the Dependent Care Subsidy Program, Vanguard "matches" the crew member's contribution (as a percent of the crew member's dependent care contribution election). The percentage "match" is 30%.

For example, if a crew member's gross household income is \$25,000, and the crew member's contribution election is \$3,000, (or  $\$3,000 \times 30\%$ ), and set the crew member's pre-tax contribution election at \$2,070 (or  $\$3,000 - \$930$ ). Then the total amount reimbursable from the plan is \$3,000 (\$930 from Vanguard and \$2,070 from the crew member).

Please refer to *CrewNet* for more details about the Dependent Care Subsidy Program. Benefits (1-800-407-8576 or 34BEN) can answer any questions you may have about the Dependent Care Reimbursement Account.

### ***Reimbursement From Your Account***

The expenses that can be reimbursed through the account are only for expenses incurred during the Plan Year and while you are an active participant in a Dependent Care Reimbursement Account. Expenses are treated as having been provided when the care that gives rise to the expense is provided, and not when you are formally billed or charged for, or pay for the care.

### ***Filing a Paper Claim***

After you have incurred an eligible expense, fill out a reimbursement claim form and send it to Aetna with a written statement (such as a bill) from the provider stating that the expense has been incurred, the

dates that the expense occurred and the amount of such expense. The statement must include the provider tax ID or Social Security number, address and signature; the dependent's name; and an itemized bill with the dates on which the provider cared for your dependent.

If you file a claim for more than the money deposited to date in your account, you will be reimbursed only up to the amount in your account. You will receive your reimbursement check via direct deposit to the same account that your paycheck is deposited. When additional funds are deducted from your pay, they will be posted to your account and you will be reimbursed for the outstanding expense.

### ***Dependent Care Reimbursement Account vs. Tax Credit***

The current tax laws provide two means of saving on dependent care expenses: dependent care assistance plans (such as the Dependent Care Reimbursement Account) and the federal dependent care tax credit. The tax credit applies to the same expenses that are eligible for reimbursement through the Account. You can take a tax credit on your federal income tax return from 20% to 30% of your eligible dependent care expenses, depending on your adjusted gross income. The amount of the credit offsets your tax liability dollar for dollar. The expenses covered by the credit are limited to a maximum of \$3,000 for one dependent and \$6,000 for more than one dependent. The credit equals a percentage of your dependent care expenses up to the maximum limit on expenses.

You can use either the Dependent Care Reimbursement Account or the tax credit – but not both – for the same expenses. More specifically, if you use the Account for \$5,000 of expenses for one child, you can save taxes on the full \$5,000, but you eliminate your ability to use the tax credit since amounts reimbursed under the Dependent Care Reimbursement Account reduces, dollar-for-dollar, the amount of the available tax credit. If, on the other hand, you are reimbursed \$1,400 through the Account for expenses for one child, you can only apply up to \$1,000 to the tax credit.

Because you will not be able to take advantage of the tax credit for amounts reimbursed through your Dependent Care Reimbursement Account, you may wish to consider which of the two methods will save you more in tax dollars. Your individual tax situation will determine which approach is better for you. Generally, the Account provides a greater tax savings for people whose marginal tax rate is above 15% of adjusted gross income. You may want to consult a tax adviser for help in determining whether the Account is more advantageous than the tax credit, as individual circumstances must be considered. You may also refer to IRS Publication 503, available by request from the IRS by calling 1-800-829-3676.

### ***If You Have a Leftover Balance***

Each year you have until March 31 to submit claims for the prior Plan Year expenses. Any leftover amounts will be forfeited. Forfeited funds will be used to offset the cost of administering the plan.

*As required under Internal Revenue Service regulations, you will forfeit the unused money remaining in your accounts at the end of the year. A “use it or lose it” rule applies. As permitted by IRS Notice 2005-42, a grace period of two-and-one-half months is now permitted for incurring expenses, so that any money contributed to an account in a given year must be used for expenses incurred by March 15 of the following year. The Plan then permits a “run-out” period during which documentation necessary to substantiate a claim may be submitted. In light of the grace period, the run-out period for substantiation now ends on May 31 of the year following the year in which the contributions are made. Any contributions remaining in the account at the close of the grace period and for which necessary substantiation is not submitted by the end of the run out period will not be available to you as a refund; so it is important for you to estimate your expenses carefully.*

***If You Leave Vanguard***

If you leave Vanguard, your contributions to the Dependent Care Reimbursement Account for the Plan Year will stop. You may continue to submit paper claims for reimbursement of expenses incurred prior to your termination date. The deadline for submitting claims is May 31 following the end of the Plan Year during which your employment terminated.

In order to be reimbursed, the expenses you submit must be for dependent care provided prior to your termination date. Expenses incurred before you enrolled in the account and expenses incurred after you terminated employment are not eligible.

You may not withdraw the money already in your account, or receive a refund. Your Dependent Care Reimbursement Account cannot be continued after you leave Vanguard.

***If you Die***

If you die, your surviving dependents may be reimbursed for expenses incurred during the Plan Year until your date of death. Your surviving dependents may submit claims for reimbursement until May 31 following the end of the Plan Year in which you died.

***Unpaid Leave of Absence***

The dependent daycare expenses that are incurred during the period of an unpaid leave of absence are not eligible for reimbursement. Crew members can elect to increase or decrease their annual dependent care pledge at the commencement or termination of an unpaid leave of absence, as stated Section II.A (Enrollment Changes).

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## E. Long Term Disability

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The Long-Term Disability benefit provides you with a continuing income for an extended period of disability. The LTD benefit will replace 66 ⅔% of your pre-disability monthly base pay if you are disabled for more than 180 days due to a qualifying illness or injury.

### ***Eligibility***

Vanguard offers Long-term Disability benefits to all crew members and their dependents who meet the eligibility requirements in Section II.A Your coverage will begin on your first day of employment in an eligible class

### ***Cost***

Vanguard pays the full cost of your LTD coverage. You will receive an allotment of flex credits, which will equal the price of the benefit. You choose whether the premium is paid for on a pre-tax or after-tax basis. This can have important tax consequences:

- ❖ *If you choose to pay for LTD coverage with pre-tax dollars* (as you do for your medical, dental, and vision benefits; supplemental life insurance; and flexible spending accounts), and you ever become disabled, your LTD benefits will be subject to federal income tax.
- ❖ *If you choose to pay for LTD coverage with after-tax dollars*, you'll be paying more now. But if you subsequently become disabled, any LTD benefits you receive will be exempt from federal income taxes.

