PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

TECHNOLOGY SERVICE CORPORATION EMPLOYEE HEALTH PLAN

Effective January 1, 2017

Benefit Year – January 1 to December 31

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INTRODUCTION

This document is a description of Technology Service Corporation Employee Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

Verification of Eligibility 800-550-8009

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Hospitalizations
Home Infusion Therapy (Intravenous, Enteral and Parenteral Services)
Inpatient Substance Abuse/ Mental Health Conditions
Durable Medical Equipment
Injectable Medication
Outpatient Procedures (potentially cosmetic only)
Transplants

Please see the Cost Management section in this booklet for details.

The Covered Person is ultimately responsible for obtaining required authorization for services. To minimize the risk of reduced benefits, the Covered Person should contact the utilization management administrator to make certain that the facility or attending Physician has initiated the necessary pre-certification process. If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by **$500.00**. The penalty for failure to pre-certify inpatient Hospital admissions will apply only to the hospital facility charge for the inpatient stay.

The Plan is a plan which contains a Network Provider Organization.

PPO name: Cigna
Internet: www.cigna.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person’s choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within a 50 mile radius from the Employee's residence.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives ancillary services by a Non-Network Provider at an In-Network facility.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Usual and Reasonable Charges

Non-Participating Provider charges shall be reimbursed as defined herein, but shall be subject to Usual and Reasonable charges as defined by the Plan. Any charges in excess of the Usual and Reasonable amount determined shall be excluded from the Plan and not covered, nor reimbursed.

If you use a non-network provider, you could be billed for the balance by the provider for the amount charged by the provider for medical services and the usual and reasonable amount allowed under this Plan for non-network providers. For emergency services, the Plan will pay the amount that would have been paid by Medicare for those services.

MEDICAL BENEFITS SCHEDULE

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
NON-NETWORK PROVIDERS ARE SUBJECT TO USUAL AND REASONABLE AS DEFINED IN THE DOCUMENT		
MAXIMUM BENEFIT LIMIT, PER CALENDAR YEAR	Unlimited	
MAXIMUM OUT OF POCKET LIMIT PER CALENDAR YEAR. The amounts shown below are the maximum amount that a participant will pay toward the cost of coverage, and include deductible, coinsurance and copayments including prescription drug copayments made during the calendar year. The limits are different for expenses with in-network or out-of-network providers. Once a participant has paid out their annual limit, then the Plan will pay 100% of allowed amounts for all benefits.		
DEDUCTIBLE, PER CALENDAR YEAR Amounts applied to the Deductible for charges from Network Providers WILL be used to satisfy the Deductible for charges from Non-Network Providers and vice versa.		
Per Covered Person	$500	$500
Per Family Unit	$1,500	$1,500
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$1,500	$2,000
Per Family Unit	$1,500	$2,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Network Providers WILL be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Network Providers and vice versa.		
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100% Cost containment penalties (such as failure to obtain prior approval when required) Non-Covered Expenses Amounts above Usual and Reasonable Charges or Balance Billing by non-network providers		
COVERED CHARGES ***Note: Benefits are payable as shown below. However, to the extent that a service is specifically described in the Summary of Benefits and Coverage and it is not specifically addressed below, benefits will be payable at the levels shown in the Summary of Benefits and Coverage.***		

COVERED SERVICES

Percentages listed indicate the portion of the Usual and Reasonable Charge that the Plan will pay in benefits subject to all exclusions and limitations described in this document. Deductibles and Co-insurance are the Covered Person's responsibility to pay.

Note: The visit maximums listed below are combined for Network and Non-Network expenses.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ROUTINE WELL ADULT CARE		
Office Visit including physical examination *Limited to one per calendar year*	100% deductible waived	100% deductible waived
Immunizations/flu shots	100% deductible waived	100% deductible waived
Hearing Exam	100% deductible waived	80% after deductible
X-rays & Lab Tests	100% deductible waived	100% deductible waived
Gynecological exam *Limited to one per calendar year*	100% deductible waive	80% after deductible
Pap smear *Limited to one per calendar year*	100% deductible waived	80% after deductible
Mammogram *Limited to one per calendar year*	100% deductible waived	80% after deductible
Prostate exam / PSA *Limited to one per calendar year*	100% deductible waived	80% after deductible
Bone Density *Limited to one per calendar year*	100% deductible waived	80% after deductible
Colonoscopy *Limited to one per 5 calendar years* *No Age restriction*	100% deductible waived	80% after deductible
ROUTINE WELL CHILD CARE *(for individuals from age 0 through age 18)*		
Office Visit including physical exam	100% deductible waived	80% after deductible
Lab tests and X-rays	100% deductible waived	80% after deductible
Immunizations/Flu shots	100% deductible waived	80% after deductible
Hearing Exam	100% deductible waived	80% after deductible
Vision Exam	100% deductible waived	80% after deductible

PREVENTIVE CARE

In addition to the items listed under Routine Well Care, the Plan will cover the following preventive services:

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force except for the recommendations issued in or around November of 2009 for breast cancer screening, mammography, and prevention are not considered to be current.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
HOSPITAL SERVICES		
Room and Board *Benefits payable at the semi-private room rate. Private room rates payable only if Medically Necessary and recommended by a Physician or semi-private rooms are not available.*	80% after deductible	80% after deductible
Emergency Room Facility	80% after deductible	80% after deductible
Contact OrchestrateHR for Utilization review at (800) 550-8009 of the admission. In cases of weekend or holiday admissions, the call must be made the later of 48 hours or the first business day after the emergency admission.		
Routine Well Newborn Care (Inpatient Care)	80% after deductible Charges are applied to the mother if enrolled timely	80% after deductible Charges are applied to the mother if enrolled timely
Pre-admission Testing	100% deductible waived	100% deductible waived
Inpatient Private Duty Nursing *Lifetime Maximum: $10,000 combined with outpatient private duty nursing care maximum*	80% after deductible	80% after deductible
Outpatient Services, excluding diagnostic x-ray and laboratory tests	80% after deductible	80% after deductible
Outpatient x-ray and lab services (Handling fees not covered)	100% deductible waived	80% after deductible
Inpatient visits Includes inpatient well newborn care	80% after deductible	80% after deductible
PHYSICIAN SERVICES		
Emergency Room Physician	80% after deductible	80% after deductible
Inpatient Visits Includes inpatient well newborn care	80% after deductible	80% after deductible
Office Visit *To include laboratory services, x-rays, diagnostic tests and injections (except for maternity, allergy and specialty). (Handling fees not covered)*	100% after $25 copayment	80% after deductible
Office Visit Services *These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below. (Handling fees not covered)*	100% deductible waived	80% after deductible
Allergy Testing	100% deductible waived	80% after deductible
Allergy injections and serum	100% after $25 copayment	80% after deductible
Injections and Specialized Treatment-Specialized Medicine Subject to $500 penalty if not pre-certified Specialized treatment; such as administered infusion and Chemotherapy in the Physician's office.	80% after deductible	80% after deductible
Inpatient Surgery	80% after deductible	80% after deductible
Outpatient Surgery	80% after deductible	80% after deductible
Office Surgery	100% after $25 copayment deductible waived	80% after deductible
Oral Surgery Inpatient Outpatient or Ambulatory Surgery Center	 80% after deductible 80% after deductible	 80% after deductible 80% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Extraction of Impacted Wisdom Teeth	80% after deductible	80% after deductible
PHYSICIAN SERVICES		
Bariatric Surgery *An individual is not eligible for bariatric surgery until the person has been covered continuously by the Plan for one year. See additional limitations in Plan Exclusions section under Obesity.* ***Benefits are not provided out of network.***	80% after deductible	Not Covered
Second Surgical Opinion	100% deductible waived	100% deductible waived
Endoscopic Tests (Non-Routine)	80% after deductible	80% after deductible
OTHER SERVICES		
Skilled Nursing Facility *Benefits payable at the facility's semiprivate room rate.*	80% after deductible	80% after deductible
Contraceptive Management Office Visit Injections Implants Intrauterine Device Diaphragm Female condom	 100% 100% 100% 100% 100% 100%	 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible Not Covered
Urgent Care Center –Visit only	100% after $25 copayment deductible waived	80% after deductible
Ambulatory Surgical Center	80% after deductible	80% after deductible
Birthing Center	80% after deductible	80% after deductible
Diagnostic x-ray and Lab services including MRI, CAT Scans, PET scans and Genetic Testing (not in Physician office and non-routine)(Handling fees are not covered)	100% deductible waived	80% after deductible
Organ Transplants *See Medical Benefits section for limits*	80% after deductible	80% after deductible
Organ Procurement *See Medical Benefits section for limits*	80% after deductible	80% after deductible
Maternity Services *First Office Visit to diagnose* *Prenatal and Inpatient* *(charges applied under the mother's plan)*	100% after $25 copayment 80% after deductible	80% after deductible 80% after deductible
Sterilization (elective) **Male** Inpatient Outpatient or Ambulatory Surgery Center	80% after deductible 80% after deductible	80% after deductible 80% after deductible
Sterilization (elective) **Female** Inpatient Outpatient or Ambulatory Surgery Center	 100% deductible waived 100% deductible waived	 80% after deductible 80% after deductible
Impotence Testing	Not Covered	Not Covered
Infertility Testing and Treatment	Not Covered	Not Covered
Outpatient Private Duty Nursing *Lifetime Maximum: $10,000 combined with inpatient private duty nursing care maximum*	80% after deductible	80% after deductible
Home Health Care *Limited to 100 visits per Calendar Year*	80% after deductible	80% after deductible
Hospice Care (Inpatient or outpatient) *Lifetime maximum: 180 days*	80% after deductible	80% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care (Family Counseling and Bereavement Counseling)	80% after deductible	80% after deductible
Occupational Therapy	80% after deductible	80% after deductible
OTHER SERVICES		
Speech Therapy	80% after deductible	80% after deductible
Physical Therapy	80% after deductible	80% after deductible
Cardiac Rehabilitation Therapy	80% after deductible	80% after deductible
Chemotherapy	80% after deductible	80% after deductible
Radiation Therapy	80% after deductible	80% after deductible
Infusion Therapy	80% after deductible	80% after deductible
Jaw Joint/TMJ Services Surgical Treatment Non-surgical Treatment	 80% after deductible Not Covered	 80% after deductible Not Covered
Durable Medical Equipment and Supplies	80% after deductible	80% after deductible
Hearing Aids and related devices, tests and exams for fitting *Calendar Year maximum: $1,000*	100% deductible waived	100% after deductible
Diabetic Education	80% after deductible	80% after deductible
Wig after Chemotherapy	80% after deductible	80% after deductible
Smoking Cessation	100% deductible waived	100% deductible waived
Prosthetics	80% after deductible	80% after deductible
Pain Management	80% after deductible	80% after deductible
Orthotics	80% after deductible	80% after deductible
Orthopedic Shoes	Not Covered	Not Covered
Spinal Manipulation Chiropractic *Limited to 25 visits per Calendar Year*	100% after $25 copayment deductible waived	80% after deductible
Acupuncture *Calendar Year Maximum: 12 visits*	100% after $25 copayment deductible waived	80% after deductible
Biofeedback	80% after deductible	80% after deductible
MENTAL HEALTH		
Inpatient	80% after deductible	80% after deductible
Partial Hospitalization	80% after deductible	80% after deductible
Outpatient (includes group and family therapy)	80% after deductible	80% after deductible
Office Visit (includes group and family therapy)	100% after $25 copayment	80% after deductible
SUBSTANCE ABUSE		
Inpatient	80% after deductible	80% after deductible
Partial Hospitalization	80% after deductible	80% after deductible
Outpatient	80% after deductible	80% after deductible
Office Visit	100% after $25 copayment	80% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT		
	NETWORK	**NON-NETWORK**
NOTE: If a Covered Person requests a Brand Name Drug instead of a Generic Drug recommended by the pharmacy, the Covered Person will pay the Brand Name Drug coinsurance as well as the prescription costs between the Brand Name and Generic Drugs.		
Pharmacy Option (30 Day Supply)		
Generic Drugs	$10 co-payment	Prescriptions are only covered at participating pharmacies
Contraceptives - Generic	No co-payment	Prescriptions are only covered at participating pharmacies
Brand and Formulary Drugs	$25 co-payment	Prescriptions are only covered at participating pharmacies
Non-Formulary Brand Name Drugs	$45 co-payment	Prescriptions are only covered at participating pharmacies
Specialty drugs are covered under the prescription plan only at Cigna Specialty Pharmacy subject to drug type co-payments.		
Mail Order Option (90 Day Supply)		
Generic Drugs	$20 co-payment	Not Applicable
Brand and Formulary Drugs	$35 co-payment	Not Applicable
Non-Formulary Brand Name Drugs	$55 co-payment	Not Applicable
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

