RULES, REGULATIONS AND PLAN ADMINISTRATION

This section of your Summary Plan Description (SPD) outlines specific plan information and procedures, as well as your rights under the Group Benefits Plan.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This document is a Summary Plan Description (SPD) of the health and welfare benefit plans sponsored by People's United Bank, N.A. The company reserves the right to change, amend, or discontinue any plan or program described in this document. This document is intended for informational purposes only and does not constitute an employment agreement for any recipient. If there is a conflict between this SPD and the insurance contract or governing plan document, the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

TABLE OF CONTENTS

Your Rights Under ERISA

As a participant in the People's United Bank Group Benefits Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Receive Information About The Plan and Benefits

You have the right to:

- 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 collective bargaining agreements, 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 Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse, or your 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 and the rules governing your COBRA continuation coverage rights.

Prudent Action 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 benefits 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 People's United Bank (the "Bank"), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies or 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 Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (see "Claim Review and Appeal Procedures"), 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, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administration

Plan Name	Plan #	Plan Type	Funding Method	Contributions	Claims Administrator – Named Fiduciary for Benefit Claims
People's United Bank Group Benefits Plan	511				
• ***Medical (includes Prescription Drugs)***		Welfare	Self-insured	Employee and Company Contributions	Medical: Cigna Health and Life Insurance Company PO Box 182223 Chattanooga TN 37422 855-648-5934 www.mycigna.com Prescription Drug Benefits: Cigna Health and Life Insurance Company PO Box 188053 Chattanooga TN 37422 800-835-3784 www.mycigna.com
• ***Dental***		Welfare	Self-insured (PPO); Fully insured (DHMO)	Employee and Company Contributions	Cigna Health and Life Insurance Company PO Box 188037 Chattanooga TN 37422 855-648-5934 www.mycigna.com
• ***Basic Life and Accidental Death & Dismemberment Insurance, Dependent Life Insurance***		Welfare	Fully insured	Company Contributions	Life Insurance Company of America 1601 Chestnut Street Philadelphia, PA 19192-2235 www.mycigna.com
• ***Business Travel Accident Insurance***		Welfare	Fully insured	Company Contributions	Hartford Life and Accident Insurance Company Hartford Plaza 690 Asylum Avenue Hartford, CT 06115 888-747-8819 www.thehartford.com
• ***Long-Term Disability***		Welfare	Fully insured	Company Contributions	Life Insurance Company of America 1601 Chestnut Street Philadelphia, PA 19192-2235 800- 732-1603 www.mycigna.com

Plan Name	Plan #	Plan Type	Funding Method	Contributions	Claims Administrator – Named Fiduciary for Benefit Claims
• ***Vision***		Welfare	Fully insured	Employee Contributions	Cigna Vision PO Box 385018 Birmingham, AL 35238 855-648-5934 www.mycigna.com
• ***Long Term Care Insurance***		Welfare	Fully insured	Employee Contributions	Unum 2211 Congress St. Portland, ME 04122 800-227-4165 www.PeoplesLTC.com
• ***Voluntary Benefits (Accidental Injury, Critical Illness and Hospital Care Insurances)***		Welfare	Fully insured	Employee Contributions	Cigna Phoenix Claim Services P.O. Box 55290 Phoenix, AZ 85078
Flexible Spending Account(s): - Health Care - Dependent Care* - Health Savings Account*	510	Welfare	Self-insured	Employee Contributions	ConnectYourCare 307 International Circle, Suite 200 Hunt Valley, MD 21030 877-292-4040 www.connectyourcare.com

* The Dependent Care Flexible Spending Account and Health Savings Account are not benefits covered by ERISA.

Additional Information

Plan Sponsor

People's United Bank, N.A.
850 Main Street
Bridgeport, CT 06604

Plan Sponsor's Employer Identification Number

The People's United Bank, N.A. employer identification number (EIN) is 06-1213065.

Plan Administrator and Named Fiduciary

People's United Bank, N.A.
850 Main Street
Bridgeport, CT 06604
Attention: Senior Vice President, Human Resources

Plan Type

The benefits described herein are health and welfare benefits (the types of welfare benefit arrangements that are subject to the provisions of ERISA).

Plan Year

The plan year is January 1 – December 31.

Agent for Service of Legal Process

If you want to seek legal action against a plan, you may serve legal process on the Plan Administrator or the Senior Vice President, Human Resources for People's United Bank.

Plan Administration

The Plan is administered by the Plan Administrator. The Plan Administrator has broad authority to determine the status and rights of participants, beneficiaries and other persons, has the discretionary authority to make rulings and prescribe procedures, to gather needed information, to exercise all of the power and authority contemplated by ERISA with respect to the Plan, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, and generally to do all other things needed to operate, manage and administer the Plan. The Plan Administrator has full authority to construe and interpret the terms of the Plan and the decisions of the Plan Administrator shall be final and binding on all parties.

Claims are generally handled by the Claims Administrator, which is the insurance company in the case of an insured plan, or the third party administrator in the case of a self-insured plan and the Flexible Spending Accounts. In making any benefits determination under the Plan, the Claims Administrator has the exclusive discretionary authority both to determine an employee's eligibility for benefits and to construe the terms of the Plan.

The Plan has other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan.

Except to the extent required by ERISA, each fiduciary is solely responsible for its own improper acts or omissions and no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another plan fiduciary, to the extent provided in ERISA Section 405(a).

Plan Amendment and Termination

People's United Bank expects to continue to offer health and welfare benefits indefinitely for eligible employees. However, the Bank, in its sole discretion, reserves the right to amend, modify, increase the cost of, or terminate any plan or provision at any time, with respect to either current employees or terminated employees (including retirees), in accordance with applicable laws and subject to contractual obligations.