LTD coverage is mandatory for all crew members: You can't waive coverage. Whether you decide to pay for coverage with pre- or after-tax dollars will depend on your personal circumstances, including your age and your financial situation.

### ***Termination of LTD Benefits***

Refer to the Appendix, Section I for information on when LTD benefits end.

### ***Termination of LTD Coverage***

The insured crew member's coverage will terminate on the earliest of the following dates:

- ❖ The date this LTD insurance policy is terminated;
- ❖ The date the crew member is no longer a member of a class eligible for LTD coverage.

Coverage may be continued while the crew member is on an approved leave of absence. Coverage during an approved leave may continue until the earlier of: 1) the date Vanguard stops paying the required premium; or 2) the date the leave ends.

Termination of coverage will not affect a covered disability that began before the date of termination.

Refer to the Appendix, Section I for more information on when LTD coverage ends.

***For More Information***

Appendix J is the MetLife LTD booklet. This booklet, which is incorporated herein by reference, constitutes the plan provisions, including all benefits, limitations and exclusions, for the Plan's LTD benefits. Additionally you may wish to reference the Vanguard Long Term Disability Leave Policy available on *CrewNet*. You may also contact Benefits at 1-800-407-8576 or internally at 34BEN to answer any questions about your LTD coverage.

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## F. Legal Services

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### ***Introduction***

The Vanguard Group Legal Plan provides personal legal services for crew members, their legally married spouse, and dependent children. If you choose to join the Legal Plan, the coverage available to you and your family through the Legal Plan can help you with many of your personal legal needs.

(Please refer to Section II.H of the document for domestic partner eligibility.)

This summary provides general information about the Legal Plan, defines who is eligible to receive benefits under the Legal Plan, and how to obtain legal services. If you have any questions that are not answered, please contact Benefits at 1-800-407-8576 or 34BEN.

Hyatt Legal Plans, Inc. has been selected to provide legal plan benefits. The services will be provided through a panel of carefully selected participating law firms. Lawyers in this network are called Plan Attorneys. The actual provisions of the Legal Plan are set forth in a written document maintained by Vanguard. All statements made in this SPD are subject to the provisions and terms of that document (which control in the event of conflict with this summary.)

### ***Eligibility***

Crew members who meet the eligibility requirements in Section II.A may enroll in the Legal Plan. If you enroll in the Legal Plan, you and your eligible dependents will be eligible to receive covered Legal Services. Eligible dependents include your spouse and your unmarried child (or children) up to the age of 21, provided he or she depends on you for support.

### ***Enrollment***

An eligible crew member may choose to join or drop out of the Legal Plan at the annual open enrollment period. If you become an eligible crew member after the annual open enrollment period, you can elect to participate in the Legal Plan by completing your election form within 30 days of employment. You will not be permitted to change your election to participate (or not to participate) in the Legal Plan for any reason during the Plan Year, even in cases of unpaid leave, unless you cease to be an eligible crew member. The Legal Plan has a minimum participation period of one plan year (starting with January 1<sup>st</sup> and ending December 31<sup>st</sup>) of the current plan year. For newly eligible crew members enrolling after January 1<sup>st</sup>, the minimum participation period will end December 31<sup>st</sup> of the first Plan Year for which they enrolled.

### ***When Coverage Begins***

Generally, Legal Plan coverage becomes effective on the first day of the first month of the Plan year in which Vanguard offers the Legal Plan, (typically January 1), for the elections you made during the previous open enrollment period. For new hires, coverage begins on your date of hire.

### ***When Coverage Ends***

Your ability to receive legal services under the Legal Plan ends if you are no longer an eligible crew member or if you choose not to enroll during future annual open enrollment periods.

If you become ineligible to participate in the Legal Plan for any reason, including termination of employment, the Legal Plan will cover the legal fees for those covered services that were opened and

pending during the period you were enrolled in the Legal Plan. Of course, no new matters may be started after you become ineligible.

### ***Administration and Funding***

The Legal Plan is provided for and administered through a contract with Hyatt Legal Plans, Inc. Hyatt Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from crew members electing this coverage are paid to Hyatt Legal Plans, Inc.

### ***Cost of The Plan***

You pay the cost of the Plan through **after-tax** payroll deductions.

### ***How To Get Legal Services***

To use the Legal Plan, call Hyatt Legal Plans' Client Service Center at 1-800-821-6400 between 8 a.m. and 7 p.m. (Eastern Time), Monday through Thursday and 8 a.m. and 6 p.m. (Eastern time) on Friday. Be prepared to identify yourself as a participant in the Hyatt Premier Legal Plan and to give your social security number. If you are a spouse or a child of an eligible person, you will need the social security number of the crew member through whom you are eligible.

The Client Service Representative who answers your call will:

- ❖ verify your eligibility for services;
- ❖ make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- ❖ give you an Authorization Number which is similar to a claim number (you will need a new Authorization Number for each new case you have);
- ❖ give you the telephone number of the Plan Attorney most convenient to you; and
- ❖ answer any questions you have about the Hyatt Premier Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you wish, you may tell the Client Service Representative that you want to use your own attorney. Hyatt Legal Plans will reimburse you for these attorneys' fees in accordance with a set fee schedule.

You **must** call Hyatt Legal Plans or register on their website ([www.legalplans.com](http://www.legalplans.com)) prior to using the services of any attorney.

### ***Plan Confidentiality, Ethics and Independent Judgment***

Your use of the Legal Plan and the legal services provided to you are confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Vanguard will know nothing about your legal problems or the services you use under the Legal Plan. Plan administrators will have access only to limited statistical information needed for administration of the Legal Plan. No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you.

All attorneys' services provided under the Legal Plan are subject to ethical rules for lawyers. The Plan Attorney's obligations are exclusively to you, and the Plan Attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the Legal Plan, is responsible for all services provided by their attorneys. The Legal Plan has no liability for the conduct of any Plan Attorney or other attorney you select who provides services to you.

Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person.

