AEROSPACE
Assuring Space Mission Success

Group Hospital Medical Plan
Preferred Provider Option (PPO Option)

Summary Plan Description

Effective January 1, 2018

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TABLE OF CONTENTS

AEROSPACE
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GROUP HOSPITAL MEDICAL PLAN OF THE AEROSPACE CORPORATION

SUMMARY PLAN DESCRIPTION FOR

THE PPO PLAN OPTION (THE "PPO PLAN" OR THE "PLAN")

SECTION 1. INTRODUCTION

(a) The Aerospace Corporation (the "Corporation") has established the Group Hospital Medical Plan of the Aerospace Corporation (the "Medical Plan"), as amended and restated effective January 1, 2018. This summary plan description, along with the attached PPO Plan Benefit Booklet describes the benefits available under the PPO Plan Option (the "PPO Plan" or the "Plan"). These documents together describe your benefits under the Plan as a Covered Individual.

(b) This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-insured medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Internal Revenue Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Covered Individual through this Plan, are not taxable income to the Covered Individual. The specific tax treatment of any Covered Individual will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Covered Individuals are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes.

(c) This Plan is "self-insured" which means benefits are paid from the Employer's general assets and are not guaranteed by an insurance company. The Plan Sponsor, has contracted with the Benefit Claims Administrator to perform certain administrative services related to this Plan.

(d) Anthem is the Benefit Claims Administrator and will process Claims, manage the network of health care providers, and answer medical benefit and Claim questions. Contact information for the Claims Administrator appears in the Section titled "Contact Information".

(e) This document and the attached PPO Plan Benefit Booklet serve as the Summary Plan Description (SPD) required under ERISA. This document is incorporated into the ERISA plan document for the Medical Plan. It is very important to review this document, the PPO Plan Benefit Booklet, and the Plan document carefully to confirm a complete understanding of the benefits available, as well as your responsibilities, under this Plan.

(f) In order for a Covered Charge to be paid by the Plan, a Claim must be properly and timely submitted in accordance with the claims procedures set forth in the Section titled "Claims Procedure". A Claim must be submitted within three hundred sixty-five (365) days from the date the expense was incurred. It is the Employee's responsibility to make sure claims are submitted on time.

SECTION 2. SUMMARY OF BENEFITS

The information in this Section summarizes certain benefits available under the Plan. It does not describe all of the benefits available, nor does it provide all of the details about how these benefits may apply in your individual situation. For more details, you must review all relevant sections of the PPO Plan Benefit Booklet, which is an attachment to this document and is incorporated herein.

(a) Cost-Sharing Amounts. Cost-Sharing Amounts are amounts that a Covered Individual is responsible for paying out-of-pocket with respect to a Covered Charge. Cost-Sharing Amounts include Deductibles, Copayments, and Cost-Sharing Percentages. There are different Cost-Sharing Amounts for Covered Services provided by In-Network Health Care Providers (providers that are within the BlueCard PPO Network) and Covered Services provided by Out-of-Network Health Care Providers (all other providers).

(b) Copayment. In general, Copayment or Copay refers to a flat dollar amount, per occurrence of a Covered Service, for which the Covered Individual is responsible. Copayment is a defined term. See the Definitions section at the end of this document for more information.

(c) Out-of-Pocket Maximum. In general, the Out-of-Pocket Maximum is the annual aggregate dollar amount of all Copayments or other cost-sharing amounts for Covered Services provided by In-Network or Out-of-Network Health Care Providers for which a Covered Individual will be financially responsible. After the Out-of-Pocket Maximum has been met, the Plan pays one hundred percent (100%) of the Covered Charge for most Covered Services for the remainder of that year. There is an Individual Out-of-Pocket Maximum and a Family Out-of-Pocket Maximum. These are both described below.

(d) Deductible. Deductible refers to the annual aggregate amount of Covered Charges for which the Covered Individual is financially responsible before the Plan has a financial responsibility. As indicated in the benefits summary, there is an Individual Deductible and a Family Deductible. Copayments do not apply towards satisfaction of the Deductible and they continue to apply after the Deductible has been met, subject to the plans medical Out-of-pocket Maximum.

There is an In-Network deductible and a higher Out of Network deductible. The amount you pay for out of network Covered Services is counted toward the In Network Deductible, but not vice versa.

The chart below provides an overview of the benefits available under the PPO Plan. The cost-sharing percentages listed below reflect the amount payable by the Plan. Please note that if your health insurance benefits are subject to collective bargaining with the Corporation, your available benefits may differ.

AEROSPACE
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Anthem PPO Plan Option	
Providers	BLUECARD NETWORK OR OUT OF NETWORK PROVIDERS
Lifetime Maximum	Unlimited
Annual Deductible – Individual* Annual Deductible – Family*	$500 in network, $750 Out of Network $1500 in network, $2,250 Out of Network
Medical Out of Pocket Maximum - Individual Medical Out of Pocket Maximum - Family	$3,000 (In network) $9,000 (Out of Network) $6,000 (In network) $18,000 (Out of Network)
Office Visit – Primary Care Physician Office Visit – Specialist	$20 Copay (50% Out of Network)** $35 Copay (50% Out of Network)**
Hospitalization	80% in network, 50% out of network Precertification required
Diagnostic X-Ray and Lab**	80% in network, 50% Out of network
Outpatient**	80% in network, 50% Out of Network
Preventive Care**	100% in network, 50% Out of Network
Emergency Room	$150 copay***
Prescription Drugs – Deductible	$200 brand drugs In network coverage only
Prescription Drugs – Out of Pocket Maximum Individual Family	In network coverage only $3,600 $7,200
Prescription Drugs – Retail (30 Days) Generic Brand Formulary	In network coverage only $10 copay 20% ($30 min/$60 max)

ANTHEM PPO PLAN OPTION	
BRAND NON-FORMULARY	50% ($60 MIN/$120 MAX)
SPECIALTY	20%, $100 COPAY MAX
PRESCRIPTION DRUGS – MAIL ORDER (90 DAYS)	IN NETWORK COVERAGE ONLY
GENERIC	$20 COPAY
BRAND FORMULARY	20% ($60 MIN/$120 MAX)
BRAND NON-FORMULARY	50% ($120 MIN/$240 MAX)
SPECIALTY (UP TO 30 DAY SUPPLY)	20%, $100 COPAY MAX

*Out of network deductible amounts are applied to the in-network deductible, but not vice versa
**Out of Network Percentage applied to the usual and customary charge as determined by Anthem Blue Cross Blue Shield
*** Waived if Admitted
****Subject to Plan approval

SECTION 3. WHEN REGULAR COVERAGE BEGINS

(a) Regular Coverage in the Plan.

(i) Eligible Employees.

A new Eligible Employee can elect to begin Regular Coverage in the Plan by properly submitting the prescribed application to the Corporation within 31 days of first becoming an Eligible Employee. In the case of a newly hired Eligible Employee, such Regular Coverage will be effective on the Eligible Employee's date of hire if the application is properly submitted.

(ii) Dependents.

An Eligible Employee's election of Regular Coverage in the Plan may also include an election of Regular Coverage for his or her eligible Dependents.

In addition, where a Spouse or Same Sex Domestic Partner is also an Eligible Employee, Regular Coverage for eligible Dependents of both can be elected by either Employee.

SECTION 4. MAXIMUM ALLOWED AMOUNT

(a) Definition of Maximum Allowed Amount.