VISION CARE BENEFIT SCHEDULE

COVERED CHARGES	BENEFIT
Eye Exam, one per calendar year	100% up to $70, deductible waived
Children up to age 18, one per calendar year	100%, deductible waived
Total Hardware allowance to include: Lenses, frames, contact lenses per calendar year	$250

Additional information on Vision Care can be found in the Vision Care Benefits section of this document.

DENTAL CARE BENEFIT SCHEDULE

DENTAL CARE BENEFIT	
DENTAL CARE DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$50
Calendar Year Deductible applies to these classes of services: Class B Services - Basic and Class C Services – Major	
MAXIMUM BENEFIT AMOUNT	**BENEFIT**
For Class A - Preventive, Class B - Basic and Class C - Major Services Per Covered Person per Calendar Year	$1,500 Unlimited to children under the age of 14.
COVERED CHARGES	
Dental Percentage Payable Class A Services - Preventive Class B Services - Basic Class C Services – Major	 100% 80% 50%

Additional information on Dental Care can be found in the Dental Benefits section of this document.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage.

A person is eligible to enroll (and if enrolled, remain enrolled) for Employee coverage from the first day that he or she is:

(1) a Full-Time Employee of the Employer;

(2) in a class eligible for coverage; and

(3) actively at work or on leave from work due to approved leave under the Family and Medical Leave Act (FMLA).

An Employee is considered to be Full-Time if he or she is on the regular payroll of the Employer as an Employee and normally works at least 30 hours per week on a non-seasonal basis, or as determined by the Employer's most recent Measurement Period.

Early Retirement Extended Medical Coverage

Effective January 1, 2006, TSC will extend the medical plan coverage period ("Extended Medical Coverage") for Employees who elect to retire early from TSC ("Early Retirement") and meet the qualifying and procedural standards established by this policy.

Eligibility:

1. The Employee must have satisfactorily completed at least five (5) years of active TSC service prior to the date of Early Retirement (end of employment due to retirement), and have reached the established Social Security early retirement age, which is currently set at age 62 years old, but not be older than the date of Medicare eligibility, and

2. The Employee must notify TSC, in writing, prior to the date of Early Retirement to request Extended Medical Coverage. Employees requesting Extended Medical Coverage may also continue to cover those Dependents who are eligible for and enrolled in the TSC Medical Plan at the date of the Employee's Early Retirement. The TSC Human Resources Department will process the request and advise the Employee, in writing, of eligibility status.

Benefit & Conditions:

1. Extended Medical Coverage will allow those eligible and approved Employees (and, where relevant, Dependents) for the period from the date of the employee's early retirement to the date that he/she becomes eligible for Medicare benefits, plus twelve (12) months. The current date Employees become eligible for Medicare is the month that they reach age 65. Dependents may not be covered for a period beyond 12 months after the Employee has become eligible for Medicare.

2. To be and remain enrolled, employees who are eligible and approved for Early Retiree Medical Coverage are responsible for paying TSC, in advance, the cost of coverage equal to the then current monthly COBRA premium(s).

3. Administration of Extended Medical Coverage with regard to qualifying events, calculation of premiums, and

other administration issues will follow the COBRA guidelines established by the U.S. Department of Labor and the U.S. Treasury Department, and the policies and procedures of the TSC Medical Plan and other applicable TSC policies.

4. TSC reserves the right to modify or terminate or substantially modify Extended Medical Coverage by providing no less than twelve (12) months advance notice of its intention to do so.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, Technology Service Corporation, 962 Wayne Avenue, Suite 800, Silver Spring, Maryland, 20910,

In the event the domestic partnership is terminated, either partner is required to inform Technology Service Corporation of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children, adopted children and children placed for adoption with the Employee's Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student

status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years and primarily dependent upon the covered Employee for support and maintenance. Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; any former Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Domestic Partner, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Technology Service Corporation shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

This Plan allows Employees to pay their contributions for health care coverage on a pre-tax basis. A portion of the Employees' compensation is deducted from their paycheck before their taxes are calculated. In this way, Employees pay for their health care coverage with pre-tax dollars and pay less in taxes.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children.

A newborn child must be enrolled within 30 days after birth. If the newborn child is not enrolled on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For newborns enrolled in the Plan, charges for covered routine Physician care and nursery care will be applied toward the mother's Plan. Coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities, or complications resulting from prematurity will be applied toward the Plan of the newborn child.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife or Domestic Partners) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

CHANGES IN PLAN ENROLLMENT

As discussed in the Funding section above, the Employer offers a premium conversion plan that allows Employees to make pre-tax contributions to this Plan. For this reason, covered Employees are generally not permitted to make a change in the Plan coverage options they elected at the initial enrollment period for a Plan Year. However, covered Employees may change their level of coverage under certain circumstances permitted by the Employer and Internal Revenue Service regulations and rulings.

If a covered Employee experiences a change in status or other permissible event and wishes to change his or her level of coverage, he or she must submit an enrollment application to the Plan Administrator within 30 days after the change. The change in coverage must be consistent with the change in status or other permissible event (i.e., the event must affect eligibility for coverage and the election change must be on account of and correspond with the event). The Plan Administrator reserves the right to require the Employee to submit proof of any change of status or other event at the Employee's expense. Coverage will become effective on the date that the change in status or other event occurs or takes effect (except as otherwise required by law) provided that the Employee has met all eligibility requirements of the Plan.