No Guarantee of Employment

Being a plan participant is not an employment contract, and your partnership in the Plan does not give you the right to keep your job with the Bank or any participating employer.

Participation under Special Circumstances

The information below provides an overview of what happens to your benefits under certain circumstances, including if you take a leave of absence or become disabled. For more detailed information, consult the Human Resources Policy Handbook under Time Away From Work.

Family and Medical Leave Act

The Family Medical Leave Act (FMLA) allows unpaid leave time when an eligible employee or covered family member has a serious health condition that requires medical care or treatment and the physician certifies the leave is necessary. Intermittent leave is permitted under certain circumstances.

If an employee takes an eligible leave under FMLA, the Bank is required to continue health insurance coverage on the same basis as prior to leave. At the conclusion of the approved leave, the employee will be reinstated to the same or equivalent job.

Your FMLA Rights

FMLA provides for continuation of coverage during a qualified leave if you are eligible for such a leave. If you take an eligible leave under FMLA, you may continue to pay your health insurance premiums on an after-tax basis. Or, if offered by the Bank, you may be able to make other arrangements (such as pre-paying on a pre-tax basis through extra salary reductions before you go on leave). A complete explanation of your FMLA rights and responsibilities will be furnished to you separately.

Eligible employees are entitled to a leave of absence for one or more of the following reasons:

- To care for a newborn child;
- Placement of a child with you for adoption or foster care;
- To care for a spouse, child or parent with a serious health condition;
- A serious health condition, which makes you unable to perform one or more of the essential functions of your job;
- A covered family member's active duty or call to active duty in the Armed Forces and/or
- To care for an injured or ill service member.

Continuation of Coverage Under FMLA

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by FMLA. If the Bank grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by the Bank.
If the Bank grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue health benefit coverage for you and your eligible dependents.

If any coverage the Bank allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date the Bank determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by the Bank.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Benefits terminate because your approved FMLA leave is deemed terminated by the Bank, you may, on the date of such termination, be eligible for COBRA on the same terms as though your employment terminated, other than for gross misconduct, on such date. If a plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date the Bank determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for the Bank following the date the Bank determines the approved FMLA leave is terminated, your coverage under a plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date the Bank determines the approved FMLA leave to be terminated. If you do not make such request within 31 days or do not return to work at least

31 days after your FMLA leave is terminated, coverage will again be effective only if and when the Plan Administrator gives its written consent, subject to the plan eligibility rules.

If any coverage being continued terminates because the Bank determines the approved FMLA leave is terminated, any conversion right will be available on the same terms as though your employment had terminated on the date the Bank determines the approved FMLA leave is terminated.

Military Leaves of Absence

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), employees who are called to national active military duty are entitled to a leave of absence for military service with reinstatement rights. The Bank will comply with any benefit continuation or reinstatement requirements of USERRA. Please contact the HR Info Line at 877-274-8383 if you have questions about benefits continuation during a military leave of absence.

Other Leaves of Absence

Benefits continue for you and your eligible enrolled dependents during an approved leave of absence as long as you continue to pay your share of the cost of coverage. During a paid leave, your share of the cost will continue to be paid through payroll deductions. During an unpaid leave, the Bank will provide you with information regarding arrangements for payment of your share of the cost of continued coverage. You have a 30-day grace period in which to make such payments. In the event that you do not pay your share of the cost on a timely basis, your benefits coverage for yourself and/or your dependents may be terminated for the remainder of your leave.

Continuing Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), you and/or your dependents may be eligible to continue health care coverage (called “COBRA coverage”) at group rates. This COBRA coverage is available in certain instances, called “qualifying events,” where coverage under the Medical, Dental, Vision and Health Care FSA Plans would otherwise end. You may elect to continue your Medical, Dental, Vision and Health Care FSA coverage at your own expense on an after-tax basis. COBRA coverage can be extended for a specific number of months, depending on the particular "qualifying event" that gave rise to the loss of coverage.

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

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. This information may change as permitted or required by changes in any applicable law.
You don’t have to show that you’re insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. The Bank reserves the right to terminate your coverage retroactively if it is determined that you’re ineligible under the terms of the Medical, Dental, or Vision Plans.

You will have to pay the entire cost of coverage — your share and the Bank’s — plus a 2 percent administrative fee. (Note: If you qualify for LTD benefits under the Plan, you will pay the same rate for COBRA coverage that an active employee pays for medical coverage.) There’s a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment following your election of COBRA continuation coverage. Failure to pay your premium on time will result in your loss of eligibility for COBRA coverage.

You may also, under certain circumstances, be eligible to continue — for the remainder of the year only — your participation in a Health Care FSA by making post-tax payments. Health Care FSA continuation under COBRA is generally available only if the money remaining in your account (the benefit amount elected less claims submitted) exceeds your required COBRA contributions for the remainder of the year when the qualifying event occurs. In other words, if the

amount you have already been reimbursed for the year equals or exceeds the money you had contributed to your account, you would not be eligible to continue participation under COBRA. You may not continue your Dependent Care FSA participation under COBRA.

COBRA AT A GLANCE

The following table provides an overview of available COBRA coverage.