The maximum allowed amount is the total reimbursement payable under the Plan for covered services that a Covered Individual receives from participating and non-participating providers. It is the Plan's payment towards the services billed by the provider combined with any Copayment paid by the Covered Individual. In some cases, a Covered Individual may be required to pay the entire maximum allowed amount. For instance, if a

Covered Individual has not met the Deductible under the Plan, the Covered Individual could be responsible for paying the entire maximum allowed amount for covered services. In addition, if these services are received from a non-participating provider, the Covered Individual may be billed by the provider for the difference between their charges and the maximum allowed amount. In many situations, this difference could be significant.

(b) Participating Providers.

The maximum allowed amount may vary depending upon whether the provider is a participating provider, a non-participating provider or other health care provider. There are two types of participant providers under this Plan – PPO Providers and Traditional Providers. See the PPO Plan Benefit Booklet for differences in costs under the Plan.

For covered services performed by a participating provider the maximum allowed amount will be the rate the participating provider has agreed with the Benefit Claims Administrator to accept as reimbursement for the covered services. Please see the Plan Document (including the PPO Plan Benefit Booklet) for additional information on participating providers.

SECTION 5. COVERED MEDICAL CARE

Subject to the maximums set forth herein, other requirements set forth in the attached PPO Plan Benefit Booklet, and the exclusions or limitations listed under Medical Care that is Not Covered, the Plan will provide benefits for the following services and supplies:

(a) Urgent Care. Services and supplies received to prevent serious deterioration of one's health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not emergency services. Services for urgent care are typically provided by an urgent care center or other facility such as a physician's office. Urgent care can be obtained from participating providers or non-participating providers.

(b) Hospital services, as described below, are subject to pre-service review to determine medical necessity.

(i) Inpatient services and supplies, provided by a hospital. The maximum allowed amount will not include charges in excess of the hospital's prevailing two-bed room rate unless physician orders, and the Benefit Claims Administrator authorizes, a private room as medically necessary.

(ii) Services in special care units.

(iii) Outpatient services and supplies provided by a hospital, including outpatient surgery.

(c) Skilled Nursing Facility. Inpatient services and supplies provided by a skilled nursing facility, for up to 180 days per stay. Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity.

(d) Home Health Care. The following services provided by a home health agency and subject to pre-service review to determine medical necessity:

(i) Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.

(ii) Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

(iii) Services of a medical social service worker.

(iv) Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if the Covered Individual is also receiving the services listed in (i) or (ii) above.

(v) Medically necessary supplies provided by the home health agency.

(vi) In no event will benefits exceed 180 visits during a calendar year. One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day.

(vii) Home health care services are not covered if received while a Covered Individual is receiving benefits under the "Hospice Care" provision of this section.

(e) Hospice Care. The services and supplies listed below are covered when provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. A Covered Individual must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by the treating physician and submitted to the Benefit Claims Administrator. Covered services are available on a 24-hour basis for the management of the condition. The Covered Individual's physician must consent to care by the hospice and must be consulted in the development of the treatment plan. The hospice must submit a written treatment plan to the Benefit Claims Administrator every 30 days.

(i) Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

(ii) Short-term inpatient hospital care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

(iii) Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

(iv) Social services and counseling services provided by a qualified social worker.

(v) Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

(vi) Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

(vii) Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member.

(viii) Pharmaceuticals, medical equipment, and supplies necessary for the management of a medical condition. Oxygen and related respiratory therapy supplies.

(ix) Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Covered Individual's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Immediate family means spouse, children, step-children, parents, and siblings.

(x) Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

(f) Infusion Therapy. The following services and supplies, when provided by a home infusion therapy provider in the Covered Individual's home or in any other outpatient setting by a qualified health care provider, for the intravenous administration of his or her total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

(i) Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

(ii) Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

(iii) Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

(iv) Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

(v) Laboratory services to monitor the patient's response to therapy regimen.

(vi) Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Infusion therapy provider services are subject to pre-service review to determine medical necessity.

(g) Ambulatory Surgical Center. Services and supplies provided by an ambulatory surgical center in connection with outpatient surgery. Ambulatory surgical center services are subject to pre-service review to determine medical necessity.

(h) Retail Health Clinic. Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

(i) Preventive services and vaccinations.

(ii) Health condition monitoring and testing.

(iii) Exams for minor illnesses and injuries.

(i) Online Visits. When available in the Covered Individual's area, coverage will include visits from a LiveHealth Online Provider. Covered services include medical consultations using the internet via webcam, chat, or voice. Online visits are covered only from providers who contract with LiveHealth Online. Non-covered services include, but are not limited to, the following:

(i) Consultations between physicians.

(ii) Reporting normal lab or other test results.

(iii) Office visit appointment requests or changes.

(iv) Billing, insurance coverage, or payment questions.

(v) Requests for referrals to other physicians or healthcare practitioners.

(vi) Benefit precertification.

(vii) Consultations provided by telephone, electronic mail, or facsimile machines.

Covered Individuals will be financially responsible for the costs associated with non-covered services.

(j) Professional Services. This includes services of a physician or an anesthetist (M.D. or C.R.N.A.).

(k) Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. This does not apply to orthognathic surgery.

(l) Ambulance. Ambulance services are covered when a Covered Individual is transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

(i) For ground ambulance, when a Covered Individual is transported:

(A) From his or her home, or from the scene of an accident or medical emergency, to a hospital,

(B) Between hospitals, including when a Covered Individual is required to move from a hospital that does not contract with the Benefit Claims Administrator to one that does, or

(C) Between a hospital and a skilled nursing facility or other approved facility.

(ii) For air or water ambulance, when a Covered Individual is transported:

(A) From the scene of an accident or medical emergency to a hospital,

(B) Between hospitals, including when a Covered Individual is required to move from a hospital that does not contract with the Benefit Claims Administrator to one that does, or

(C) Between a hospital and another approved facility.

Ambulance services are subject to medical necessity reviews. Pre-service review is required for air ambulance in a non-medical emergency. When using an air ambulance in a non-emergency situation, the Benefit Claims Administrator reserves the right to select the air ambulance provider. If a Covered Individual does not use the air ambulance the Benefit Claims Administrator selects in a non-emergency situation, no coverage will be provided. A Covered Individual must be taken to the nearest facility that can provide care for the Covered Individual's condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility. Ambulance services are not covered when another type of transportation can be used without endangering a Covered Individual's health. Ambulance services for a Covered Individual's convenience or the

convenience of a Covered Individual's family members or physician are not a covered service. Coverage includes medically necessary treatment of an illness or injury by medical professionals from an ambulance service, even if the Covered Individual is not transported to a hospital.

If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital.

Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. Air ambulance will not be covered if a Covered Individual is taken to a hospital that is not an acute care hospital (such a skilled nursing facility), or if a Covered Individual is taken to a physician's office or their home.

If a Covered Individual is being transported from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger their health and if the hospital that first treats the Covered Individual cannot provide the needed medical services.

(m) Diagnostic Services. Certain outpatient diagnostic imaging and laboratory services.

(n) Advanced Imaging Procedures. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. Certain services require pre-service review. See the Plan Document and the PPO Plan Benefit Booklet for details.

(o) Radiation Therapy. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

(p) Chemotherapy. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

(q) Hemodialysis Treatment. This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis. The following renal dialysis services are covered:

(i) Outpatient maintenance dialysis treatments in an outpatient dialysis facility;

(ii) Home dialysis; and

(iii) Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

(r) Prosthetic Devices.