If you have a complaint about the legal services you have received or the conduct of Plan Attorney, call Hyatt Legal Plans at 1-800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

### ***What Services are Covered***

The Legal Plan entitles you and your eligible dependents to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions that apply. Please take time to read the description of benefits carefully.

The following services are covered under the Legal Plan:

### **ADVICE AND CONSULTATION**

#### **Office Consultation**

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

#### **Telephone Advice**

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

### **CONSUMER PROTECTION**

#### **Consumer Protection Matters**

This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction. The controversy must be evidenced by a written document such as a sales slip, contract,

note or warranty. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

**Small Claims Assistance**

This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

**DEBT MATTERS**

**Debt Collection Defense**

This benefit provides Participants with negotiation with creditors for a repayment schedule, limiting creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It does not include defense against a judgment, vacating a judgment, counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with the sponsor or employer.

**Identify Theft Defense**

This benefit provides Participants with consultations with an attorney regarding potential creditor actions resulting from identity theft, and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts as set forth in the Debt Collection Defense coverage. In addition it provides Participants with online help and information about Identity Theft and prevention.

**Personal Bankruptcy or Wage Earner Plan**

This service covers the Employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Employer, even if the Employee or spouse chooses to reaffirm that specific debt.

**Tax Audits**

This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant or the preparation of any tax returns.

**DEFENSE OF CIVIL LAWSUITS**

**Administrative Hearing Representation**

This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It does not apply where services are available or are being provided by virtue of a homeowner or vehicle insurance policy. It does not include divorce or post-decree matters, paternity, support or custody matters, or litigation of a job-related incident.

**Civil Litigation Defense**

This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of

general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include divorce or post-decree matters, paternity, support or custody matters, or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims, even when this may be part of the defense.

**Incompetency Defense**

This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

**DOCUMENT PREPARATION**

**Affidavits**

This service covers preparation of any affidavit in which the Participant is the person making the statement

**Deeds**

This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

**Demand Letters**

This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

**Mortgages**

This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

**Notes**

This service covers the preparation of any promissory note for which the Participant is the payor or payee.

**Document Review**

This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

**Immigration Assistance**

This service covers advice and consultation, preparation of affidavits and powers of attorney and review of any immigration documents.

## **FAMILY LAW**

### **Name Change**

This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

### **Premarital Agreement**

This service covers the preparation of an agreement by an Employee and his or her fiancé(e) prior to their marriage, outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Employee. The fiancé(e) must have separate counsel or must waive representation.

### **Uncontested Adoption**

This service covers all uncontested governmental agency and stepparent adoptions for the Employee and spouse. If an adoption becomes contested, the Employee or spouse must pay all additional legal fees.

### **Uncontested Guardianship or Conservatorship**

This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Employee or spouse is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork and attending the hearing. If the proceeding becomes contested, the Employee or spouse must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings once guardianship or conservatorship has been established.

## **PERSONAL INJURY**

### **Personal Injury (25% Network Maximum)**

Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

## **REAL ESTATE MATTERS**

### **Eviction and Tenant Problems (Primary Residence – Tenant Only)**

This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

### **Refinancing of Home (Primary Residence)**

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of a Participant's primary residence. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, unimproved land, rental property or property held for business or investment. Home equity loans are not included under this service.

**Sale or Purchase of Home (Primary Residence)**

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, unimproved land, new construction, rental property, property held for business or investment or leases with an option to buy. Home equity and construction loans are not included under this service.

**TRAFFIC AND CRIMINAL MATTERS**

**Juvenile Court Defense**

This service covers the defense of an Employee's dependent child in any juvenile court matter, provided there is no conflict of interest with the Employee, in which case this service provides an attorney for the Employee only.

**Traffic Ticket Defense (No DUI)**

This service covers representation of the Participant in defense of any traffic ticket except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

**Restoration of Driving Privileges**

This service covers the Participant with representation in proceedings to restore the Participant's driving license.

**WILLS AND ESTATE PLANNING**

**Living Trusts**

This service covers the preparation of a living trust for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

**Living Wills**

This service covers the preparation of a living will for the Participant.

**Powers of Attorney**

This service covers the preparation of any power of attorney when the Participant is granting the power.

**Probate (10% Network Discount)**

Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

**Wills and Codicils**

This service covers the preparation of a will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

***What Services Are Not Covered - Exclusions***

Certain matters are excluded from coverage under the Legal Plan. No services, not even a consultation, can be provided on the following matters:

- Payment made to a third party (someone other than the attorney) such as costs, witness fees, transcripts, recording fees, filing fees, fines, penalties, judgments or orders of restitution ordered by any court;
- Appeals, class actions, interventions, derivative actions and amicus curae filings;
- Business, farm, commercial or rental property transactions, including any legal services which would ordinarily be deductible under the Internal Revenue Code as a necessary expense of doing business;
- Admiralty, patents, trademarks and copyrights;
- Tax return preparation;
- Disputes or proceedings involving Vanguard or any of its divisions or affiliated organizations;
- Disputes, claims or proceedings involving any Acordia company, Hyatt Legal Plans, Inc., Hyatt Legal Services, or any affiliates, any participating law firm or attorney, or the Plan;
- Matters for which you are or have been receiving legal services before you received an Authorization Number;
- Legal expenses for matters handled by an attorney who is not a Plan Attorney in excess of the fee schedule determined by Hyatt Legal Plans;
- Matters which Hyatt Legal Plans deems frivolous, non-meritorious or unethical;
- Services on behalf of a spouse or dependent where you are an adversary.

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## **G. Purchased Paid Time Off**

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### ***Introduction***

In addition to Vanguard's regular paid time off entitlement, crew members may elect to purchase additional paid time off under the Plan.

### ***Eligibility***

Crew members who meet the eligibility requirements in Section II.A may elect to purchase up to one additional workweek of paid time off per year.

### ***Enrollment***

If you are interested in this option, you must sign up for it during the annual open enrollment period (newly hired crew members are not eligible in their year of hire). For each day you purchase, an amount equivalent to one day of your salary will be spread over the year and deducted from your biweekly paycheck on a pre-tax basis. You are not permitted to change your purchased vacation election for any reason during a Plan Year, except in the case of the taking of or the return from an unpaid leave, or in the case of an employment status change (such as a reduction in hours) where the crew member is no longer benefits eligible.