Who Is Affected	Qualifying or Other Event	Who Is Eligible for COBRA Coverage†	Duration of COBRA Coverage
You	Your employment ends for reasons other than gross misconduct	You, your spouse, and dependent child (who lose coverage)	Up to 18 months
	You experience a reduction in hours below the level required for benefit eligibility	You, your spouse, and dependent child (who lose coverage)	Up to 18 months
	You are Social Security disabled when you become eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your spouse, and dependent child	Up to 29 months*
	You qualify for LTD benefits	You, your spouse, and dependent child	Up to 18 months (beginning after 5-month extension of coverage after termination of employment for a total of 23 months continuation)
Your Spouse or Dependent Child	You die	Your spouse, and dependent child (who lose coverage)	Up to 36 months
	You and your spouse become divorced or legally separated	Your spouse or your dependent child if the decree causes them to lose coverage	Up to 36 months
	Your spouse or dependent child is disabled when he/she becomes eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You , your spouse, and dependent child	Up to 29 months*
	You become entitled to Medicare (Part A, Part B, or both) less than 18 months before the end of your employment or reduction of hours that causes loss of coverage	Your spouse and dependent child (who lose coverage)	Up to 36 months
Your Dependent Child	Your dependent child is no longer an eligible dependent (for example, due to age limit)	Your dependent child (who loses coverage)	Up to 36 months

*You are required to provide proof of eligibility for Social Security benefits to be eligible for additional COBRA coverage beyond 18 months.

WHO IS ELIGIBLE FOR COBRA

If you're covered by the Medical, Dental, or Vision Plan, or Health Care FSA on the day before a qualifying event, you have the right to choose COBRA coverage if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (unless you are terminated because of your gross misconduct).

If you are the spouse of an employee and you are covered by the Medical, Dental, or Vision Plan on the day before the qualifying event, you are considered a qualified beneficiary. That means you have the right to elect COBRA coverage for yourself if you lose group health coverage under the Medical, Dental, or Vision Plan for any of the following reasons:

- The employee dies;
- The employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- Your divorce or legal separation from the employee; or

The dependent child of an employee who is covered under the Medical, Dental, or Vision Plan on the day before the qualifying event will also be considered a qualified beneficiary. This means the child has the right to elect COBRA coverage if his or her coverage under the Medical, Dental or Vision Plan is lost for any of the following reasons:

- The employee dies;
- The employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- The employee divorces or legally separates;
- The child ceases to be a "dependent child" under the Medical, Dental, or Vision Plan.

If you're enrolled in the Medical, Dental, or Vision Plan, or a General or Limited Purpose Health Care FSA and don't return to work following a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

YOUR DUTIES

The Bank will not be aware of all qualifying events — such as divorce or a child no longer qualifying as a dependent. Under COBRA law, an active employee, a family member, or their representative must inform the Plan Administrator (People's United Bank, Human Resources) of a divorce, legal separation, or a child's loss of dependent status under the Medical, Dental, or Vision Plan or Health Care FSA. You must notify the Plan Administrator within 60 days from the latest of (1) the date of the divorce, legal separation or loss of dependent status, (2) the date coverage is lost because of the event, or (3) the date on which you were informed of the responsibility to provide the notice.

Notifications can be made through www.my-peoples.com or by contacting the HR Info Line at 877-274-8383.
If an employee, family member, or personal representative fails to notify Human Resources and/or provide supporting documentation to Human Resources during this 60-day period, any family member who loses coverage will lose the right to elect COBRA coverage.

When Human Resources is notified that one of these events has happened, the COBRA administrator, ConnectYourCare, will in turn notify you that you have the right to choose COBRA coverage.

PEOPLE'S UNITED BANK'S DUTIES

Qualified beneficiaries will be notified of the right to elect COBRA coverage (without any action required by the employee or a family member) if they lose coverage because of any of the following events:

- The employee dies;
- The employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced; or
- People's United Bank experiences a bankruptcy.

Electing COBRA

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier or, if later, 60 days after you receive notice of your right to elect COBRA coverage. Your completed election form must be received by the COBRA administrator, ConnectYourCare, within this 60-day period. This election form will be provided to you along with the notice of your right to elect COBRA coverage.

An employee or family member who doesn't choose COBRA coverage within the 60-day time period described above loses the right to elect COBRA coverage, and coverage will end according to the applicable plan's normal provisions. The employee and family members will be required to reimburse the Bank for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

You will have the same opportunity to change coverage as active employees have, e.g., at open enrollment or if you gain a new dependent. This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified in the same way.

Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse and dependent child can elect COBRA coverage even if the covered employee chooses not to. However, an employee or spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA Coverage

Medical, Dental, and Vision Coverage

If elected, COBRA coverage begins on the first day of the month following the date your coverage as an active employee ends. For dependents that no longer satisfy the requirements for dependent coverage, COBRA coverage also begins on the first day of the month following the date their dependent coverage ends. However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is timely received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered spouse and dependent child for up to 18 months. Employees that terminate employment due to an approved LTD or Workers' Compensation claim will be offered COBRA continuation coverage for up to 18 months followed by 5 months of continuation on a direct bill basis, for a combined continuation of 23 months.

COBRA coverage for your covered spouse and dependent child may continue for up to 36 months if coverage would otherwise end because:

- You die;
- You divorce or legally separate;
- Your dependent child loses eligibility for coverage; or
- You become entitled to Medicare less than 18 months before the end of your employment or reduction of hours that causes loss of coverage.

Health Care FSA

You may also be eligible to continue Health Care FSA participation under COBRA until December 31 of the calendar year in which any of the above qualifying events occurs.

Cost of COBRA Coverage

Your cost for COBRA coverage is determined as described below. The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis by the first day of each month. For payments other than the initial payment, you have a grace period of 30 days. Failure to pay on a timely basis will result in cancellation of coverage.

Medical, Dental, and Vision Benefits

You and your covered dependents are generally required to pay the full cost of medical, dental, and/or vision coverage, which include the Bank's full cost for providing your coverage, plus an additional 2 percent of that amount to cover the cost of administrative services. If the Bank's cost for providing coverage changes, your cost will also change.

If you are continuing coverage after the expiration of the initial 18-month eligibility period due to a determination of Social Security disability, you may be required to pay up to 150 percent of the cost of COBRA coverage beginning with the 19th month of coverage.