(i) Breast prostheses following a mastectomy.

(ii) Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.

(iii) The Plan will pay for other medically necessary prosthetic devices, including:

(A) Artificial limbs or eyes;

(B) Surgical implants;

(C) The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery;

(D) Scalp hair prostheses when required as a result of hair loss due to alopecia areata or alopecia totalis, chemotherapy, radiation therapy, or permanent hair loss due to injury, limited to one per calendar year;

(E) Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and

(F) Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

(s) Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

(i) Of no further use when medical needs end;

(ii) For the exclusive use of the patient;

(iii) Not primarily for comfort or hygiene;

(iv) Not for environmental control or for exercise; and

(v) Manufactured specifically for medical use.

Specific durable medical equipment is subject to pre-service review to determine medical necessity.

(t) Pediatric Asthma Equipment and Supplies. The following items and services when required for the medically necessary treatment of asthma in a dependent child:

(i) Nebulizers, including face masks and tubing. These items are covered under the plan's medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").

(ii) Education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the Plan's benefits for office visits to a physician.

(u) Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

(v) Dental Care.

(i) Admissions for Dental Care. Listed inpatient hospital services for up to three days during a hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.). The Benefit Claims Administrator will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or a Covered Individual's medical condition. Hospital stays for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified below.

(A) General Anesthesia. General anesthesia and associated facility charges when a Covered Individual's clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if (a) the Covered Individual is less than seven years old, (b) the Covered Individual is developmentally disabled, or (c) the Covered Individual's health is compromised and general anesthesia is medically necessary. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

(B) Dental Injury. Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by the accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not accidental injury unless the chewing or biting results from a medical or mental condition.

(C) Cleft Palate. Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

(D) Orthognathic Surgery. Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is medically necessary to attain functional capacity of the affected part.

(w) Pregnancy and Maternity Care.

(i) All medical benefits for a Covered Individual when provided for pregnancy or maternity care, including the following services:

(A) Prenatal, postnatal and postpartum care;

(B) Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other medically necessary maternity services performed outside of a hospital);

(C) Involuntary complications of pregnancy;

(D) Diagnosis of genetic disorders in cases of high-risk pregnancy; and

(E) Inpatient hospital care including labor and delivery. Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge.

(ii) Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is a Covered Individual. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

(x) Transplant Services. Services and supplies provided in connection with a non-investigative organ or tissue transplant, if the Covered Individual is:

(i) The recipient; or

(ii) The donor.

Benefits for an organ donor are as follows:

(A) When both the person donating the organ and the person getting the organ are Covered Individuals under this Plan, each will get benefits under their plans.

(B) When the person getting the organ is a Covered Individual under this plan, but the person donating the organ is not, benefits under this plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

(iii) If a Covered Individual is donating the organ to someone who is not a Covered Individual, benefits are not available under this Plan.

The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum

allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The Plan's payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants will not exceed $30,000 per transplant. See the Plan document and attachments for additional details.

(y) Bariatric Surgery. Services and supplies in connection with medically necessary surgery for weight loss, only for morbid obesity and only when performed at a designated CME facility. Covered Individuals must obtain pre-service review for all bariatric surgical procedures.

(z) Transgender Services. Services and supplies provided in connection with gender transition when a Covered Individual has been diagnosed with gender identity disorder or gender dysphoria by a physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, medically necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

(i) Coverage is provided for specific services according to plan benefits that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, medically necessary surgery; hormone therapy would be covered under the plan's prescription drug benefits (if such benefits are included).

(ii) Transgender services are subject to prior authorization in order for coverage to be provided.

(aa) Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the medically necessary treatment of mental or nervous disorders or substance abuse, or to prevent the deterioration of chronic conditions.

(i) Inpatient hospital services and services from a residential treatment center.

(ii) Partial hospitalization, including intensive outpatient programs and visits to a day treatment center. Partial hospitalization is covered as stated in the "Hospital" provision of the PPO Plan Benefit Booklet, for outpatient services and supplies.

(iii) Physician visits during a covered inpatient stay.

(iv) Physician visits for outpatient psychotherapy or psychological testing for the treatment of mental or nervous disorders or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

(v) Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

(bb) Preventive Care Services. Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means for preventive care services, the calendar year deductible will not apply to these services or supplies when they are provided by a participating provider. No co-payment will apply to these services or supplies when they are provided by a participating provider.

(i) A physician's services for routine physical examinations.

(ii) Immunizations prescribed by the examining physician.

(iii) Radiology and laboratory services and tests ordered by the examining physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

(iv) Health screenings as ordered by the examining physician for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

(v) Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

(vi) Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

(vii) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

(A) All FDA-approved contraceptive drugs, devices and other products for women, including over-the-counter items, if prescribed by a physician. This includes contraceptive drugs, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited

to management of side effects, counseling for continued adherence, and device insertion and removal.

At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a physician, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

In order to be covered as preventive care, contraceptive prescription drugs must be either a generic or single-source brand name drug (those without a generic equivalent). Multi-source brand name drugs (those with a generic equivalent) will be covered as preventive care services when medically necessary according to a Covered Individual's attending physician, otherwise they will be covered under the Plan's prescription drug benefits.

(B) Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

(C) Gestational diabetes screening.

(D) Preventive prenatal care.

(E) Preventive services for certain high-risk populations as determined by the Covered Individual's physician, based on clinical expertise.

This list of preventive care services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no copayment and will not apply to the calendar year deductible.

A Covered Individual may call member services using the number on his or her ID card for additional information about these services, or view the federal government's web sites:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

(cc) Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

(i) Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

(ii) Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a preventive care service, BRCA testing will be covered under the Preventive Care Services benefit.

(iii) Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

(iv) Reconstructive surgery of both breasts performed to restore and achieve symmetry following a medically necessary mastectomy.

(v) Breast prostheses following a mastectomy (see "Prosthetic Devices").

This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions.

(dd) Clinical Trials. Coverage is provided for routine patient costs received as a participant in an approved clinical trial. The services must be those that are listed as covered by this plan for Covered Individuals who are not enrolled in a clinical trial.

(i) Routine patient care costs include items, services, and drugs provided to a Covered Individual in connection with an approved clinical trial that would otherwise be covered by the Plan.

(ii) An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

(A) Federally funded trials approved or funded by one or more of the following:

(1) The National Institutes of Health,

(2) The Centers for Disease Control and Prevention,

(3) The Agency for Health Care Research and Quality,

(4) The Centers for Medicare and Medicaid Services,

(5) A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

(7) Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(a) The Department of Veterans Affairs,

(b) The Department of Defense, or

(c) The Department of Energy.

(8) Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

(9) Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by a Covered Individual's physician after determining participation has a meaningful potential benefit. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the Plan's Clinical Coverage Guidelines, related policies and procedures.

(B) Routine patient costs do not include the costs associated with any of the following:

(1) The investigational item, device, or service.

(2) Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(3) Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(4) Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

(ee) Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

(i) Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under plan benefits for office visits to physicians.

(ii) Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

(iii) Visits for fitting, counseling, adjustments and repairs for a one-year period after receiving the covered hearing aid.

(iv) Benefits are provided for one hearing aid per ear every three years.

(v) No benefits will be provided for the following:

(A) Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than one hearing aid per ear every three years.