A change in status is:

- a change in the covered Employee's legal marital status including marriage, divorce, death of a Spouse, legal separation, and annulment;
- a change in the covered Employee's number of Dependents, including birth, adoption, placement for adoption, and death;
- a change in the employment status of the covered Employee or the covered Employee's Dependent, including a leave of absence or switching from full-time to part-time employment;
- a change that causes a Dependent to satisfy or cease to satisfy the requirements for coverage under the Plan,
- a change in the residence of the covered Employee or Dependent, and
- a commencement or termination of adoption proceedings.

Other permissible events include significant cost changes; significant coverage curtailment; addition or significant improvement of benefit package option; change in coverage under other employer's plan; loss of coverage under group health plan of governmental or educational institution; HIPAA special enrollments; COBRA qualifying events; judgments, decrees, or orders; Medicare or Medicaid entitlement; FMLA leaves of absence.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

There may be a right to enroll in this Plan if (a) an Employee or Dependent loses eligibility for coverage under Medicaid or a State child health plan or (b) if the Employee or Dependent becomes eligible for assistance under such Medicaid plan or State child health plan. However, the Employee must request enrollment within 60 days after (a) the date the Medicaid or State child health plan coverage ends or (b) the date the employee or dependent is determined to be eligible for such assistance, as applicable.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Coverage obtained due to this Special Enrollment event will be effective on the day after the other coverage ends.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Dependent beneficiaries.** If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event,

the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received, or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee who enrolls in a timely manner (see Enrollment section) will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Effective dates for Special Enrollees and Late Enrollees are identified in the Enrollment section.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The day the Covered Employee ceases to be in one of the Eligible Classes (including death or termination of Active Employment of the covered Employee) or is no longer actively at work due to disability, leave of absence (whether approved or not) for a period of more than five days unless the Plan specifically provides for continuation during these periods.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability. A person may remain eligible for a limited time if Active, full-time work ceases due to disability. This continuance will end as follows:

For disability leave only: A person may remain eligible for a limited time if full-time work ceases due to Employer-certified disability and the person continues to be classified as an Employee by the Employer and pays the required contributions toward the cost of coverage. This continuance will end 6 months after the Employee’s last day of full-time work.

While continued, coverage will be that which was in force on the last day worked as an Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Rehiring a Laid-off Employee or reinstating an Employee who lost coverage due to reduction in hours. Employees who are called back to work within 31 days after a layoff or who increase hours to full-time status within 31 days after a reduction in hours may reapply for coverage within 31 days after the return to work or the increase in hours.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Technology Service Corporation, 962 Wayne Avenue, Suite 800, Silver Spring, Maryland, 20910,. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

Every December, the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverage options are right for them.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless there is a change in status during the year (such as birth, death, marriage, divorce, adoption, or loss of coverage due to loss of a Spouse's employment). See the section on Changes in Plan Enrollment. To the extent previously satisfied coverage Waiting Periods Limits will be considered satisfied when changing from one plan to another plan. Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

Employees and their Dependents who are not already enrolled in the Plan will also be able to enroll in the Plan during the annual open enrollment period.

Plan Participants will receive detailed information regarding open enrollment from their Employer

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Technology Service Corporation Employee Health Plan, including the ones described in this document. The Maximum Benefit Amount for Essential Health Benefits will not apply in Plan Years beginning on or after January 1, 2014.

COVERED CHARGES

The Plan Administrator shall have full, sole, full and final discretionary authority in determining that a condition, treatment, or surgery meets the established criteria of a covered charge under the plan.

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.
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(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 48 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee, covered Spouse or dependent.

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

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional

procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(d) If a Certified Registered Nurse Anesthetist (CRNA) is required, the CRNA's covered charge will not exceed 50% of the Anesthesiologist's Usual and Reasonable Charge.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Charges for Private Duty Nursing Care are subject to the limits as described in the Schedule of Benefits.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled

Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Biofeedback.**

(d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(f) Initial **contact lenses** or glasses required following cataract surgery.

(g) **Diabetic Education**. The Plan covers diabetic self-management education. Coverage is limited to visits for the diagnosis of diabetes, when a Physician diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in the Covered Person's self-management, or where reeducation or refresher education is necessary. Coverage includes home visits when Medically Necessary.

The diabetic education must be provided by a Physician or other licensed health care provider, or his or her staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian, upon the referral of a Physician or other licensed health care provider.

(h) Rental and / or purchase of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. NOTE: Benefits for rental charges of durable medical or surgical equipment are limited to the Usual and Reasonable Charge for the purchase price of the equipment.

The Plan also covers necessary maintenance and repairs of purchased durable medical equipment and loaner equipment used while repairs are being made. Replacement is covered only if (i) the patient has experienced a change in his or her physiological condition, or (ii) required repairs would exceed the cost of a replacement device or the parts that need to be replaced, or (iii) there has been irreparable change in the device's condition or in a part of the device due to normal wear and tear.

Replacement of lost or stolen equipment is not a covered expense.

(i) **Dialysis Treatment.** Renal dialysis visits will be payable as shown in the Schedule of Benefits.

(j) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(k) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(l) Treatment of **Mental Health Conditions and Substance Abuse**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Health Conditions and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or treatment limitation on

Mental Health Conditions and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Health Conditions and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment limits shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(m) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth. This repair must be made within 6 months from the date of an accident.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate not related to fitting of dentures.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(n) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(o) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue. Transplants for other organs or tissues are not covered.

- Heart
- Heart/Lung
- Lung
- Double Lung
- Liver
- Pancreas
- Kidney
- Cornea

- Bone Marrow and/or Peripheral Blood Stem Cell

The Plan will cover selective testing of potential donors from an organ registry (no benefits for screening of general population) and donor charges for organ procurement including.

- removing, preserving, and transporting the organ from a non-living donor
- for a live donor, costs involved in screening the donor, transporting the donor to and from the site of the transplant (up to a maximum of $5,000), removing the organ, and providing interim and follow-up care,
- in the case of a bone marrow transplant, removing the marrow and storing the marrow up to the time of reinfusion.

Benefit payments for donor charges are subject to the separate Donor Maximum Benefit limit as shown in the Schedule of Benefits.

When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. The Plan will always pay secondary to any other coverage.

The Plan also covers assessment/evaluation charges, transplant related care prior to transplantation, transplantation services, retransplantion services of the same organ/tissue type performed within one year after the transplant, and follow-up care, including transplant related services after discharge from the Hospital and immuno-suppressant therapy.