If you are disabled under the Long-Term Disability Plan and not yet eligible for Medicare, People's United Bank will subsidize the cost of your COBRA coverage. You will pay the same cost as an active employee for Employee-Only coverage. However, your covered dependents will be required to pay the full cost of coverage as described above. The cost of group health coverage periodically changes. If the Bank's cost for providing coverage changes, your cost will also change. If you elect COBRA coverage, you will be notified of any changes in the cost.

Health Care FSA

If you are eligible to continue contributing to a Health Care FSA under COBRA, you must make your contributions on an after-tax basis. You are also required to pay an administrative fee for continuing your participation. This fee is equal to 2 percent of your contribution.

If You Become Entitled to Medicare

If you become entitled to Medicare while you are an active employee and you later experience a qualifying event (for example, terminate your employment or reduction in work hours), you and your dependents may be eligible for continued health care coverage when the qualifying event occurs. If you become entitled to Medicare after you elect to continue coverage under COBRA, your continued coverage under the Medical Plan will end on the date of your Medicare entitlement. Your covered dependents, however, can continue COBRA coverage for the remainder of the 18-month period.

Type of Coverage

The Medical, Dental, Vision, and Health Care FSA Plans available to you through COBRA are the same as the plans offered to active employees. Any changes to the plans for active employees will automatically apply to you and your dependents' COBRA coverage.

Annual Open Enrollment Period

While you are continuing coverage under COBRA, you and your covered dependents may change your medical, dental, and vision coverage during the annual open enrollment period. If you did not elect COBRA during the 60-day election period (see "Electing COBRA"), you may not elect it during a subsequent annual enrollment period.

Because Health Care FSA participation under COBRA ends on December 31 of the calendar year in which the qualifying event occurs, you may not elect to continue participation in a Health Care FSA during annual enrollment.

Qualified Status Changes

You may also make certain changes to your coverage if you incur a change in status, such as:

- Adding a new spouse, or a newborn, a newly adopted child, or a child that is placed for adoption to your Medical, Dental, and Vision Plan,
- Adding an eligible dependent who loses other medical coverage, and

- Adding a dependent to your medical coverage if required by a Qualified Medical Child Support Order.

You must contact Human Resources or the COBRA Administrator in writing within 60 days of the event that caused the status change in order to change your coverage while on COBRA. Coverage will be effective on the date of birth, adoption, or placement for adoption for newborn or newly adopted children who are enrolled within 30 days following birth, adoption, or placement for adoption. In the case of a domestic relations judgment, decree, or order, the child will be covered on the date specified in the judgment, decree, or order. In all other cases, coverage will be effective on the date you provide written notice of the event to Human Resources.

While you are continuing participation in the Health Care FSA under COBRA, you may submit eligible expenses for a new spouse or newborn or newly adopted child for reimbursement from your account.

Newborn and Newly Adopted Children

If you elect continuation coverage and then have a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage, the new child is a qualified beneficiary eligible for COBRA continuation coverage. In accordance with the terms of the Medical, Dental, and Vision Plans and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing Human Resources with written notice of the child's birth, adoption, or placement for adoption. This written notice should include information about the employee or qualified beneficiary receiving COBRA coverage and the new child who will be receiving COBRA coverage. Human Resources may ask you to provide documentation supporting the birth, adoption, or placement for adoption of the new child.

If you fail to notify Human Resources within 30 days following the date of birth, adoption, or placement for adoption, you will not be entitled to COBRA coverage for the new child.

A parent or legal guardian can make COBRA elections on behalf of a minor child.

Additional Qualifying Events

Your spouse and dependents may have additional qualifying events while they are covered by COBRA. These events can extend their 18-month continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the date of the first qualifying event that originally allowed them to elect coverage.

This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee dies or gets divorced or legally separated, or if the child stops being an eligible dependent child, but only if the additional event would have caused the spouse or dependent child to lose coverage under the Medical, Dental, or Vision Plan had the first qualifying event not occurred.

To be eligible for extended coverage, you must notify Human Resources in writing if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event, (2) the date coverage would have been lost because of the event, or (3) the date on which the qualified beneficiary is informed of the responsibility to provide the notice.

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, the qualified beneficiary may be asked to provide Human Resources with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by Human Resources:

- Death—a copy of the death certificate
- Divorce—a copy of the divorce decree
- Legal separation—a copy of the separation agreement
- Child no longer qualifies as a dependent—a copy of a driver's license or birth certificate showing the child's age

Notice of the additional qualifying event any required documentation must be provided to Human Resources in writing.

If a qualified beneficiary (or their representative) fails to provide the appropriate notice and supporting documentation, if required, to Human Resources during the 60-day notice period, the qualified beneficiary will not be entitled to extended COBRA coverage.

Special Rules for Disability

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is determined by the Social Security Administration to be disabled before the qualifying event or at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. It applies even to family members who aren't disabled.

To benefit from the extension, the qualified beneficiary must provide Human Resources with the disability determination within 60 days after the later of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying event occurs, (3) the date coverage is lost because of the qualifying event, or (4) the date on which the qualified beneficiary is informed of the responsibility to provide the notice. The notice of Social Security disability must be furnished to Human Resources before the end of the original 18-month COBRA coverage period.