### ***Reimbursement***

If you purchase vacation days and do not use them during the Plan Year, they cannot be carried over to the following Plan Year; however, you will be reimbursed for the days you did not use provided that you inform your management by the first pay period in December if you will be requesting reimbursement. IRS regulations do not allow us to reimburse after December 31 of the year for which the vacation was purchased.

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## H. Domestic Partners

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### ***Introduction***

Effective January 1, 2005, a crew member who meets the eligibility requirements in Section II.A may elect health benefits (including medical, prescription, dental and vision coverage) and legal benefits through the Plan for his or her eligible Domestic Partner and the eligible Domestic Partner's children. The tax implications of such benefits will depend upon whether the Domestic Partner or the Domestic Partner's children qualify as dependents of the crew member within section 152 of the Internal Revenue Code, as described below.

Additionally, effective January 1, 2005, eligible Domestic Partners (or, where applicable, the Domestic Partner's children) may take advantage of the following programs:

- ✓ Group Auto and Home Insurance
- ✓ Long Term Care
- ✓ Crew Assistance Program (CAP)
- ✓ Adoption Assistance (adoption of Domestic Partner's children is excluded)
- ✓ Scholarship benefit (for the children of a Domestic Partner)
- ✓ Retiree Medical (no Retiree Medical Account will be established for the eligible Domestic Partner, but such Domestic Partner may elect to purchase coverage on an after-tax basis at the retiree rate until the Domestic Partner becomes eligible for Medicare).

### ***Eligibility***

The benefits listed above are offered to same and opposite sex domestic partners who meet the eligibility criteria listed below. Crew members must complete and submit an *Affidavit of Domestic Partnership*, which is available on *CrewNet*. In order to be an eligible Domestic Partner, an individual must:

- ✓ Be at least 18 years of age;
- ✓ Have lived with the crew member for at least six months and continue to be a member of the crew member's household for the entire coverage period;
- ✓ Be (a) financially interdependent with the crew member, (b) jointly responsible for the common welfare and financial obligations of the household, or (c) chiefly dependent upon the crew member for care and financial assistance;
- ✓ Not be related to the crew member in any way that would prohibit legal marriage;
- ✓ Neither be legally married to, nor be the domestic partner of, anyone other than the crew member; and
- ✓ Not be otherwise eligible for coverage through The Vanguard Group, Inc. Benefit Plan.

If an individual is an eligible Domestic Partner, the crew member may elect to provide health benefits (including medical, prescription, dental and vision coverage) for any unmarried children of the crew member's eligible Domestic Partner who are under the age of 19 (or 25 if a full-time student), even if coverage is not elected for the eligible Domestic Partner; provided, however, that to be eligible for such coverage the Domestic Partner's children must be dependents of the crew member within the meaning of section 152 of the Code. Crew members will be required to submit proof of full-time student status for eligible dependents age 19-25 annually prior to student's birthday.

### ***Affidavit of Domestic Partnership***

The crew member and the Domestic Partner will be required to sign an affidavit and provide at least two of the following documents as proof of the Domestic Partnership relationship:

- ✓ Any loan agreement or credit card agreement where the loan or credit card is a joint obligation.
- ✓ Any life insurance policy or Last Will and Testament on which the crew member names the Domestic Partner as a beneficiary or the Domestic Partner names the crew member as his or her beneficiary.
- ✓ Any documentation indicating joint ownership of property, such as real estate, automobiles, bank accounts, etc.
- ✓ Any durable or health care power of attorney granting the crew member power of attorney for the Domestic Partner or vice versa.
- ✓ Any lease of residence in joint names.
- ✓ Proof of civil union or marriage from another state.

The entire record of evidence presented with the *Affidavit of Domestic Partnership* will be considered in deciding whether an individual is an eligible Domestic Partnership.

### ***Levels of Coverage Available to Crew Members and Domestic Partners***

The following is a list of all the levels of coverage offered to crew members beginning January 1, 2005. To the extent the crew member's Domestic Partner (and/or the Domestic Partner's children) qualify as dependents of the crew member within the meaning of section 152 of the Internal Revenue Code (see below), the crew member may elect from among the following coverage levels:

- ✓ Crew member only
- ✓ Crew member plus eligible Domestic Partner
- ✓ Crew member plus eligible Domestic Partner's child
- ✓ Crew member plus eligible Domestic Partner and/or eligible Domestic Partner's children.

The benefits afforded under the above coverage levels shall not result in taxable income to the crew member, the eligible Domestic Partner and/or the Domestic Partner's children.

To the extent the crew member's eligible Domestic Partner (and/or the Domestic Partner's children) do not qualify as dependents of the crew member within the meaning of section 152 of the Internal Revenue Code (see below), the crew member may elect from among the following coverage levels:

- ✓ Domestic Partner Adult
- ✓ Domestic Partner Child
- ✓ Domestic Partner Adult and/or Child(ren)

The benefits afforded under the above coverage levels shall result in imputed income to the crew member.

### ***Section 152 Dependent***

An eligible Domestic Partner and/or the eligible Domestic Partner's children will constitute qualify as dependents of the crew member within the meaning of section 152 to the extent they:

- Have the same principal place of abode as the crew member throughout the entire period and are members of the crew member's household;
- Have gross income for the entire coverage period that is less than the "exemption amount" described in section 151(d) of the Internal Revenue Code (\$2,000 for 2005);
- Rely upon the crew member for the entire coverage period for over one-half of their support; and
- Are not "qualified children" (as described in section 152(c) of the Internal Revenue Code) of any other taxpayer for the entire coverage period.

### ***Cost of Coverage***

The crew member will be responsible to pay for Domestic Partner coverage through biweekly payroll deductions.

Generally, if you cover a Domestic Partner or his or her children under The Vanguard Group, Inc. Benefit Plan, the cost of such coverage is paid by you on an after-tax basis through payroll withholding. In addition, imputed income will be added to the crew member's biweekly pay equal to the value of coverage minus the after-tax amount the crew member pays for domestic partner coverage.

If, however, you establish to the satisfaction of Vanguard's Benefits Unit that any individuals for whom you seek coverage are your dependents within the meaning of Section 152 of the Internal Revenue Code, any amounts paid by you for coverage for such dependents will be treated as pre-tax contributions to the Plan.