(B) Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically necessary surgically implanted hearing devices may be covered under the Plan's benefits for prosthetic devices (see "Prosthetic Devices").

(ff) Physical Therapy, Physical Medicine, Occupational Therapy (non-work related), Acupuncture, and Chiropractic Care. The following services provided by a licensed physician under a treatment plan:

(i) Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)

(ii) Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

(iii) Acupuncture services of a physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination,

treatment planning and treatment evaluation, electro-acupuncture, acupressure, cupping and moxibustion.

(iv) Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a physician in that physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

(v) Up to 24 visits in a year for all covered services (except acupuncture) are payable if medically necessary. Up to 34 visits in a year for acupuncture services are payable. If additional visits for physical therapy, physical medicine or occupational therapy are needed, pre-service review must be obtained prior to receiving the services.

(vi) If it is determined that an additional period of physical therapy, physical medicine or occupational therapy is medically necessary, the Benefit Claims Administrator will specify a specific number of additional visits. Such additional visits are not payable if pre-service review is not obtained.

(vii) There is no limit on the number of covered visits for medically necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

(gg) Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a physician's office if medically necessary.

(hh) Speech Therapy and Speech-language pathology (SLP) services. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment.

(ii) Diabetes. Services and supplies provided for the treatment of diabetes, including:

(i) The following equipment and supplies:

(A) Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

(B) Insulin pumps.

(C) Pen delivery systems for insulin administration (non-disposable).

(D) Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

(E) Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

(ii) Diabetes education program which:

(A) Is designed to teach a Covered Individual who is a patient and Covered Individual of the patient's family about the disease process and the daily management of diabetic therapy;

(B) Includes self-management training, education, and medical nutrition therapy to enable the Covered Individual to properly use the equipment, supplies, and medications necessary to manage the disease; and

(C) Is supervised by a physician.

Diabetes education services are covered under plan benefits for office visits to physicians.

(iii) The following items are covered as medical supplies:

(A) Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.

(B) Testing strips, lancets, and alcohol swabs.

(iv) Screenings for gestational diabetes are covered under the Preventive Care Services benefit.

(jj) Jaw Joint Disorders. The Plan will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

(kk) Special Food Products. Special food products and formulas that are part of a diet prescribed by a physician for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

(ll) Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

(mm) Prescription Drugs Obtained from or Administered by a Medical Provider. The Plan includes benefits for prescription drugs when they are administered to a Covered Individual as part of a physician visit, services from a home health agency, or at an outpatient hospital. This includes drugs for infusion therapy, chemotherapy, specialty pharmacy drugs, blood products and any drug that must be administered by a physician.

(i) Benefits for drugs that a Covered Individual injects or get at a retail pharmacy (i.e., self-administered drugs) are not covered under this section.

(ii) Prior Authorization. Certain specialty pharmacy drugs require written prior authorization. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics process. In order to get a specialty pharmacy drug that requires prior authorization, a physician must make a request to the Benefit Claims Administrator. The request may be made by either telephone or facsimile to the Benefit Claims Administrator. At the time the request is initiated, specific clinical information will be requested from the physician based on medical policy and/or clinical guidelines, based specifically on a Covered Individual's diagnosis and/or the physician's statement in the request or clinical rationale for the specialty pharmacy drug. If the request is not for urgently needed drugs, after the Benefit Claims Administrator gets the request from the physician:

(A) Based on the Covered Individual's medical condition, as medically necessary, the Benefit Claims Administrator will review it and decide if they will approve benefits within 5-business days.

(B) If more information is needed to make a decision, the Benefit Claims Administrator will tell the physician in writing within 5-business days after they get the request what information is missing and why they cannot make a decision. If, for reasons beyond the Benefit Claims Administrator's control, they cannot tell the physician what information is missing within 5-business days, the Benefit Claims Administrator will tell the physician that there is a problem as soon as they know that they cannot respond within 5-business days.

If you have any questions regarding whether a specialty pharmacy drug requires prior authorization, please call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

If the Benefit Claims Administrator denies a request for prior authorization of a specialty pharmacy drug, the Covered Individual or the prescribing physician may appeal the decision by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

SECTION 6. BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

(a) This Plan provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of the Plan that apply to all other medical conditions, except as specifically stated in this Section. Behavioral health treatment services covered under this plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the

"Definitions" below) will be covered under plan benefits for office visits to physicians, whether services are provided in the provider's office or in the patient's home. Services provided in a facility, such as the outpatient department of a hospital, will be covered under plan benefits that apply to such facilities.

A Covered Individual must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this plan (see section entitled "Utilization Review Program" for details). No benefits are payable for these services if pre-service review is not obtained.

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in this section, the first letter of each word will be capitalized.

(b) Definitions.

(i) Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified. Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

(ii) Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings depending on the individual's needs and progress.

Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

(iii) Qualified Autism Service Provider is either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

(B) A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment

for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

The network of participating providers may be limited to licensed Qualified Autism Service Providers who contract with a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

(iv) Qualified Autism Service Professional is a provider who meets all of the following requirements:

(A) Provides behavioral health treatment,

(B) Is employed and supervised by a Qualified Autism Service Provider,

(C) Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,

(D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and

(E) Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

(v) Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

(A) Is employed and supervised by a Qualified Autism Service Provider,

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,

(C) Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and

(D) Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

(c) Behavioral Health Treatment Services Covered. The behavioral health treatment services covered by this plan for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual

with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

(i) The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,

(ii) The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and

(iii) The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

(A) Describes the patient's behavioral health impairments to be treated,

(B) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,

(C) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,

(D) Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and

(E) The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to the Benefit Claims Administrator upon request.

SECTION 7. MEDICAL CARE NOT COVERED

No payment will be made under this Plan for expenses incurred for or in connection with any of the items below.

(a) Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

(b) Experimental or Investigative. Any experimental or investigative procedure or medication. But, if a Covered Individual is denied benefits because it is determined that the requested treatment is experimental or investigative, such Covered Individual may request an independent medical review.

(c) Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.

(d) Crime or Nuclear Energy. Conditions that result from: (1) commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

(e) Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by the Benefit Claims Administrator. This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated herein.

(f) Excess Amounts. Any amounts in excess of maximum allowed amounts.

(g) Waived Cost-Shares Non-Participating Provider. For any service for which a Covered Individual is responsible under the terms of this Plan to pay a co-payment or deductible, and the co-payment or deductible is waived by a non-participating provider.

(h) Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if those benefits are not claimed.

(i) Government Treatment. Any services actually received by a Covered Individual that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. The plan will not cover payment for these services if a Covered Individual is not required to pay for them or they are given to a Covered Individual for free.

(j) Services of Relatives. Professional services received from a person who lives in a Covered Individual’s home or who is related to a Covered Individual by blood or marriage.

(k) Voluntary Payment. Services for which a Covered Individual is not legally obligated to pay or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

(i) It must be internationally known as being devoted mainly to medical research;

(ii) At least 10% of its yearly budget must be spent on research not directly related to patient care;

(iii) At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

(iv) It must accept patients who are unable to pay; and

(v) Two-thirds of its patients must have conditions directly related to the hospital's research.

(l) Not Specifically Listed. Services not specifically listed in this plan as covered services.

(m) Private Contracts. Services or supplies provided pursuant to a private contract between the Covered Individual and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

(n) Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

(o) Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of this document.

(p) Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

(i) Extraction, restoration, and replacement of teeth;

(ii) Services to improve dental clinical outcomes.