If, during COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, you must notify Human Resources in writing within 30 days of either the re-determination or the date on which the qualified beneficiary is informed of the responsibility to provide the notice and the procedures for providing such notice. The 11-month COBRA extension will end at the end of the month in which the notice is received. The notice must include information about the employee or covered family member requesting a disability COBRA coverage extension or notifying Human Resources that he/she is no longer disabled.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and has another qualifying event during the 29-month continuation period, then the COBRA coverage period extends until 36 months after the date coverage was originally lost. The qualified beneficiary must provide the appropriate notice to Human Resources.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be terminated before the expiration of your applicable COBRA continuation coverage period for any of the following reasons:

- People's United Bank stops offering Medical, Dental, Vision, and/or Health Care FSA benefits to all employees.
- The premium for COBRA coverage isn't paid on time (within the applicable grace period).
- The qualified beneficiary becomes covered — after the date COBRA coverage is elected — under another group health plan.
- The qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected.
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

Health Care FSA participation under COBRA ends on the earlier of December 31 of the calendar year in which the qualifying event occurs or the date that any of the events listed above occurs.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- You or your dependent is covered by the Medical, Dental, or Vision Plan or Health Care FSA on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- You don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you inform Human Resources that you're definitively not returning to work; or
- The end of the leave, if you don't return to work.

However, if the Bank extends coverage beyond such date, COBRA coverage will begin when coverage is terminated and the applicable COBRA coverage period will be measured from the date when coverage is lost.

Continuing Benefits during Military Leave

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the date in which you enter active military service. However, according to your situation as outlined here, you have the following rights to continue coverage:

- If your military leave period is for thirty days or less, you have the right to continue medical coverage for yourself and dependents that were covered under our group Medical Plan at a cost of not more than the cost for a similarly situated active employee.
- If your military leave period is for more than thirty days, you have the right to elect COBRA-like continuation coverage for yourself and your dependents for up to 24 months from the date that military leave began or the date you fail to apply for or return to work with the Company, whichever is earlier. You will pay 102 percent of the cost of this coverage.

Trade Act of 2002 & Trade Adjustment Assistance Act of 2011

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be trade adjustment assistance (TAA) eligible individuals. TAA-eligible individuals who declined COBRA when they were first eligible can elect COBRA within the 60-days of the first day of the month in which they become TAA eligible individuals. Nonetheless, this election may not be made more than six months after the date the TAA-eligible individual's group health plan coverage ended. The TAA of 2011 amends COBRA to extend the maximum COBRA coverage period for such individuals to the later of, but not beyond, (i) the maximum COBRA coverage period, and (ii) January 1, 2014.

TAA-eligible individuals are also eligible for a health coverage tax credit of up to 72.5 percent of qualified health insurance premiums, including COBRA coverage. If you're in this situation, you'll be notified.

If you have questions about your extended ability to elect COBRA coverage or this tax credit, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 866 628 4282. More information about the Trade Act of 2002 and Trade Adjustment and Assistance Act of 2011 is also available at www.doleta.gov/tradeact.

Questions About COBRA

If you have any questions about COBRA coverage or the application of the law, contact Human Resources or the COBRA administrator, ConnectYourCare, at the addresses listed below. You may also contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's Web site at www.dol.gov/ebsa.

Also, you must notify Human Resources in writing immediately at the address listed below if:

- Your marital status has changed;
- You, your spouse, or a dependent child has changed address;
- A dependent child loses eligibility for dependent coverage under the terms of the Plan(s); or
- You, your spouse, or a dependent child are determined to be disabled or are determined to be no longer disabled by the Social Security Administration.

All notices and other communications regarding COBRA coverage and People's United Bank-sponsored group health plan should be directed to Human Resources at:

People's United Bank
Human Resources – BC03/RC563
850 Main Street
Bridgeport, CT 06604

Your initial COBRA election notice should be directed to the COBRA administrator, ConnectYourCare, at:
ConnectYourCare
P.O. Box 2639
Omaha, NE 68103

About QMCSOs

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for medical coverage as stated in the order. A QMCSO is a judgment, decree, or order issued by a court of law or a notice or ruling by a state agency and which has the force and effect of law under the applicable state law, which:

- Specifies your name and last known address;
- Specifies the child's name and last known address;
- Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- States the period of time to which it applies; and
- Specifies each plan to which it applies.

A QMCSO may not require health insurance coverage that is not already included under the applicable plan or policy. The People's United Bank Group Benefits Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of the procedures from the Claims Administrator.

For purposes of a QMCSO, the term "child" means your natural child, an adopted child or a child placed for adoption. Any requirements for enrollment and effective date described in this document, which apply to a newborn child, will also apply to an adopted child or a child placed for adoption. If a child placed for adoption is not adopted, all health coverage will cease when placement ends. No continuation provisions will apply.

Claim and Appeal Procedures

If the booklets and other descriptive materials you receive from the benefit plan vendors contain claims and appeal procedures, please refer to the claims and appeal procedures described therein for each welfare benefit plan. Otherwise, please refer to the general ERISA claims and appeal procedures described below. These procedures have been revised effective January 1, 2015.

Note: Dependent Care Flexible Spending account benefits are not subject to ERISA and are therefore not subject to these claims and appeal procedures.

Under U.S. Department of Labor ("DOL") regulations, you are entitled to full and fair review of any claims made under the People's United Bank Group Benefits Plan. The procedures described in this section are intended to comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and DOL regulations by providing reasonable procedures governing the filing of claims for plan benefits, notification of benefit decisions, and appeal of adverse benefit decisions including rescission of coverage. These procedures describe how benefits claims and appeals are made and decided for the respective benefits offered under the Plan.

Claims for benefits may be made directly to the applicable Claims Administrator for the particular benefit. The Claims Administrators for the welfare benefits vary by benefit and are listed in the *Plan Administration* Section. When you file a claim for benefits, the Claims Administrator will advise you of any benefits to which you are entitled under the benefit plan.

Appointment of Designated Representative

You may designate an authorized representative to file a claim or an appeal on your behalf. At all times, the appointment of an authorized representative is revocable by you. An insurer may require you to designate your authorized representative in writing using a form approved by the insurer.

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

Denial of a Claim/Adverse Benefit Determination

Special procedures apply if you receive an adverse benefit determination. An "adverse benefit determination" is a denial of your claim, in whole or in part, a reduction in or termination of benefits, or a failure to provide payment for a benefit.