The following services are not provided under the Organ Transplant benefit:

1. Travel, lodging and other non-medical expenses for your travel companion other than to accompany you to and from the Transplant Program Provider (see Special Transplant Benefit below). Non-medical expenses include but are not limited to: Charges for the repair or maintenance of a motor vehicle; Personal expenses incurred for the maintenance of your or your travel companion’s residence. Examples of these are childcare costs, house-sitting costs, or kennel charges;
2. Reimbursement of any wages lost by you or your travel companion;
3. The services and medical expenses incurred by a donor (except as specified under covered services) as a result of such transplant procedure.
4. Expenses associated with clinical trials.

Additional Covered Benefits

1. Access to transplant Centers of Excellence across the United States
2. Reimbursement for travel and lodging expenses incurred during the transplant (immediately prior to and after the transplant) up to a $5,000 maximum for the Covered Person and a companion. Travel and lodging discounts are also available with select airlines and hotels.
3. Waiver of Covered Person’s deductible and out-of-pocket expenses, up to a $1,500 maximum.
4. Services of a Transplant Facilitator, who will coordinate the cost savings.

These benefits are only available when a Covered Person fully participates in the Special Transplant Program and meets all of the following requirements:

1. Pre-notification of the upcoming transplant must be given by the Covered Person or his or her Physician as soon as the Covered Person is identified as a potential transplant candidate. Pre-notification must be made to OrchestrateHR at (800) 550-8009.

2. Pre-certification must be obtained by calling OrchestrateHR; and

3. All transplant services must be rendered at a transplant Center of Excellence facility in the preferred transplant network.

If these requirements are not met, Special Transplant Program benefits may be reduced.

A Center of Excellence is a facility designated by the Utilization Management Administrator as an approved transplant facility.

General Provisions

Early notification to OrchestrateHR at (800) 550-8009 must be made as soon as the Covered Person is identified as a potential transplant candidate. Once enrolled in the program, a Transplant Facilitator will be assigned and will coordinate the cost savings with the patient and Physician from Hospital selection to travel arrangements to prescription drug options. The Transplant Facilitator will contact OrchestrateHR for benefit information, as well as contact the Covered Person's referring Physician for additional information. Information on the program will be forwarded to the Covered Person regarding network Hospitals and other relevant information. The Transplant Facilitator will work with the Covered Person, his Physician, and the Claims Administrator to ensure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

(p) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. However, orthopedic shoes and corrective shoes are NOT covered.

(q) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(r) **Prescription** Drugs (as defined).

(s) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - -Women's contraceptives, sterilization procedures, and counseling.
  - -Breastfeeding support, supplies, and counseling.
  - -Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - -Diphtheria,
  - -Pertussis,
  - -Tetanus,
  - -Polio,
  - -Measles,
  - -Mumps,
  - -Rubella,
  - -Hemophilus influenza b (Hib),
  - -Hepatitis B,
  - -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(t) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. This does not include dental prosthetics or dentures.

(u) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(v) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat

or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Health Conditions.

(w) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

(x) **Sterilization** procedures.

(y) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(z) Surgical treatment for bone degeneration, arthritis, or a medical diagnosis related to Temporomandibular **Joint Dysfunction (TMJ) and Myofascial Pain Dysfunction (MPD).**

(aa) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the first 4 days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

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

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for routine pediatric care for the first 4 days after birth while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(bb) Charges associated with the initial purchase of a **wig after chemotherapy**.

(cc) Diagnostic **x-rays**.

(dd) **Genetic Testing.** Testing recommended by the U.S. Preventive Services Task Force or testing considered medically necessary. Medically necessary must meet at least one of the following:

(a) The test result will directly impact/influence the disease treatment of the covered member.
(b) The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
(c) Conventional diagnostic procedures are inconclusive.
(d) The patient has risk factors or a particular family history that indicate a genetic cause.

(e) The patient meets defined criteria that place them at high genetic risk for the condition.

Exclusion

Genetic testing is not covered for:

(a) Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies.
(b) Informational purposes alone (i.e., testing of minors for adult-onset conditions, and self-referrals or home testing).
(c) Test is considered Experimental or Investigational.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

OrchestrateHR
800-550-8009

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 in advance of services being rendered or within 24 hours after a Medical Emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Home Infusion Therapy (Intravenous, Enteral and Parenteral Services)
Inpatient Substance Abuse/ Mental Health treatments
Durable Medical Equipment
Injectable Medication
Outpatient Procedures (potentially cosmetic)
Transplants

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 24 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $500 on facility only.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid at 100% before the deductible.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

ALTERNATIVE CARE

The Plan may consider coverage of charges for Medically Necessary alternative care not otherwise specifically shown as a Covered Expense in the Plan or policy subject to all of the following conditions:

1. Coverage is limited to the maximum benefit payable for the substituted benefit under the Plan and subject to any applicable deductible, coinsurance and Plan exclusions and limitations.
2. Care is Medically Necessary, non-custodial, non-Experimental and non-Investigational.
3. Such care is provided as a cost containment alternative with significant savings.
4. Substitution of less expensive alternative care is made only with the consent of the patient and upon the recommendation of the patient's attending physician or licensed health care provider that such services will adequately meet the patient's needs.
5. The alternate care provided is generally-accepted treatment or service that is standard medical practice for the particular injury or sickness in the medical community in which the policy is issued.

Medicare Part B Reimbursement

If you or your covered dependent has End-Stage Renal Disease ("ESRD"), the Plan's medical programs primary status applies during the first 30 months of dialysis, or the first 30 months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits.