To claim dependent status for your Domestic Partner or any child(ren) of your Domestic Partner, you must complete the Affidavit of Legal Tax Dependency in the presence of a notary public and then present the completed Affidavit and supporting documentation to the Benefits Unit, mailstop M22. (This document is completed in addition to the Affidavit of Domestic Partnership.) The Benefits Unit will review the Affidavit and evidence before making its determination and will inform you if any further information or action is required.

### ***Special Enrollment Rights***

If you cover your Domestic Partner and/or his or her children under The Vanguard Group, Inc. Benefit Plan and you paying the cost of such coverage on an after-tax basis you may elect or terminate coverage for such individual at any time during the Plan Year. If you cover your Domestic Partner and/or his or her child(ren) under the Vanguard Group, Inc. Benefit and, because such individual(s) are your dependents within the meaning of section 152 of the Internal Revenue Code, you may elect or terminate coverage for such individuals only if a change in status occurs (as described in Section II.A. of this SPD). Note that you may not choose different options within the same benefit for the Domestic Partner. For example, if the crew Member is enrolling the Domestic Partner in a medical plan, the Domestic Partner must be enrolled in the same medical plan.

### ***Domestic Partners and COBRA***

Domestic partners are not qualified beneficiaries under any circumstances and, therefore, domestic partners have no independent right to elect continuation coverage. However, to the extent that a crew member has elected domestic partner coverage before a qualifying event that is the crew member's termination of employment (other than for gross misconduct) or reduction of hours, the crew member who is a qualified beneficiary shall have the ability to elect continuation of domestic partner coverage after the qualifying event.

### ***Termination of Domestic Partnership***

A crew member can remove a Domestic Partner from his or her benefits coverage by submitting a status change with a completed "Statement of Termination of Domestic Partnership" affidavit. Reasons coverage may end include:

- ✓ The Domestic Partner has obtained coverage elsewhere.
- ✓ The Domestic Partner relationship ends.
- ✓ The Domestic Partner no longer meets the eligibility requirements (ex: becomes Medicare eligible).
- ✓ The crew member is no longer benefits eligible.

- ✓ The crew member terminates employment at Vanguard.
- ✓ The crew member dies.

Domestic Partners will not be eligible for COBRA coverage when their Vanguard benefits end.

If you have any questions in reference the Domestic Partner policy on *CrewNet* or call Benefits at 1-800-407-8576 or 34BEN.

## Section III – Optional Benefits

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### A. Academic Assistance Plan

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#### ***Introduction***

The Vanguard Academic Assistance Plan was established to assist in furthering the education of crew members and improving their skills. The plan provides reimbursement for tuition and books to eligible crew members enrolled in eligible graduate and undergraduate courses at accredited institutions. In addition, it may cover some non-job-related certificate programs from time to time, depending on Vanguard's business needs.

It is intended that reimbursed amounts be excludable from the gross income of eligible crew members to the extent permitted by Sections 127 and 132 of the Internal Revenue Code. Notwithstanding the preceding sentence, reimbursement under the plan is not limited to amounts that are excludable from income under Section 127 or 132 of the Internal Revenue Code.

The Academic Assistance Plan exists solely for the improvement of crew members. No crew member will receive any other compensation if he or she does not participate in the plan.

#### ***Eligibility***

To be eligible for Academic Assistance benefits, a crew member must be an active, regular full-time crew member (scheduled to work 37.5 or more hours per week) at the time of enrollment in the course, upon its completion, and at the time of reimbursement. Crew members classified as part-time, interns or seasonal are not eligible for Academic Assistance benefits. An otherwise eligible crew member who has submitted his or her resignation or has been discharged before the time reimbursement is made is not eligible for reimbursement. If a crew member's child is participating in Vanguard's Scholarship Program, the crew member may not participate in the Academic Assistance Program during the same academic year.

#### ***Reimbursable Expenses***

Reimbursable Expenses. Reimbursement is limited to tuition and book expenses associated with two eligible courses per semester (spring, summer, and fall), up to \$9,000 per calendar year. Expenses relating to travel, meals, lodging, parking, supplies, or other fees, are not reimbursable.

If a crew member is receiving financial assistance from other sources, the crew member will only be eligible for reimbursement under this plan to the extent his or her eligible expenses exceed the amount of such financial assistance. The term "financial assistance" includes scholarships, fellowships, grants, tuition waivers, or any other form of public or private financial assistance that effectively reduces the financial obligation incurred by the crew member in connection with his or her education. Notwithstanding the preceding sentence, a student loan is not considered financial assistance.

Eligible Courses. Subject to compliance with all other terms of the plan, the following courses, if taken at an accredited school, college, or university, are eligible for reimbursement.

*Undergraduate courses* required under a liberal arts, business-related, or computer science program.  
*Job-related graduate courses:*

A graduate-level course is job-related if it maintains or improves the skills necessary in the crew member’s job or it is required by Vanguard (or applicable law or regulations) as a condition for the crew member to retain his or her position or compensation level.

*Courses in a Master of Science in Information Technology (“MSIT”) program, even if not job-related.*

*Courses in a non-job-related certificate program may be covered, depending on Vanguard’s business needs. A current list of covered programs is available on CrewNet (search term: “certificate”).*

*Law degree program.* The law degree must be job-related and reimbursement must be pre-approved by Vanguard’s CEO and Managing Director of Human Resources.

For all other courses other than undergraduate courses, certain repayment conditions apply to any reimbursement received. Crew members will be required to repay reimbursements in accordance with the terms of the reimbursement contract signed at the time the request for reimbursement is made.

Exclusions. Medical and other doctoral programs (other than a law degree), professional designation programs, regulatory licensing, job-related certificate programs, and academic review courses (such as those given in preparation for the GMAT) are not covered by the Plan. In addition, expenses for any course that instructs the crew member in any sport, game, or hobby are not covered by the plan. Job-related certificate programs are not covered by the plan, but may be covered by the crew member’s department. Crew members interested in pursuing such certificate programs should contact their supervisors for additional details.

### ***Amount of Reimbursement***

The amount of reimbursement that a crew member will receive for each course will depend on his or her grade, as shown below:

<u>Grade</u>	<u>Reimbursement</u>
A or B	100%
C or “Pass” in a pass/fail course*	50%
Below C or “fail” in a pass/fail course	None

\*For certificate courses in which pass/fail is the only grading option, a crew member who earns a “pass” grade will receive 100% reimbursement.