For purposes of the Medical Plan, an adverse benefit determination also includes any rescission of coverage (cancellation or discontinuance of coverage that has a retroactive effect). The procedures that apply may depend on the type of claim.

- An Urgent Care Claim is one that (i) is medically determined to require a fast decision in order to avoid seriously jeopardizing your life or health or ability to regain maximum function or (ii) in the opinion of your physician, could cause severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.
- A Pre-Service Claim is one that requires notification or approval prior to receiving medical care.
- A Post-Service Claim is one that is filed for payment of benefits after care has been received. Claims for benefits under the Health Care Flexible Spending Account Plan will always be Post-Service Claims.
- A Concurrent Care Claim occurs when a health plan approves an ongoing course of treatment for a fixed period of time or a fixed number of treatments and (i) reconsideration results in a reduction or termination of treatment or (ii) an extension is requested beyond the initially approved time or number of treatments.

You will receive written notification from the Claims Administrator of an adverse benefit determination within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Health Benefits*		
- Urgent Care Claims	As soon as possible, not later than 72 hours	None
- Pre-Service Claims	15 days	15 days
- Post-Service Claims	30 days	15 days
- Concurrent Care Claims	Prior to termination of care (if sufficient notice)	None
Life Insurance, Long Term Care, and Business Travel Accident Insurance	90 days	90 days
Long Term Disability Benefits	45 days	up to two 30 day extensions

* Health Benefits include Medical, Dental, Vision, and Health Care Flexible Spending Account Plans

If the Claims Administrator needs more information to make a determination on your claim, you will be notified within a reasonable period of time and the notice will describe the required information. If your Urgent Care Claim is incomplete, then you will be notified within 24 hours of filing your claim. Extensions are permitted if the Claims Administrator determines that special circumstances beyond its control require an extension of time for processing the claim as described in the above table. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

The Claims Administrator's notice of an adverse benefit determination will include the following:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific benefit plan provision on which the adverse benefit determination was based;
- a description of any additional material or information needed for you to complete the claim and an explanation of why such material is necessary; and
- a description of the benefit plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the appeals process.

For claims for health or disability benefits, the Claims Administrator's notice of an adverse benefit determination will also include the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the information relied upon in making the determination; or a statement that such information was relied upon in making the adverse determination, and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- if the claim is for urgent care, a description of the expedited review process for urgent care claims.

For claims for benefits under the Medical Plan (and not the dental, vision or health Flexible Spending Account), the Claims Administrator's notice of an adverse benefit determination will also include the following:

- the date of service, health-care provider, and claim amount (if applicable), and any other information necessary to sufficiently identify the claim involved;
- diagnosis and treatment codes and their corresponding meanings or notice that you may request the codes; and
- the description of the Medical Plan's review procedures will include the internal appeals and external review processes, how to initiate an appeal, and the availability of and contact information for office of health insurance consumer assistance or other party who can assist individual with internal claims and appeals and external review processes.

APPEALING A CLAIM-INTERNAL APPEALS PROCESS

If you receive an adverse benefit determination, you or your duly authorized representative may submit either verbally or in writing a request for reconsideration of the claim to the Claims Administrator within the following timeframe:

Type of Claim	Time Limit for Appealing Denial
Health Benefits*	180 days
Life Insurance, Long Term Care, and Business Travel Accident Insurance	180 days
Long Term Disability Benefits	180 days

* Health Benefits include Medical, Dental, Vision, and Health Care Flexible Spending Account benefits.

Any such request may be accompanied by documents or records in support of the appeal. You or your representative are entitled to reasonable access to, and copies of, all documents, records and other information relevant to your claims for benefits and a listing of medical or vocational experts whose advice was obtained on behalf of the benefit plan in connection with the adverse benefit determination. A failure to request a review of an adverse benefit determination will be treated as full and complete agreement with the adverse benefit determination.

Your appeal for an Urgent Care Claim may require immediate action. In these situations, you or your physician should call or e-mail the Claims Administrator as soon as possible.

DETERMINATION ON APPEAL

The Claims Administrator will respond within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Appeal Denial	Extension Permitted
Health Benefits*		
- Urgent Care Claims	72 hours	None
- Pre-Service Claims	30 days	None
- Post-Service Claims	60 days	None
- Concurrent Care	Prior to termination of care (if sufficient notice)	None
Type of Claim	**Time Limit for Appeal Denial**	**Extension Permitted**
Life Insurance, Long Term Care, and Business Travel Accident Insurance	60 days	60 days
Long Term Disability Benefits	45 days	45 days

* Health Benefits include the Medical, Dental, Vision, and Health Care Flexible Spending Account Benefits.

If the adverse benefit determination on a claim for health or disability benefits was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional and provide a decision maker who was not consulted in connection with the adverse benefit determination that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical judgment. In making the determination on appeal, the Claims Administrator will not afford deference to the initial claim adverse benefit determination.

If the decision on appeal under the Medical Plan is based on a new rationale or evidence not taken into account in your initial adverse benefit determination, then the Claims Administrator will provide to you, free of charge, with the rationale or evidence sufficiently in advance of the final decision so that you can respond to the new rationale and/or evidence. In addition, you will have the right to review your claim file.

All necessary information with respect to an Urgent Care Claim will be provided by telephone, fax, and/or email.
In its response to the appeal, the Claims Administrator will explain, in writing, the following:

- the specific reason or reasons for the adverse benefit determination;
- specific reference to benefit plan provisions on which the adverse benefit determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement of your right to sue under Section 502(a) of ERISA; and
- a statement that you and your benefit plan may have other voluntary alternative dispute resolution options, such as a voluntary appeal to the Plan Administrator and mediation. One way to find options that may be available is to

contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Contact information will be included.