The Medicare Secondary Payer Statute requires the Plan to identify members in the Plan, including eligible dependents, who are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

During the period where the Plan has primary status, Medicare Part B monthly premiums for covered members and their dependents that have become entitled, including dually entitled, to Medicare based on ESRD, will be covered by the Plan. Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each Plan Year.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at 100% for In-Network services and 80% for Out-of-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The deductible will also be waived for these tests.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid at the rate of 80% for In-Network services and 80% for Out-of-Network services.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is a full-time Employee of the Employer on the regular payroll of the Employer, is a class eligible for coverage and who is actively at work performing the duties of his or her job and not on leave.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Balance Bill. The amount that an Out of Network Provider may charge an Insured Person after benefits under the Plan are paid. Such amount charged equals the difference between the amount of an Out of Network Provider's billed charge and the amount paid by the Plan.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

CIGNA Pharmacy Management – CIGNA's Pharmacy Benefits Manager (PBM)

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Technology Service Corporation.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. A **Waiting Period** is the time period that must pass before coverage becomes effective for an Employee who is otherwise eligible to enroll under the terms of the Plan.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Genetic Testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person’s chance of developing or passing on a genetic disorder.

Genetic counseling is the process of helping people understand and adapt to the medical, psychological and familial implications of genetic contributions to disease. This process integrates the following: Interpretation of family and medical histories to assess the chance of disease occurrence or recurrence. Education about inheritance, testing, management, prevention, resources and research. Counseling to promote informed choices and adaptation to the risk or condition.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Health Conditions. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Conditions means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Negotiated Rate means the rate mutually agreed upon between the Plan and a Provider in a specific instance.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Technology Service Corporation Employee Health Plan, which is a benefits plan for certain Employees of Technology Service Corporation and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written

prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease of Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Health Conditions.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Third Party Networks (TPNs) are CIGNA “wrap” networks. The member’s residence zip code will determine whether the member will be in the CIGNA network or a TPN.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual, Reasonable and Customary. The Maximum Allowable Charge allows the plan to pay, "the lesser of" (1) the Plan at the Usual, Reasonable and Customary amounts for Covered Charges, (2) the allowable charge specified under the terms of the plan, (3) the negotiated rate established in a contractual arrangement with a provider, (4) the actual billed charges for the covered services, or (5) on a pre-negotiated fee basis for services obtained from In Network Providers.

Benefits for Out of Network Providers are paid as follows: The lesser of: (1) the Out of Network Provider's billed charges; (2) a Negotiated Rate with the Out of Network Provider; (3) for all charges other than Facility and Ambulance, in the absence of a Negotiated Rate, Usual Reasonable and Customary amounts for the relevant geographic area, subject to the applicable Out of Network Deductible and Coinsurance; or (4) for Facility and Ambulance Charges in the absence of a Negotiated Rate, 70% of Our lowest In-Network Provider rate for the relevant geographic area, subject to the applicable Out of Network Deductible and Coinsurance. You may receive a Balance Bill.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest. However, complications from a non-covered abortion are covered.

(2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from the Covered Person being the victim of an act of domestic violence or from a Medical Condition.

(3) **Breast Reduction** unless deemed Medically Necessary.

(4) **Completion of claim forms** or preparation of medical reports for missed appointments; for telephone consultations; or for consultations, medical record reviews, medical opinions, or similar services provided via the Internet, other electronic means, or by any method in which the Covered Person is not seen in person by the Physician or other health care provider.

(5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(6) **Cosmetic Surgery.** Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the Benefits for Reconstructive Mammoplasty / Plastic Surgery provision in this document. Breast reduction unless deemed Medically Necessary.

(7) **Court-ordered treatment.** Court ordered treatment or testing

(8) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(9) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as medications for hair growth or removal.

(10) **Educational or vocational testing.** Services for educational or vocational testing or training.

(11) **Employment, Insurance, or License related care.** Physical exams or immunizations or any other treatment required for enrollment in any insurance program, as a condition of employment, for licensing, or other similar purposes.

(12) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(13) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(14) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. For Plan Years beginning on or after January 1, 2014, this exclusion shall not apply to the extent that the charge is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional

conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(15) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Schedule of Benefits for Vision Benefits and coverage under the Vision Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. Also, one pair of contact lenses or eyeglasses will be covered after eye surgery if Medically Necessary.

(16) Genetic testing is not covered for:
Testing performed entirely for nonmedical reasons (eg, social, genealogy or personal ancestry)

(17) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(18) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(19) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

(21) **Handling Fees.** Handling and/or conveyance of specimen.

(22) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, jet ski operating or bungee jumping. This exclusion does not apply if the Injury resulted from the Covered Person being the victim of an act of domestic violence or from a Medical Condition.

(23) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan. Hearing aids and their related charges for testing and fitting are covered up to the limit specified in the Schedule of Benefits.

(24) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(25) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond

a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical condition.

(26) Illegal drugs or medications. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition.

(27) Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence. Except as covered under the pharmacy benefit.

(28) Infertility. Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(29) Maintenance care. Maintenance care, which consists of services and supplies furnished mainly to maintain rather than improve a level of physical or mental function or to provide a protected environment free from exposure that can worsen the Covered Person's physical or mental condition.

(30) Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

(31) No charge. Care and treatment for which there would not have been a charge if no coverage had been in force. This includes services and supplies provided through a medical department, clinic, or other facility provided by or maintained by an employer, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Covered person.

(32) Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(33) Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(34) No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

(35) No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(36) Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(37) Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. However, gastric bypass or similar surgical procedures are covered if medical documentation is provided to the Plan Administrator demonstrating Clinically Severe Obesity.

(38) Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(39) Off-label drugs. A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses. However, the use of chemotherapy drugs or agents to treat a cancer for which the drugs or agents are not approved treatment by the FDA will be covered by the Plan if the chemotherapy drugs or agents are approved by the National Comprehensive Cancer Network.

(40) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(41) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(42) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(43) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(44) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(45) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(46) **Self-Inflicted.** Charges incurred by the Insured Person related to an Injury or Sickness that is intentionally self-inflicted while sane, except that this exclusion does not apply to any self-inflicted Injury or Sickness that is the result of a medical condition.

(47) **Sex changes and sex counseling.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(48) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(49) **Surrogate parenting expenses.**

(50) **Therapies.** Massage therapy unless applied in conjunction with other active physical therapy modalities for a specific Illness or Injury, music therapy, aquatic therapy, or remedial reading therapy. Also excluded are charges for sex therapy, hypnotherapy; diversional, recreational, or educational therapies (such as hobbies, arts and crafts, dance) and any related testing; developmental, primal, or perceptual therapy; or milieu therapy primarily directed toward self-enhancement or to change or control one’s environment.