A crew member will be fully reimbursed for eligible expenses, regardless of the grade earned in the course, if the course is taken at the direction of Vanguard or Vanguard determines, in its sole discretion, that Vanguard’s business requirements make it necessary for the crew member to discontinue the course.

### ***Tax Treatment***

Whether an amount reimbursed under the plan is taxable to the crew member depends on the nature of the course and the federal tax rules in effect at the time reimbursement is made.

Under current tax law, the first \$5,250 in reimbursed expenses per calendar year for undergraduate courses, non-job-related courses that are part of an MSIT program, law school courses, and non-job-related certificate courses will be subject only to state tax (and not federal income or employment taxes).

Any amount in excess of \$5,250 will be treated as ordinary income for tax purposes. However, all reimbursed expenses under the plan for job-related graduate courses (other than law school courses) will not be subject to employment taxes.

### ***Reimbursement Procedures***

To be eligible for reimbursement for a particular course under the plan, a crew member must submit a completed application for reimbursement to the Benefits Unit at least fourteen (14) days before enrollment in the course. An email will be provided to the crew member if the application is approved. If the application is not approved, it will be returned to the crew member with an explanation and/or request for additional information. By the later of six (6) months after the end of or seven (7) days after the crew member receives his or her final grade for a previously approved course, the crew member must submit: (i) an itemized tuition bill along with original receipts for books (credit card receipts are not acceptable) and (ii) official documentation of his or her grade in the course. After the Benefits Unit verifies the expenses and satisfactory completion of the course, the crew member will be reimbursed. For purposes of the \$9,000 per year maximum and for tax purposes, expenses are considered to have been received in the calendar year during which the crew member actually receives the reimbursement, regardless of when the course was completed.

### ***Source of Reimbursement***

All reimbursements are paid solely from Vanguard's general assets. Vanguard does not maintain any trust or special fund for reimbursing crew members in conjunction with the plan.

### ***Termination of Employment***

If a crew member's employment with Vanguard is terminated for any reason within one year of receiving reimbursement for non-MSIT graduate level courses, the crew member is required to reimburse Vanguard 100% of any education assistance paid within the 12 month period prior to the termination. For MSIT courses, crew members terminating for any reason are required to reimburse Vanguard a) 100% of the assistance paid within 12 months of the termination and b) 50% of the assistance paid between 12 and 24 months of the termination.

Crew members enrolling in graduate level programs, including the MSIT program, must sign an agreement acknowledging the repayment requirements as part of the Academic Assistance application process. Repayment must begin within 30 days of the date of termination and must be completed within 90 days of the termination. Repayment arrangements are made through the Payroll Department.

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## **B. Adoption Assistance Plan**

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### ***Introduction***

The Adoption Assistance Plan provides financial assistance to eligible crew members seeking to adopt a child. This Plan is intended to qualify as an adoption assistance program under the meaning of Section 137 of the Internal Revenue Code.

### ***Eligibility***

If you are an active, regular full-time crew member (scheduled to work 37.5 or more hours per week) you are eligible for the Adoption Assistance Plan. Crew members classified as part-time, interns and seasonal crew members are not eligible for the Adoption Assistance Plan.

### ***Reimbursable Expenses***

Eligible reimbursable expenses mean reasonable and necessary adoption fees, court costs, attorney fees, traveling expenses (including amounts expended for meals and lodging while away from home) and other expenses that are directly related to the legal adoption of an eligible child. In addition, eligible expenses also include certain counseling expenses and uninsured maternity expenses of the birth mother. An eligible child means an individual who is not a relative of an eligible crew member or a domestic partner (please refer to Section II.H for details) and who:

- ❖ has not attained age eighteen (18); or
- ❖ is physically or mentally incapable of caring for oneself

### ***Exclusions***

Eligible reimbursement expenses do not include expenses that are:

- ❖ paid, reimbursed, or excused under any other program;
- ❖ incurred in violation of any state or federal law or in carrying out any surrogate parenting arrangement;
- ❖ incurred with respect to the adoption of a child of the eligible crew member's spouse (i.e. a step-child)
- ❖ incurred prior to the date the crew member becomes an eligible participant of the Plan; or
- ❖ incurred with respect to the adoption of an eligible child who is not a U.S. citizen or resident until and unless the adoption is finalized.
- ❖ incurred due to adopt the child of a domestic partner

### ***Reimbursement Procedures***

You may request reimbursement by completing the Adoption Assistance Benefit form located on *CrewNet* and mailing it to the Benefits Unit (along with documents reflecting proof of custody and substantiation of expenses). You must be an active crew member at the time of reimbursement. The maximum amount payable per adoption is \$5,000 (or \$6,000 in the case of an eligible child with special needs). A claim for reimbursement must be submitted prior to the end of the Plan Year following the Plan Year which includes the later of the date the adoption becomes final or the expense is incurred.

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## C. Crew Assistance Plan

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### ***Introduction***

The Vanguard Group, Inc. has established the Crew Assistance Plan (CAP) recognizing that a healthy crew member is the heart of a strong, healthy organization.

### ***Eligibility***

All active, regular full-time crew members or active, regular part-time crew members, and the spouses, domestic partners, dependent children and children of domestic partners of such crew members are eligible to utilize the Crew Assistance Plan. Crew members classified as interns and seasonal are not eligible to participate under this plan. To qualify as a dependent child under this plan, the child must meet the definition of “dependent” under Section 152 of the Internal Revenue Code and must be under 19 years of age.

### ***Participation***

Through self-referral crew members (and their eligible dependents as listed above) may use CAP for help with treatment and recovery associated with addiction, personal, or family issues. In addition, a crew member found to have violated Vanguard’s Drug- and Alcohol-Free Environment Policy, or whose emotional state is negatively affecting job performance, may be directed to CAP as a condition of continued employment at Vanguard. Admission to CAP will not exempt a crew member from other disciplinary action resulting from any other Vanguard policy violation that may occur subsequent to CAP enrollment. Any crew member seeking to participate in CAP should either contact CAP directly by calling (800) 366-4841, or contact the Crew Relations Representative for his or her department for information.