(iii) This exclusion does not apply to the services which are required by law to cover. See the PPO Plan Benefit Booklet for additional details.

(q) Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under "Hearing Aid Services" and "Preventive Care Services".

(r) Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam under "Preventive Care Services".

(s) Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the "Infusion Therapy" provision of the PPO Plan Benefit Booklet or when provided by a home health agency or hospice, as specifically stated in the "Home Health Care", "Hospice Care", or "Physical Therapy, Physical Medicine And Occupational Therapy (non-work related), Acupuncture, and Chiropractic Care" provisions of the PPO Plan Benefit Booklet. This exclusion also does not apply to the medically necessary treatment of Pervasive Developmental Disorder or autism, to the extent stated herein.

(t) Speech Therapy. Speech therapy except as stated in "Speech Therapy and Speech language pathology (SLP)" section herein. This exclusion also does not apply to the medically necessary treatment of Pervasive Developmental Disorder or autism, to the extent stated herein.

(u) Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

(v) Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa.

(w) Sterilization Reversal. Reversal of an elective sterilization.

(x) Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

(y) Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(z) Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom

molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in "Prosthetic Devices".

(aa) Air Conditioners. Air purifiers, air conditioners, or humidifiers.

(bb) Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specifically provided under "Hospice Care" or "Infusion Therapy" provisions herein. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specifically stated under the "Skilled Nursing Facility" provision herein.

(cc) Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(dd) Personal Items. Any supplies for comfort, hygiene or beautification.

(ee) Educational or Academic Services. This Plan does not cover:

(i) Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.

(ii) Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.

(iii) Academic or educational testing.

(iv) Teaching skills for employment or vocational purposes.

(v) Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.

(vi) Teaching manners and etiquette or any other social skills.

(vii) Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the medically necessary treatment of Pervasive Developmental Disorder or autism, to the extent otherwise covered herein.

(ff) Food or Dietary Supplements. Nutritional and/or dietary supplements and counseling, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

(gg) Telephone, Facsimile Machine, and Electronic Mail Consultations. Consultations provided using telephone, facsimile machine, via the internet or electronic mail.

(hh) Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Preventive Care Services" provision herein.

(ii) Acupuncture. Acupuncture treatment except as specifically stated under "Physical Therapy, Physical Medicine and Occupational Therapy (non-work related), Acupuncture, and Chiropractic Care"" provisions herein. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

(jj) Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

(kk) Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated under "Home Health Care", "Hospice Care", " Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy (non-work related), Acupuncture, and Chiropractic Care" provisions herein. This exclusion also does not apply to the medically necessary treatment of Pervasive Developmental Disorder or autism, to the extent otherwise covered herein.

(ll) Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated herein. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specifically stated herein. Cosmetics, health or beauty aids.

(mm) Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated under "Injectable Drugs and Implants for Birth Control".

(nn) Private Duty Nursing. Private duty nursing services.

(oo) Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the Benefit Claims Administrator.

(pp) Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated under "Clinical Trials".

SECTION 8. COORDINATION OF BENEFITS

(a) If a Covered Individual is covered by more than one group medical plan, the benefits under this Plan will be coordinated with the benefits of those other plans, as shown below. These coordination provisions apply separately to each Covered Individual, per

calendar year, and are largely determined by California law. Any coverage that a Covered Individual has for medical or dental benefits will be coordinated as shown below or in the attached PPO Plan Benefit Booklet.

(b) Order of Benefits Determination. The first of the following rules which applies will determine the order in which benefits are payable:

(i) A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that this Plan pays before Medicare.

(ii) A plan which covers a Covered Individual as a participant pay before a plan which covers a Covered Individual as a dependent. But, if a Covered Individual are retired and eligible for Medicare, Medicare pays (a) after the plan which covers a Covered Individual as a dependent of an active employee, but (b) before the plan which covers a Covered Individual as a retired Employee.

(iii) For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception: for a dependent child of parents who are divorced or separated, the following rules will be used in place of this rule:

(A) If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

(B) If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

(1) The plan which covers that child as a dependent of the parent with custody.

(2) The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

(3) The plan which covers that child as a dependent of the parent without custody.

(4) The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

(C) Regardless of the foregoing, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

(D) The plan covering an Employee as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering an Employee as other than a laid-off or retired employee or the dependent of such a person.

(E) The plan covering a Covered Individual under a continuation of coverage provision in accordance with state or federal law pays after a plan covering a Covered Individual as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the other plan does not agree under these circumstances with the Order of Benefit Determination provisions of this Plan, this rule will not apply.

When the above rules do not establish the order of payment, the plan on which a Covered Individual has been enrolled the longest pays first unless two of the plans have the same effective date.

SECTION 9. UTILIZATION REVIEW PROGRAM

(a) Utilization Review. The Plan includes the process of utilization review to decide when services are medically necessary or experimental / investigative as those terms are defined herein. A service must be medically necessary to be a covered service. When level of care, setting or place of service is part of the review, services that can be safely delivered in a lower level of care or lower cost setting / place of care, will not be medically necessary if they are given in a higher level of care, or higher cost setting / place of care. Certain services must be reviewed to determine medical necessity in order to receive medical benefits under the Plan. Utilization review criteria will be based on many sources including medical policy and clinical guidelines. The Benefit Claims Administrator may decide that a service that was asked for is not medically necessary if a Covered Individual has not tried other treatments that are more cost-effective.

(b) Coverage not guaranteed. Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date that the Covered Individual receives service:

(i) He or she must be eligible for benefits;

(ii) The service or supply must be a covered service under this Plan;

(iii) The service cannot be subject to an exclusion under this Plan;

(iv) The Covered Individual must not have exceeded any applicable limits under this Plan.

(c) Types of reviews.

(i) Pre-service Review – A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.

(ii) Precertification Review – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for a Covered Individual to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is experimental / investigative as those terms are defined herein.

(iii) Continued Stay / Concurrent Review – A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment. Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any physician with knowledge of a Covered Individual's medical condition, without such care or treatment, his or her life or health or his or her ability to regain maximum function could be seriously threatened or the Covered Individual could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

(iv) Post-service Review – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Plan has a related clinical coverage guideline and are typically initiated by the Benefit Claims Administrator.

(d) Types of Admissions.

(i) Emergency Admissions - For admissions following an emergency, the Covered Individual or their authorized representative or physician must tell the Benefit Claims Administrator within 24 hours of the admission or as soon as possible within a reasonable period of time.

(ii) Childbirth Admissions - For childbirth admissions, precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

(iii) Mastectomy Admissions - For inpatient hospital stays for mastectomy surgery, including the length of hospital stays associated with mastectomy, precertification is not needed.

(e) Services Requiring Precertification. Services for which precertification is required (i.e., services that need to be reviewed by the Benefit Claims Administrator to determine whether they are medically necessary) include, but are not limited to, the following:

(i) Scheduled, non-emergency inpatient hospital stays and residential treatment center admissions. However, pre-service review is not required for inpatient hospital stays for the following services:

(A) Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and

(B) Mastectomy and lymph node dissection.

(ii) Specific non-emergency outpatient services, including diagnostic treatment and other services.

(iii) Specific outpatient surgeries performed in an outpatient facility or a doctor's office.

(iv) Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:

(A) For bone, skin or cornea transplants, if the physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

(B) For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) facility or a Blue Distinction Centers for Specialty Care (BDCSC) facility.