(51) **Non-surgical TMJ treatment or Myofascial Pain Dysfunction** or other jaw joint conditions.

(52) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

(53) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Cigna is the administrator of the pharmacy drug plan.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply. For Plan Years beginning on or after January 1, 2015, copayments will apply toward satisfaction of the Plan's Maximum Out-of-Pocket amount.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Cigna, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Specialty drugs and medications

Specialty Drugs must be obtained through Cigna Specialty Pharmacy, usually at a lower cost to the employee. If obtained and billed through Cigna Specialty Pharmacy, the doctor can administrator the medication in the doctor’s office.

Specialty Medication Program

Specialty drug prescriptions must be obtained through Cigna Specialty Pharmacy. A specialty drug is a drug of limited distribution that is administered by injection, infusion, or inhalation. Cigna Specialty Pharmacy currently has prescription programs with include:

Multiple Sclerosis
Rheumatoid Arthritis
Hepatitis C
Psoriasis
Cancer
Growth issues
Bleeding Disorders (hemophilia)
HIV
RSV

Your doctor may contact Cigna Specialty Pharmacy directly and the drug can be shipped to his/her office as needed. You may also contact Cigna Specialty Pharmacy to verify whether your prescribed drug is within its program. Through Cigna Specialty Pharmacy’s comprehensive patient care management program, patients have 24-hour access to a wide range of assistance, nurses, counseling, education, and refill reminders which can help to increase compliance to a prescribed medication regimen.

Cigna Specialty Pharmacy can be reached at (800) 351-3606

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Any ingredients in a compound drug that are not FDA approved, will not be covered. Any ingredient used in a compound drug that is part of our PA program, will also require Prior authorization.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

(5) All Contraceptives including oral, Implants, and IUD devices. Patient has no co-payment responsibility for generic.

(6) Medication in connection with treatment for impotence, limited to six doses per month

(7) Smoking Cessation. Patient has no co-payment responsibility. Excludes vapor cigarettes.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device except in accordance with the list of covered items listed above.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Immunization.** Immunization agents or biological sera.

(9) **Infertility.** A charge for infertility medication.

(10) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(13) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(15) **Off-label drugs**. A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses. However, the use of chemotherapy drugs or agents to treat a cancer for which the drugs or agents are not approved by the FDA will be covered by the Plan if the chemotherapy drugs or agents are approved by the National Comprehensive Cancer Network.

(16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(17) **Vapor Cigarette.** Any type of smokeless electronic cigarette.

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.

(7) **Training.** Charges for vision training or subnormal vision aids.

DENTAL BENEFITS

If a Covered Person incurs expenses for dental care that are Medically Necessary and recommended by a Physician or Dentist, the Plan will pay the Usual and Reasonable Charge amount shown in the Schedule of Benefits.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each calendar year.

(2) One bitewing x-ray series 2 per calendar year.

(3) One full mouth x-ray or panoramic films every 24 months.

(4) Extraoral superior or inferior maxillary film.

(5) One fluoride treatment for covered Dependent children under age 18 each Calendar Year.

(6) Space maintainers for covered Dependent children under age 18 to replace primary teeth.

(7) Emergency palliative treatment for pain and other non-routine, unscheduled visits.

(8) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 18.

(9) Fixed and Removable Appliances to inhibit thumb sucking and other harmful habits (includes night guards) - allowance includes all adjustments in the first 6 months after installation.

(10) Space Maintainers –allowance includes all adjustments in the first 6 months after installation.

- Fixed, unilateral, band or stainless steel crown type
- Fixed, unilateral, cast type
- Removable, bilateral type

Class B Services:
Basic Dental Procedures

(1) Office Visits and Examination – Diagnostic consultation, providing it is:

a. With a dentist other than the one providing treatment, and
b. Not with a dentist specializing in prosthodontics or orthodontics.

(Limited to 1 consultation for each dental specialty per Calendar Year.)

(2) Diagnostic Services – Allowance includes examination and diagnosis including:
Diagnostic casts and
Biopsy and examination of oral tissue

(3) Oral surgery. Allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

Extractions
Uncomplicated extraction, 1 or more teeth
Surgical removal of erupted teeth, involved tissue flap and bone removal
Surgical removal of impacted teeth
Excision of pericoronal gingiva, per tooth
Removal of palatal torus
Removal of cyst or tumor
Incision and drainage of abscess
Closure of oral fistula or maxillary sinus
Reimplantation of tooth
Frenectomy
Suture of soft tissue injury
Sialolithotomy for removal of salivary calculus
Closure of salivary fistula
Dilation of salivary duct
Sequestrectomy for osteomyelitis or bone abscess, superficial
Maxillary sinusotomy for removal of tooth fragment or foreign body

(4) Periodontics (gum treatments). Allowance includes the treatment plan, local anesthetics and post-surgical care.

Gingivectomy or gingivoplasty, per quadrant
Gingivectomy, per tooth (fewer than 6 teeth)
Sub-gingival curettage and root planing, per quadrant
(limited to a maximum of 4 quadrants in any 12 consecutive month period)
Pedicle or free soft tissue grafts, including donor sites
Osseous surgery, including flap entry and closure, per quadrant
Osseous grafts, including flap entry, closure and donor sites
Muco-gingival surgery
Occlusal adjustment not involving restorations and done in conjunction with periodonticsurgery, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period)

(5) Endodontics (root canals). Allowance includes routine x-rays and cultures, but excludes final restoration.

- Pulp capping, direct
- Remineralization (Calcium Hydroxide), as a separate procedure
- Vital pulpotomy
- Apexification
- Root canal therapy of non-vital (nerve-dead) teeth
- Traditional therapy
- Medicated paste therapy, N2 Sargenti
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures

(6) Oral Surgery – Allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

Extractions

- Uncomplicated extraction, 1 or more teeth
- Surgical removal of erupted teeth, involved tissue flap and bone removal
- Surgical removal of impacted teeth
- Excision of pericoronal gingiva, per tooth
- Removal of palatal torus
- Removal of cyst or tumor
- Incision and drainage of abscess
- Closure of oral fistula or maxillary sinus
- Reimplantation of tooth
- Frenectomy
- Suture of soft tissue injury
- Sialolithotomy for removal of salivary calculus
- Closure of salivary fistula
- Dilation of salivary duct
- Sequestrectomy for osteomyelitis or bone abscess, superficial
- Maxillary sinusotomy for removal of tooth fragment or foreign body

If any of the above-listed procedures are covered under the medical plan, they are not eligible under the dental plan.