### ***How the Plan Works***

CAP involves the use of professional services – external to Vanguard – that provide the crew member (and/or spouse and dependent children) with a resource for assistance with personal, family, alcohol, or drug concerns. The individual will be evaluated by a CAP professional and, if appropriate, will be offered counseling up to eight sessions per year. CAP sessions are provided at no cost to the crew member, spouse, or dependent child. In most cases, issues can be resolved within CAP. However, if longer-term treatment is necessary, the CAP professional will refer the individual to an appropriate resource. **With the exception of instances of mandatory enrollment in CAP as a condition of employment, the CAP provider will not give Vanguard any information regarding a crew member’s involvement.**

### ***Termination of Coverage***

Termination of your coverage (and that of a spouse, domestic partner or dependent) under the CAP benefit occurs at the earliest of the following events:

- ❖ Your employment terminates;
- ❖ The plan or offered benefits terminates;
- ❖ You are no longer in an eligible class; or
- ❖ You fail to make any required contribution at then end of the period of which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.

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## D. Wellness Programs

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### ***Introduction***

Vanguard provides programs and opportunities for crew members to improve their mental and physical well-being. These wellness programs include prevention education, early detection screening, and informational programs.

### ***Eligibility***

All regular crew members, including those classified as interns and seasonal crew members, are eligible to participate in Vanguard's wellness programs.

### ***Participation***

Crew members may voluntarily participate in the wellness programs.

### ***Cost***

Vanguard subsidizes some of the costs of the wellness programs, but fees are required for some of the programs. The cost, if any, of each program will be determined at the time the program is offered. Information on the cost will be available on *CrewNet*.

### ***How the Plan Works***

Wellness Programs are offered throughout the year. Some programs do require registration. Information on all of the programs is provided on *CrewNet*. Please check the Work-Life tab for program information and registration.

### ***Termination of Eligibility***

Your eligibility to participate in Vanguard's wellness programs ends when your employment with Vanguard terminates.

## Section V— When You Have a Claim for Benefits

### ***Filing a Claim***

Certain of the claim-filing procedures for each type of benefit are outlined in the section of the SPD related to the benefit. In general, you, your eligible dependents or your designated beneficiary (as applicable) must file a written claim on the proper form and submit it to the claims administrator responsible for reviewing the claim. You can obtain the necessary claim forms on *CrewNet* or by calling Benefits at 1-800-407-8576 or 34BEN.

### ***What is a “Claim”?***

A request for benefits is a “claim” subject to these procedures only if it is a communication that is filed in accordance with the applicable plan’s claim filing guidelines. In general, claims must be filed in writing with the responsible third party insurer or claims administrator. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in Section VIII. A request for prior approval of a benefit or service where prior approval is not required under the applicable plan is not a “claim” under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under a plan is not a “claim” under these rules. If a claim is received, but there is not enough information to allow the applicable third party insurer or claims administrator to process the claim, you will be given an opportunity to provide the missing information.

### ***Designation of an Authorized Representative***

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable third party insurer or claims administrator identifying such authorized representative. In the case of a claim involving urgent care, a health care professional with knowledge of your medical condition may act as your authorized representative.

### ***Reviewing Your Claim***

The claim review procedures for each type of benefit are governed by the procedures described below. These procedures will not apply, however, to the extent that different claims procedures are set forth in the claim administration materials provided by a third party insurer or third party claims administrator with respect to certain benefits, except to the extent such claim procedures fail to comply with applicable law. Claim information materials from the Plan’s third party insurers and claims administrators with respect to certain benefits are located in the Appendix.

The claims administrator has a specified amount of time to evaluate and process claims for benefits from the date the claim is first filed, as follows:

- For claims other than those specifically mentioned below, this time period is 90 days. If more time is needed, you will be notified of the reasons for the extension within 90 days of the date the claim was first filed. In no event can this extension exceed an additional 90 days.
- For claims involving disability benefits, this time period is 45 days. If more time is needed, you will be notified of the reasons for the extension within 45 days of the date the claim was first filed. In no event will such extension exceed 30 days. If, prior to the end of the first 30-day extension period, it is determined that a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days (for a maximum claim determination period of 105 days).

- For claims involving group health plan benefits, the time periods vary depending on whether the claim is an urgent care claim, pre-service claim, post-service claim or concurrent care review claim. Group health plan benefits include medical (including retiree medical), dental, vision, prescription drug, crew assistance, healthcare reimbursement account and wellness programs. Specific details on the time periods for these types of claims can be found in Appendix N and in the claim administration materials provided by the Plan's third party claims administrators and insurers, also located in the Appendix Sections II through VII.

### ***If Your Claim Is Denied***

If your claim is denied in full or in part, your notice of the claim denial will include:

- the specific reasons for the denial;
- the specific plan provisions on which the denial is based;
- a request for any additional information needed to reconsider the claim and the reason this information is needed;
- for certain types of benefits, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request; and
- an explanation of the Plan's appeal procedures, including the time limits applicable for such procedures.

### ***Appealing a Denial***

If you receive notice that your claim has been denied and you disagree with the decision, you are entitled to appeal the denial. The appeal process described herein must be exhausted before you can pursue the claim in court.

### ***Group Health Plan Claims***

Appeal procedures for group health plan benefits (including the time periods for responding to such appeals) are described in the **Appendix, Section VIII**. These procedures will not apply, however, to the extent that different appeal procedures are set forth in the claim administration materials provided by third party insurers or claims administrators with respect to certain benefits, except to the extent such claims procedures fail to comply with applicable law. Claim administration materials from the Plan's third party insurers and claims administrators with respect to certain benefits are located in the Appendix Sections II through VI.

### ***All Other Claims***

For all other types of benefit claims, the following appeal procedures apply:

You (or your appointed representative) can appeal and request a claim review within 60 days after you have received the denial notice (180 days in the case of a claim involving LTD benefits). If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal. You must file your appeal in writing with the claims administrator responsible for reviewing the claim (see Section VIII). In some cases, the claims administrator may be Vanguard in which case you must file your written appeal with Vanguard's Benefits Unit. If you are unsure who the claims administrator is, you may contact the Vanguard's Benefits Unit.

Your appeal must state the specific reasons that you believe entitle you to benefits or to greater or different benefits.