In its response to appeals involving health or disability benefits, the Claims Administrator's written explanation will also include the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the information relied upon in making the determination; or a statement that such information was relied upon in making the adverse determination, and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Notice of an adverse determination on appeal of an Urgent Care Claim may be provided orally, but written notice must be furnished not later than three (3) days after the oral notice.

In response to appeals involving benefits under the Medical Plan (and not the dental, vision of health Flexible Spending Account), the Claims Administrator's notice of an adverse benefit determination will also include the following:

- the date of service, health-care provider, and claim amount (if applicable), and any other information necessary to sufficiently identify the claim involved;
- diagnosis and treatment codes and their corresponding meanings or notice that you may request the codes;
- a discussion of the adverse benefit determination; and
- the description of the Plan's review procedures will include the internal appeals and external review processes, how to initiate an appeal, and the availability of and contact information for office of health insurance consumer assistance or other party who can assist individual with internal claims and appeals and external review processes.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

When an appeal is expedited, the Claims Administrator will respond orally with a decision within 72 hours, followed up in writing.

Exhaustion of Process/Legal Action

You must exhaust the appeals process before you bring any legal action in a court of law or arbitration. The time limit on filing a legal claim against the plan is the later of one (1) year from the date of the adverse benefit determination on appeal or three (3) years from the earliest date on which the claimant knew or should have known that he or she was entitled to benefits under the applicable benefit plan.

External Review Process

If you receive an adverse benefit determination under the Medical Plan and you have exhausted the internal appeals process, then you may be able to request an external review of your claim by an accredited independent review organization. The external review process applies only to an adverse benefit determination that involves (i) **medical judgment** (including, but not limited to, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational) or (ii) **a rescission of coverage**. The external review process is not available if:

- you were not covered under the Plan at the time are or service was provided;

- the adverse benefit determination is based on your failure to meet eligibility requirements;
- you have not exhausted the internal appeals process; or
- you have not provided all required forms and information to process an external review.

You or your authorized representative must send a written request for external review to the Claims Administrator within four (4) months of the date you received the final adverse benefit determination under the Medical Plan. You must also include a copy of the notice and all other relevant information that supports your request. The Claims Administrator will conduct a preliminary review to determine if your claim is eligible for the external review process. You will not be required to pay any fees. The Plan will pay the cost of the external review process.

EXPEDITED REQUEST FOR EXTERNAL REVIEW

You will not be required to exhaust the applicable internal appeals process before requesting an external review if:

- the Claims Administrator has failed to make a decision within the required timeframes;
- you and the Claims Administrator agree to bypass the internal appeals process;
- your life or health is in serious jeopardy; or
- you have died.

You will be notified of the decision of the external review organization within forty-five (45) calendar days of receipt of your request form and all necessary information. If your appeal related to an Urgent Care Claim, then a decision will be made no later than seventy-two (72) hours after receipt of the request.

The Claims Administrator will abide by the decision of the external independent review organization.

Appeal to the Plan Administrator

If you choose to file a voluntary appeal to the Plan Administrator or its designee following a decision by external review where applicable or an adverse benefit determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with the Claims Administrator or the ERO (including any EOBs); and
- Any applicable information that you have not yet sent to the Claims Administrator and the ERO.

If you file a voluntary appeal to the Plan Administrator, you will be deemed to authorize the Plan Administrator or its designee to obtain information from the Claims Administrator relevant to your claim.
Mail your written appeal directly to:

People's United Bank, N.A.
Human Resources – BC-03
850 Main Street
Bridgeport, CT 06604
Attn: Vice President, Benefits

The Plan Administrator or its designee will review your appeal of an adverse benefit determination. The reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension. The reviewer will follow relevant internal rules maintained by the Claims Administrator to the extent they do not conflict with the Plan's own internal guidelines.

The reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what plan provisions apply. All decisions by the Plan Administrator or its designee with respect to your claim shall be final and binding.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. You are not required to undertake a voluntary appeal before pursuing legal action.

If you choose not to file a voluntary appeal, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Authority of the Claims Administrators and Your Rights under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Plan and to make findings of fact in order to carry out their respective Claims decision-making responsibilities. Interpretations and claims decisions by the Claims Administrators are final and binding on Participants. If you are not satisfied with the Administrator's final appellate decision, you may file a civil action against the Plan under section 502 of the U.S. Employee Retirement Income Security Act (ERISA) in U.S. federal court. You and the Plan may have other voluntary alternative dispute resolution options, such as voluntary appeals and mediation. One way to find out what may be available is to contact the U.S. Department of Labor Office. If you are a U.S. resident, you may also contact the state insurance regulatory agency of the state in which you reside. If you file a lawsuit, you must do so within 180 days from the date of the Administrator's final written decision. Failure to file a lawsuit within the 180-day period will result in your waiver of your right to file a lawsuit.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) is a Federal statute that protects employees from discrimination due to health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. Group health plans, such as the Medical Plan, and providers cannot charge higher premiums or adopt eligibility rules that prevent employees from entering into a plan, or remove someone from a plan, based upon these factors.

Your Rights Under HIPAA

Pre-Existing Conditions

Preexisting condition exclusions are prohibited for all group health plans and health insurance issuers. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months of "the date of enrollment" — the time when the employee seeks entry into a new health plan.

Non-Discrimination

HIPAA contains rules that ensure that group health plans do not discriminate against participants or beneficiaries based on health status.

Eligibility Rules

Generally, group health plan eligibility rules must not discriminate against an employee based on any health factor. Eligibility rules include enrollment rules, effective dates of coverage, waiting or affiliation periods, late and special enrollment, eligibility for certain benefit packages, termination of coverage rules and others. Plans may contain separate eligibility rules for different groups of similarly situated individuals, but within the same group of similarly situated individuals, the eligibility rules must be the same.