(v) Air ambulance in a non-medical emergency.

(vi) Visits for physical therapy, physical medicine and occupational therapy beyond those described under "Physical Therapy, Physical Medicine and Occupational Therapy". A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for medically necessary physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance.

(vii) Specific durable medical equipment.

(viii) Home infusion therapy if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.

(ix) Admissions to a skilled nursing facility if the Covered Individual requires daily skilled nursing or rehabilitation, as certified by the attending physician.

(x) Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss if:

(A) The services are to be performed for the treatment of morbid obesity;

(B) The physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

(C) The bariatric surgical procedure will be performed at a BDCSC facility.

(xi) Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. The Covered Individual may call the toll-free member services telephone number on their identification card to find out if an imaging procedure requires pre-service review.

(xii) Behavioral health treatment for Pervasive Developmental Disorder or autism, as specified in under "Benefits For Pervasive Developmental Disorder or Autism".

(xiii) Transgender services as specified under "Transgender Services". The Covered Individual must be diagnosed with gender identity disorder or gender dysphoria by a physician.

For a list of current procedures requiring precertification, please call the toll-free number for Member Services printed on your Identification Card.

(f) Responsibility for Pre-Certification. Typically, participating providers know which services need precertification and will get any precertification when needed. The Covered Individuals physician and other participating providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, hospital or attending physician ("requesting provider") will get in touch with the Benefit Claims Administrator to ask for a precertification. However, A Covered Individual may request a precertification or may choose an authorized representative to act on his or her behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	Responsibility to Obtain Precertification	Comments
Participating Providers	Provider	The provider must get precertification when required.
Non-Participating Providers	Covered Individual	Covered Individual must get precertification when required. (Call Member Services.) Covered Individual may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be medically necessary.
Blue Card Provider	Covered Individual (Except for in-patient admissions)	Covered Individual must get precertification when required. (Call Member Services.) Covered Individual may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be medically necessary. Blue Card Providers must obtain precertification for all inpatient admissions.
NOTE: For an emergency admission, precertification is not required. However, the Covered Individual or their authorized representative or physician must notify the Benefit Claims Administrator within 24 hours of the admission or as soon as possible within a reasonable period of time.		

(g) How Decisions Are Made. The Benefit Claims Administrator uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity decisions. This includes decisions about prescription drugs as detailed in the section "Prescription Drugs Obtained From Or Administered By a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical

practice. The Benefit Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time. Covered Individuals are entitled to ask for and get, free of charge, reasonable access to any records concerning their request. To ask for this information, call the precertification phone number on the back of the identification card. If a Covered Individual is not satisfied with the Plan's decision under this section, he or she may call the Member Services phone number on the back of the Identification Card to find out what rights may be available.

(h) Decision and Notice Requirements.

(i) The Benefit Claims Administrator will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, the plan will follow state laws. If a Covered Individual lives in and/or gets services in a state other than the state where the Plan was issued, other state-specific requirements may apply.

Request Category	Timeframe Requirement for Decision
Urgent Pre-Service Review	72 hours from the receipt of the Request
Non-Urgent Pre-Service Review	5 business days from the receipt of the Request
Continued Stay/Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the Request
Urgent Continued Stay/Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the Request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous request	72 hours from the receipt of the Request
Non-Urgent Continued Stay/Concurrent Review	5 business days for the receipt of the Request
Post-Service Review	30 calendar days for the receipt of the Request

(ii) If more information is needed to make a decision, the Benefit Claims Administrator will tell the requesting physician of the specific information needed to finish the review. If the Plan does not get the specific information it needs by the required timeframe identified in the written notice, the Benefit

Claims Administrator will make a decision based upon the information received.

(iii) The Benefit Claims Administrator will notify the Covered Individual and his or her physician of the plan's decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

(iv) For a copy of the medical necessity review process, please contact Member Services at the telephone number on the back of the Identification Card.

(i) Revoking or modifying a Precertification Review decision. The Benefit Claims Administrator will determine in advance whether certain services (including procedures and admissions) are medically necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

(i) A Covered Individual's coverage under this Plan ends;

(ii) The agreement with the plan administrator terminates;

(iii) The Covered Individual reaches a benefit maximum that applies to the service in question;

(iv) Benefits under the plan change so that the service is no longer covered or is covered in a different way.

(j) Exceptions to the Utilization Review Program. From time to time, the Benefit Claims Administrator may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in their discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, the Benefit Claims Administrator may select certain qualifying health care providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Benefit Claims Administrator may also exempt claims from medical review if certain conditions apply.

(i) If the Benefit Claims Administrator exempts a process, health care provider, or claim from the standards that would otherwise apply, the Benefit Claims Administrator is in no way obligated to do so in the future, or to do so for any other health care provider, claim, or Covered Individual. The Benefit Claims Administrator may stop or modify any such exemption with or without advance notice.

(ii) The Benefit Claims Administrator also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then the Benefit Claims Administrator may use one or more

clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services under the Plan.

SECTION 10. MEDICAL NECESSITY

(a) The benefits of this plan are provided only for services which the Benefit Claims Administrator determines to be medically necessary. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States.

(b) Medically necessary procedures, supplies, equipment or services are those considered to be:

(i) Appropriate and necessary for the diagnosis or treatment of the medical condition;

(ii) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;

(iii) Provided for the diagnosis or direct care and treatment of the medical condition;

(iv) Within standards of good medical practice within the organized medical community;

(v) Not primarily for the Covered Individual's convenience, or for the convenience of the physician or another provider;

(vi) Not costlier than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

(vii) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

(A) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Covered Individual with the particular medical condition being treated than other possible alternatives; and

(B) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

SECTION 11. TERMINATION OF REGULAR COVERAGE

(a) Termination of Regular Coverage in the Medical Plan.

(b) Termination of Coverage in the Context of Disability.

An Employee who becomes totally disabled before age 62 may continue to be covered under the Medical Plan until the earlier of recovery, age 65, or death.

An Employee who becomes totally disabled at age 62 or older may remain covered by paying the appropriate cost-sharing for the length of time shown in the following table or until recovery or death, whichever occurs first. Normal Retirement Age means the Social Security Retirement age as stated in the 1983 revision of the United States Social Security Act.

Monthly active medical benefit schedule	
Age at Disability	**Coverage Period**
62 but less than 63	3 years, 6 months
63 but less than 64	3 years
64 but less than 65	2 years, 6 months
65 but less than 66	2 years
66 but less than 67	1 year, 9 months
67 but less than 68	1 year, 6 months
68 but less than 69	1 year, 3 months
69 or over	1 year

Where an Employee does not have long-term disability coverage, he or she will be required to submit proof of continuing total disability subject to the approval of the company or its designee. Otherwise, coverage will be terminated.

(c) Termination of Employee's Regular Coverage. An Employee's Regular Coverage in the Plan will terminate as of the earliest of the following dates:

(i) The date when the Corporation terminates such Regular Coverage for nonpayment of Employee Contributions; or

(ii) The date when the Plan is terminated; or

(iii) The date when any reduction in coverage or increased cost to the Employee is effective due to a Qualifying Event.