The reviewer will reconsider your claim and will make a decision within 60 days after you file your appeal (45 days in the case of a claim involving disability benefits). If more time is needed, the reviewer may take up to an additional 60 days (45 days in the case of a claim involving disability benefits), so long as you are notified in advance of the need and reasons for the delay. If your claim is denied in whole or in part, you will be notified in writing of the reviewer's final and binding decision. This notice will include:

- ✓ specific references to the pertinent Plan provisions on which the decision is based;
- ✓ your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- ✓ for certain types of benefits, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request; and
- ✓ a statement of your right to bring a civil action under ERISA, if applicable.

See the "Your Rights Under ERISA" section for information on legal action you can take if after you have exhausted the appeal process you feel your right to a benefit that is subject to ERISA has been improperly denied.

## Section VI – Administrative Information

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### **A. Subrogation and Reimbursement Rights**

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#### ***Subrogation***

The Plan reserves the right to be subrogated to any and all claims of or on behalf of a participating crew member or covered spouse or dependent ("Covered Person") against a third party that involves recovery of amounts paid or payable under the terms of the Plan.

#### ***Reimbursement***

If a Covered Person receives any recovery with respect to a benefit claim made under the Plan in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a third party, (2) a liability insurer for a third party, or (3) any other source (including but not limited to any form of uninsured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverage, or any other form of insurance coverage), the Covered person must repay the Plan in full for any such benefits which have been paid or which will in the future have to be paid under the Plan for expenses already incurred or which are reasonably foreseeable at the time of said recovery. Reimbursement to the Plan will be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in collecting damages. The Plan may require a Covered Person as a precondition to benefit payments to both sign a reimbursement agreement and to agree, in writing, to assist the Plan to secure the Plan's right to reimbursement of payment from a third party.

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

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

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### **B. Amendment and Termination**

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Vanguard reserves the right to amend or terminate The Vanguard Group, Inc. Benefit Plan at any time by action of its Board of Directors or such other officers as may be authorized from time to time by the Board. Additionally, the Benefits Committee has authority to make any amendment to the Plan that will not have a material adverse financial impact on Vanguard or its affiliates. You will be notified if any material changes are made to The Vanguard Group, Inc. Benefit Plan.

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## C. ERISA Information

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

### ***Plan Sponsor***

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

The Vanguard Group, Inc.  
100 Vanguard Boulevard  
Malvern, PA 19355  
610-669-1000

### ***Employer Identification Number***

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

### ***Plan Administrator***

The Plan Administrator for the Plans is:

The Benefits Committee  
The Vanguard Group  
100 Vanguard Boulevard  
Malvern, PA 19355  
610-503-6863

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

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

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

The Vanguard Group, Inc.  
Human Resources Department  
100 Vanguard Boulevard  
Malvern, PA 19355

Questions can also be directed to Benefit at 1-800-407-8576 or 34BEN.

### ***Agent for Service of Legal Process***

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

The Vanguard Group, Inc.  
100 Vanguard Boulevard  
Malvern, PA 19355  
610-503-6863

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

### ***Plan Name***

The Vanguard Group Benefit Plan

### ***Plan Number***

506

### ***Plan Type***

The Plan includes medical, dental, vision, prescription drug, life insurance, disability, accidental death and dismemberment insurance, legal services, purchased vacation, health care and dependent care reimbursement accounts, academic assistance, adoption assistance and crew assistance and wellness benefits provided by Vanguard to eligible crew members.

### ***Plan Funding/Administration***

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

The benefits in the chart below are insured through contracts with insurance companies, vendors, or health maintenance organizations that also administer claims for these plans and are solely responsible for providing benefits.

<b>Insured Benefits</b>	<b>Insurer/Claims Administrator</b>
* Employee Life Insurance, Spousal Life Insurance, Dependent Children Life Insurance * Accidental Death and Dismemberment	Ætna Health Plans 1000 Middle Street Middletown, CT 06451
* Business Travel Accident	CNA Insurance Company 2599 Lucien Way Maitland, FL 32571
* Long Term Disability	Met Life One Madison Avenue New York, NY 10010-3690
* Legal	Hyatt Legal Plans, Inc. 1212 Superior Avenue Cleveland, OH 44114
* Health Maintenance Organization	Ætna Health Plans 1425 Union Meeting Road Blue Bell, PA 19422

The following benefits are self-insured by Vanguard through contributions made solely by Vanguard. Vanguard has engaged the services of the following third party administrators who are responsible for processing claims for these self-insured benefits:

<b>Self-Insured Benefits</b>	<b>Claims Administrator</b>
* <b>Medical</b>	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
* <b>Vision</b>	Independence Blue Cross (QCC) Vanguard Customer Service Team P.O. Box 13156 Philadelphia, PA 19101-3156
* <b>Dental</b>	Ætna Health Plans 1425 Union Meeting Road Blue Bell, PA 19422
* <b>Prescription Drug</b>	Caremark Inc. 2211 Sanders Road Northbrook, IL 60062
* <b>Flexible Spending Accounts (Health Care and Dependent Care)</b>	
* <b>Crew Assistance</b>	North, Clawson & Bolt, LTD. P.O. Box 593 Moorestown, NJ 08057
* <b>Short Term Disability</b>	VPA, Inc. 24025 Park Sorrento; Suite 200 Calabasas, CA 91302-1501

### ***Plan Year***

The Plan Year is January 1 - December 31.

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## **D. Your Rights Under ERISA**

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

ERISA provides that all participants in a plan covered by ERISA shall be entitled to:

### ***Receive Information About Your Plan and Benefits***

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

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

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

### ***Continue Group Health Plan Coverage***

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### ***Reduction or Elimination of Exclusionary Periods of Coverage for Preexisting Conditions under Your Group Health Plan***

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### ***Prudent Actions by Plan Fiduciaries***

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

### ***Enforce Your Rights***

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

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

### ***Assistance with Your Questions***

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of

Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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

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## **E. HIPAA PRIVACY**

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

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Federal law requires group health plans that provide mastectomy benefits to also provide certain related benefits and to tell participants that they are available.

In the case of a crew member or covered spouse or dependent who is covered under the Plan and who in connection with a mastectomy elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- ❖ reconstruction of the breast on which the mastectomy was performed;
- ❖ surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ❖ prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

These reconstructive benefits are subject to annual Plan deductibles and coinsurance provisions like other medical and surgical benefits covered under your medical plan.

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### **G. Notice Under the Newborn and Mothers Act**

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