Application to Benefits

Benefit limitations, such as dollar limits or specific exclusions, must affect participants generally. They may not be directed at specific participants. Plan amendments that apply uniformly to all participants and are implemented in a subsequent plan year are presumed to meet that requirement.

In general, "source of injury" restrictions are allowed. Group health plans may not deny coverage based on participation in dangerous recreational activities. However, plans may limit or exclude benefits for an injury resulting from such activities. For example, plans may limit coverage for injuries that stem from a motorcycling accident or exclude expenses incurred by a participant while bungee jumping. However, group health plans may not limit or exclude benefits for injuries resulting from domestic violence or a medical condition (physical or mental, such as depression). For example, plans may not exclude benefits for injuries that are generally covered because they were self-inflicted, if the injuries resulted from a medical condition such as depression.

Non-Confinement and Actively-at-Work

A plan may not require that coverage be delayed until the individual is no longer confined to a hospital. Likewise, a plan generally cannot require an employee to be "actively at work" when he completes a waiting period and becomes eligible, unless an employee absent due to health factors is treated as actively at work. However, if general plan rules require working a certain number of hours per week or month to remain eligible, they are enforceable even if the employee's inability to work the required hours is due to illness.

Favorable Treatment of Individuals with Adverse Health Factors

Group health plans may treat individuals with adverse health factors more favorably than others. For example, plans may extend coverage for a disabled dependent child of a participant beyond the normal age limit. A group health plan may charge an individual with an adverse health factor a higher premium or contribution if eligibility for enhanced or extended coverage is due to the adverse health factor. Group health plans may also charge an individual with an adverse health factor a lower premium or contribution than similarly situated individuals. For example, a plan may contain a "waiver of premium" clause for disabled employees.

Participant Rights and Responsibilities

The People's United Bank Group Benefits Plan offers participants certain rights and responsibilities. For example, members have the right to request complete and current information, the right to confidentiality of health care records (except as otherwise provided by law or contract), the right to continue coverage under COBRA under certain circumstances, and the right to file a formal grievance if complaints or concerns arise.

The Plan shall not be deemed to constitute a contract between People's United Bank and any participant or to be consideration or inducement for the employment of any participant or employee. Nothing contained in the Plan shall be deemed to give any participant or employee the right to be retained in the service of the Bank or to interfere with the right of People's United Bank to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon them as a participant of the Plan.

As a participant in the Plan, your responsibilities generally include providing necessary information about the covered individuals, and notifying the Plan Administrator about a change in your name, address, or any other important information that may be reasonably requested by the Plan Administrator. You also may need to receive pre-certification for certain treatment, hospitalization or other major services (e.g., mental health, substance abuse, and hospice).

Right to Recovery for the Plan

If the amount of the benefits paid by the Claims Administrator is more than it should have paid under the coordination of benefits (COB) provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. This excess amount includes the reasonable cash value of any benefits provided in the form of services.

If you or a covered dependent suffers an injury due to the negligence, wrongful act or omission by a third party, the plan has the right to pursue recovery of your medical expenses where permitted by law. For further details about the Plan's right to recovery, see the Subrogation and Right of Recovery section.

Subrogation and Right of Reimbursement– Expenses for Which a Third Party May Be Liable

DEFINITIONS

As used throughout this section, the term **responsible party** means any party actually, possibly, or potentially responsible for making any payment to a covered person due to a covered person's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

As used throughout this section, the term **insurance coverage** refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, worker's compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

As used throughout this section, a **covered person** includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the Plan.

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. No adult covered person hereunder may assign any rights that person may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

SUBROGATION

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a covered person has against any responsible party due to a covered person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. A covered person or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.

REIMBURSEMENT

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the covered person receives from any responsible party whether by settlement, judgement, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits provided by the Plan.

FIRST-PRIORITY CLAIM

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person acknowledges that the Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered

person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue the covered person's damage claim.

APPLICABILITY TO ALL SETTLEMENTS AND JUDGMENTS

The terms of this entire subrogation and right of reimbursement provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The Plan's claim will not be reduced due to any claim of fault on the part of the covered person, whether under comparative negligence or otherwise.

COOPERATION

The covered person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered person. The covered person and his/her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the covered person or the institution of court proceedings against the covered person.

The covered person shall do nothing to prejudice the Plan's subrogation or reimbursement interest or to prejudice the Plan's ability to enforce the terms of the plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan. A covered person shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder; specifically, no court costs, attorneys' fees or other representative's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine."

In the event that a covered person fails or refuses to honor his or her obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof, including, but not limited to, attorneys' fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the covered person has fully complied with his obligations hereunder, regardless of how those future medical benefits are incurred.

The covered person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The Plan reserves the right to notify the responsible party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The covered person acknowledges that the Plan has notified covered persons that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share personal health information in exercising its subrogation and reimbursement rights.

JURISDICTION

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered persons hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile. By accepting such benefits, covered persons agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

CONSTRUCTIVE TRUST

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that if he/she receives any payment from any responsible party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the Plan.

LIEN RIGHTS

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the covered person, the covered person's representative or agent; responsible party; responsible party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

ASSIGNMENT

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

INTERPRETATION

In the event that any claim is made that any part of this subrogation and right of Reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Worker's Compensation

If benefits are paid by a plan and the Plan Administrator determines you received Worker's Compensation benefits for the same incident, the Plan has the right to recover as described under the Subrogation and Right of Recovery section. The Plan will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided, you will notify the Plan Administrator of any

Worker's Compensation claim you make, and that you agree to reimburse the Plan as described above.

If benefits are paid and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, the Plan has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.