(iv) The last day of the month following or coinciding with:

(A) The date when the Employee elects to terminate such Regular Coverage in the Plan, provided that the Corporation has been properly notified in advance of such date; or

(B) The date when the Employee no longer qualifies as an Eligible Employee for one of the following reasons:

(1) The termination of the Employee's employment with the Corporation; or

(2) The reduction of the Employee's regular work schedule below the hours per week required of a Regular Employee; or

(3) The failure to meet the definition of Eligible Employee for any reason, including the transfer to a class of Employees who are not eligible for Regular Coverage under the Plan; or

(4) The date when the Employee no longer qualifies for the Plan because he or she no longer resides within the Plan's service area, if applicable.

(d) Termination of a Dependent's Regular Coverage the Plan. A Dependent's Regular Coverage in the Plan will terminate as of the earliest of the following dates:

(i) The date when the Corporation terminates such Regular Coverage for nonpayment of Employee Contributions; or

(ii) When any reduction in coverage or increased cost to the Employee is effective due to a Qualifying Event.

(iii) The last day of the month following or coinciding with:

(A) The date when the Employee elects to terminate the Dependent's Regular Coverage in the Plan, provided that the Corporation has been properly notified in advance of such date; or

(B) The date when the Dependent ceases to be a Dependent for any reason, including age, divorce from the Employee, termination of a Same Sex Domestic Partnership, or entering into a new Same Sex Domestic Partnership.

(e) Termination of Coverage for Fraud or International Misrepresentations.

Notwithstanding any other provision of the Plan, if an Employee or Dependent commits fraud or makes an intentional misrepresentation of a material fact, coverage for the

Employee and his or her Dependent(s) may be immediately and permanently terminated by the Corporation in its sole discretion.

SECTION 12. CONTINUATION COVERAGE

(a) COBRA Coverage.

In accordance with the requirements of the Consolidated Medical Budget Reconciliation Act of 1985 (COBRA) (or other applicable state law), the Plan will provide a temporary extension of health coverage at group rates plus an administrative fee to a Qualified Beneficiary in certain instances where coverage under the Plan would otherwise end.

An Employee or Dependent who has Regular Coverage in the Plan as of the day prior to a Qualifying Event and such Regular Coverage terminates due to a Qualifying Event is eligible to elect COBRA coverage. Such individuals are referred to as "Qualified Beneficiaries."

For additional details regarding COBRA coverage, see the PPO Plan Benefit Booklet.

(b) USERRA Continuation Coverage During Military Service Leave.

General.

If an Employee's Regular Coverage under the Plan would terminate as a result of the Employee's absence from employment by reason of active service in the Uniformed Services of the United States, such Employee (and his or her covered Dependents) will be eligible for USERRA Continuation Coverage for up to 24 months in the Plan

(i) Right to USERRA Continuation Coverage.

An Employee who is on a Military Service Leave may elect USERRA Continuation Coverage without interruption if his or her Regular Coverage in the Plan would terminate because of the Employee's absence from employment by reason of active service in the Uniformed Services of the United States. Such coverage may be elected by the Employee and any of his or her Dependents who are covered under the Plan on the day immediately before the Employee's absence from work for active duty in the Uniformed Services of the United States begins.

(ii) Election of USERRA Continuation Coverage.

In order to qualify for USERRA Continuation Coverage, the Employee must elect such coverage for him or herself and any covered Dependents by properly submitting the prescribed application for USERRA Continuation Coverage to the Corporation within 60 days of the date that the Employee's and covered Dependents Regular Coverage in a Plan terminates due to the Employee's absence from employment by reason of active service in the Uniformed Services of the United States. An election of USERRA Continuation Coverage will be effective on the day after the Employee's and any of his

or her covered Dependents' Regular Coverage in the Plan terminates due to the Employee's absence from employment by reason of active service in the Uniformed Services of the United States.

(iii) Required Contributions for USERRA Continuation Coverage.

Employees who elect USERRA Continuation Coverage must pay contributions in the same amount (not to exceed 102% of the total contributions required under the Plan). Notwithstanding the foregoing, in the event that an Employee performs less than 31 days of active duty in the Uniformed Services, the Employee shall not pay more than the amount, if any, that an Eligible Employee would pay for such coverage.

(iv) Maximum Period of USERRA Continuation Coverage.

An Employee or Dependent's period of USERRA Continuation Coverage shall begin on the date of the event which results in the Employee or Dependent becoming eligible for USERRA Continuation Coverage and shall end on the earliest of the following dates:

The 24-month period beginning on the date on which the Employee's absence from work for active duty in the Uniformed Services of the United States begins; or

The period ending on the day after the date on which the Employee fails to timely apply for or return to a position of employment with the Company, as determined under § 4312(e) of the Uniformed Services Employment and Reemployment Rights Act of 1994.

SECTION 13. CHANGES TO REGULAR COVERAGE OR CONTINUATION COVERAGE

(a) Open Enrollment Period.

Eligible Employees may commence, change, or cease Regular Coverage in the Plan for themselves and their eligible Dependents during the Open Enrollment Period, provided that such Eligible Employee properly submits the prescribed application with the Corporation during the Open Enrollment Period in accordance with the procedures established by the Corporation for this purpose. Commencement, change, or cessation of coverage selected during the Open Enrollment Period shall be effective on the first of the month of the Plan Year following the Open Enrollment Period.

Qualified Beneficiaries may change or cease Continuation Coverage in the Plan for themselves and their eligible Dependents and may add their eligible Dependents to their Continuation Coverage during the Open Enrollment Period, provided that such Qualified Beneficiary properly submits the prescribed application with the Corporation during the Open Enrollment Period in accordance with the procedures established by the Corporation for this purpose. Commencement, change, or cessation of coverage selected during the Open Enrollment Period shall be effective on the first of the month of the Plan Year following the Open Enrollment Period.

Notwithstanding Subsections (i) and (ii) above, the following individuals shall not be eligible to elect to commence or change their Continuation Coverage or to add a Dependent to their Continuation Coverage during an Open Enrollment Period:

An Employee or Dependent who is enrolled in Continuation Coverage when the maximum period of Continuation Coverage will end prior to the Open Enrollment Period Effective Date; or

Any individual who has been added as a Dependent to Continuation Coverage and who is not a Qualified Beneficiary.

(b) Special Enrollment Periods.

Special Enrollment Period Eligible Individuals shall be eligible to commence Regular Coverage in the Plan and may enroll otherwise eligible Dependents in a Survivor Coverage or Continuation Coverage, as applicable, during any one of the Special Enrollment Periods described below, provided they meet the requirements of Subsections (2) through (5), below. These Special Enrollment Periods are in addition to any right to enroll during the Open Enrollment Period. Special Enrollment Period Eligible Individuals shall be those individuals eligible to commence, change, or cease Regular Coverage or Continuation Coverage, as applicable, during an Open Enrollment Period, except that such group shall be determined by substituting the date that coverage would be effective under this Section for the Open Enrollment Period Effective Date.

(c) Loss of Other Health Care Coverage.

Special Enrollment Period Eligible Individuals may enroll (if not already enrolled) and/or enroll in the Plan certain of their otherwise eligible Dependents described below who have lost health care coverage at any time during the Plan Year provided all of the following requirements are met:

(i) Such Special Enrollment Period Eligible Individual was covered by another group health plan or other health insurance arrangement (including COBRA continuation coverage) at the time the Employee, or Eligible Employee declined Regular Coverage or Continuation Coverage for themselves and/or such Dependent under this Medical Plan; and

(ii) Such Special Enrollment Period Eligible Individual became ineligible for coverage under such other health plan or health insurance arrangement (other than for reasons of ineligibility resulting from cause, failure to timely pay premiums, or termination of COBRA continuation coverage for any reason other than its expiration) or the employer ceased contributing to such coverage.