(7) Fillings, other than gold. Multiple restorations on 1 surface will be considered 1 restoration.

Amalgam restorations

Synthetic restorations

- Silicate cement
- Acrylic or plastic
- Composite resin

Pins

- Pin retention, exclusive of restorative material

Recementation

- Inlay or onlay
- Crown
- Bridge

(8) General anesthetics, upon demonstration of Medical Necessity.

(9) Antibiotic drugs.

Major Dental Procedures
(Subject to Deductible)

(1) **Restorative**

Gold Foil Restorations
- gold foil - 1 surface
- gold foil - 2 surfaces
- gold foil - 3 surfaces

Gold Inlay Restorations
- inlay - gold, 2 surfaces
- inlay - gold, 3 surfaces
- onlay - per tooth (in addition to above)

Porcelain Restorations
- inlay – porcelain

Crowns - Single Restorations Only
- plastic (acrylic)
- plastic (prefabricated)
- plastic with gold
- plastic with nonprecious metal
- porcelain
- porcelain with gold
- porcelain with nonprecious metal
- gold (full cast)
- nonprecious metal (full cast)
- gold (3/4 cast)
- stainless steel
- cast post and core in addition to crown

(3) Other Restorative Services

Crown buildups – pin retained

(4) Complete Dentures – Including 6 months post-delivery care
- Complete upper
- Complete lower
- Immediate upper
- Immediate lower

(5) Partial Dentures – Including 6 months post-delivery care
- Upper - without clasps, acrylic base
- Lower - without clasps, acrylic base
- Upper - with 2 gold clasps with rests, acrylic base
- Lower - with 2 gold clasps with rests, acrylic base
- Lower - with gold lingual bar and 2 clasps, acrylic base
- Lower - with gold lingual bar and 2 clasps, cast base
- Upper - with gold palatal bar and 2 gold clasps, cast base
- Removable unilateral partial denture 1 piece gold casting, clasp attachments, per unit including pontics
- Full cast partial - with 2 gold clasps (upper)
- Full cast partial - with 2 gold clasps (lower)

(6) Additional Units for Partial Dentures

Each additional clasp with rest

Each tooth (applies only to full cast partial)

(7) Repair of crowns, bridgework and removable dentures.

(8) Prosthodontics, Fixed

(9) Fixed Bridges (Each abutment and each pontic constitutes a unit in a bridge)

(10) Bridge Pontic
Cast gold
Cast nonprecious
Slotted facing
Slotted pontic
Porcelain fused to gold
Porcelain fused to nonprecious metal
Plastic processed to gold
Plastic processed to nonprecious metal

(11) Crowns
Plastic (acrylic)
Plastic processed to gold
Plastic processed to nonprecious metal
Porcelain
Porcelain fused to gold
Porcelain fused to nonprecious metal
Gold (3/4 cast)
Gold (full cast)
Nonprecious metal (full cast)

(12) Other Prosthetic Services
Dowel pin, metal
Implants

(13) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if:

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(7) **No listing.** Services which are not included in the list of covered dental services.

(8) **Orthodontia.** Orthodontic treatment and orthognathic surgery.

(9) **Personalization.** Personalization of dentures.

(10) **Replacement.** Replacement of lost or stolen appliances.

(11) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

OrchestrateHR
5050 Spring Valley Road
Dallas, Texas 75244
(800) 550-8009

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the

claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and

will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process. In addition, a statement that "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

Voluntary appeals

In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If

the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Technology Service Corporation Employee Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Technology Service Corporation, 962 Wayne Avenue, Suite 800, Silver Spring, Maryland, 20910,. COBRA continuation coverage for the Plan is administered by OrchestrateHR, 5050 Spring Valley Rd, Dallas, Texas 75244, 800-550-8009. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available 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.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an

individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner and his or her children are treated as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. This gives the domestic partner and children the contractual rights outlined in this Section but does not extend statutory provisions to the domestic partner or child.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA"), as amended does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request

special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

Under the rules of this Plan, premiums for continuation on the group health plan must be paid to the Administrator by the participant or a member of the participant's immediate family. Third parties cannot pay those premiums directly to the Plan or its Administrator. There are options for individual health insurance through the Federally-Facilitated Marketplace or state-based Exchanges. Please contact the Plan Administrator for details.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

Additional Information:
COBRA participants cannot utilize their prescription drug card for prescription fills or refills. The Third Party Administrator will terminate all COBRA participants' drug card coverage with the Pharmacy Benefits Manager effective on their termination of active coverage through their employer. The participants' benefits will not change.

The COBRA participant will be required to pay his/her prescription at the pharmacy and submit the receipt to the Third Party Administrator for reimbursement. The claim will be processed promptly, minus appropriate copayment (generic, brand or non-formulary).

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Human Resources Department
Technology Service Corporation
962 Wayne Avenue, Suite 800
Silver Spring, Maryland 20910

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf,

the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Technology Service Corporation Employee Health Plan is the benefit plan of Technology Service Corporation, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Technology Service Corporation to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Technology Service Corporation shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage, but only for Plan Years that begin before January 1, 2014.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Technology Service Corporation Employee Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 95-4399083

PLAN EFFECTIVE DATE: June 1, 1967

PLAN AMENDED AND REINSTSTATED: January 1, 2017

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Technology Service Corporation
962 Wayne Avenue, Suite 800
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PLAN ADMINISTRATOR

Laura Grieco, Administrator
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Silver Spring, Maryland 20910

NAMED FIDUCIARY

Technology Service Corporation
962 Wayne Avenue, Suite 800
Silver Spring, Maryland 20910

AGENT FOR SERVICE OF LEGAL PROCESS

Laura Grieco, Administrator
962 Wayne Avenue, Suite 800
Silver Spring, Maryland 20910

CLAIMS ADMINISTRATOR

OrchestrateHR
5050 Spring Valley Road
Dallas, Texas 75244
(800) 550-8009