(iii) In the case of COBRA continuation coverage, the maximum period of COBRA continuation coverage has expired; and

(iv) The Special Enrollment Period Eligible Individual provides the Corporation with any proof of such loss of coverage as the Corporation may request; and

(v) The Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 31 days from the date the other coverage is lost.

(vi) Loss of eligibility for coverage under Subsection (B), above includes (but is not limited to) the following:

(1) Loss as a result of legal separation, divorce, cessation of dependent status (for example, a dependent child attains the maximum age for coverage under such other health plan or health insurance arrangement), death of an employee, termination of employment, reduction of hours of employment, and any loss of coverage after a period that is measured by reference to any of the foregoing; or

(2) In the case of coverage offered through an HMO or other health insurance arrangement in the individual market, the individual no longer resides, lives or works in the HMO's or other health insurance arrangement's service area; or

(3) In the case of coverage offered through an HMO or other health insurance arrangement in the group market, the individual no longer resides, lives or works in the HMO's or other health insurance arrangement's service area and no other benefit package is available to the individual; or

(4) The individual incurs a claim that would meet or exceed a lifetime limit on certain benefits under the terms of such other health plan or HMO or other health insurance arrangement; or

(5) The individual was enrolled in a health plan or health insurance arrangement that no longer offers any benefits to the class of similarly situated individuals to which the individual belonged.

Special Enrollment Period coverage will become effective on the day following the date the other coverage is lost.

(d) Newly Acquired Dependents.

Special Enrollment Period Eligible Individuals may enroll (if not already enrolled) and/or enroll certain otherwise eligible Dependents described below in a Plan in which they would otherwise qualify for Regular Coverage or Continuation Coverage, as applicable, at any time during the Plan Year as follows. Such coverage shall be Regular Coverage to the extent that such Special Enrollment Period Eligible Individual (or his or her Dependent) is otherwise eligible for Regular Coverage. Such coverage shall be Continuation Coverage to the extent that such Special Enrollment Period Eligible Individual (or his or her Dependent) is otherwise eligible for Continuation Coverage.

(e) New Spouse.

If a Special Enrollment Period Eligible Individual acquires a new Spouse during the Plan Year who otherwise qualifies as a Dependent he or she may enroll (if not already enrolled) and may also enroll the new Spouse in Regular Coverage or Continuation Coverage, as applicable, provided the Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 31 days of the date of marriage. Coverage for the Special Enrollment Period Eligible Individual and/or a new Spouse under this Section will become effective on the first day of the calendar month coinciding with or next following the date of marriage.

(f) New Same Sex Domestic Partner.

If a Special Enrollment Period Eligible Individual acquires a new Same Sex Domestic Partner during the Plan Year who otherwise qualifies as a Dependent, he or she may enroll (if not already enrolled) and may also enroll the new Same Sex Domestic Partner in Regular Coverage or Continuation Coverage, as applicable, provided the Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 31 days of the date all of the requirements for Same Sex Domestic Partner coverage as determined by the Corporation are first met (other than its execution and submission to the Corporation). Coverage for the Special Enrollment Period Eligible Individual and/or a new Same Sex Domestic Partner under this Section will become effective on the first day of the calendar month coinciding with or next following the date all of the requirements of the Corporation's for Same Sex Domestic Partner coverage are first met.

(g) Acquisition of a New Dependent Child by Birth or Adoption.

If a Special Enrollment Period Eligible Individual, his or her Spouse, or his or her Same Sex Domestic Partner acquires a child by birth, adoption or Placement for Adoption during the Plan Year and such child otherwise qualifies as a Dependent, the Special Enrollment Period Eligible Individual may enroll (if not already enrolled) and may also enroll an otherwise eligible Spouse or Same Sex Domestic Partner and such new Dependent Child in Regular Coverage or Continuation Coverage, as applicable, provided the Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 31 days of the date of the child's birth or the earlier of the date of adoption or Placement for Adoption. Coverage for the Special Enrollment Period Eligible Individual, and his or her Spouse or Same Sex Domestic Partner and/or a new Dependent Child under this Section will become effective on the date of the child's birth or the earlier of the date of adoption or Placement for Adoption.

(h) Other New Dependent Children (Including Through Marriage).

If a Special Enrollment Period Eligible Individual acquires an otherwise eligible Dependent Child (including through a marriage) who is not described in (A), (B), or

(C) above; the Special Enrollment Period Eligible Individual may enroll such new Dependent Child in Regular Coverage or Continuation Coverage, as applicable, provided the Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 31 days of the date the Special Enrollment Period Eligible Individual first acquires such Dependent Child. Coverage for such new Dependent Child under this Section will become effective on the first day of the calendar month coinciding with or next following the date the individual first becomes a Dependent Child.

(i) Change in CHIP or Medicaid Eligibility.

Special Enrollment Period Eligible Individuals may enroll (if not already enrolled) and/or enroll certain otherwise eligible Dependents described below in a plan in which they would otherwise qualify for Regular Coverage or Continuation Coverage, as applicable, at any time during the Plan Year as follows. In addition, if a Special Enrollment Period Eligible Individual is already enrolled in a Company-sponsored health plan, then such Special Enrollment Period Eligible Individual may change coverage to another plan in which they would otherwise qualify for Regular Coverage or Continuation Coverage, as applicable. Such coverage shall be Regular Coverage to the extent that such Special Enrollment Period Eligible Individual (or his or her Dependent) is otherwise eligible for Regular Coverage. Such coverage shall be Continuation Coverage to the extent that such Special Enrollment Period Eligible Individual (or his or her Dependent) is otherwise eligible for Continuation Coverage.

(A) Loss of Medicaid or CHIP Eligibility.

If a Special Enrollment Period Eligible Individual or his or her Dependent was covered under a Medicaid plan or under a State child health plan under title XXI of the Social Security Act ("CHIP") and coverage of such Special Enrollment Period Eligible Individual and/or Dependent under Medicaid or CHIP is terminated as a result of loss of eligibility for such coverage, the Special Enrollment Period Eligible Individual may enroll (if not already enrolled) and may also enroll an otherwise eligible Dependent in Regular Coverage or Continuation Coverage, as applicable, provided the Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 60 days of the date of termination of such coverage. Special Enrollment Period coverage under this Section will become effective on the first day of the month following the date the Medicaid or CHIP coverage ended.

(B) New Eligibility for Medicaid or CHIP Subsidies.

If a Special Enrollment Period Eligible Individual or his or her Dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), the Special Enrollment Period Eligible Individual may enroll (if not already

enrolled) and may also enroll an otherwise eligible Dependent in Regular Coverage or Continuation Coverage, as applicable, provided the Special Enrollment Period Eligible Individual properly files an application for Regular Coverage or Continuation Coverage with the Corporation within 60 days of the date the Special Enrollment Period Eligible Individual or his or her Dependent is determined to be eligible for the assistance. Special Enrollment Period coverage under this Section will become effective on the first day of the month following the date the Special Enrollment Period Eligible Individual or Dependent became eligible for the assistance.

(C) Procedures with Respect to Medical Child Support Orders.

In the event that a Medical Child Support Order (including a National Medical Support Notice) is received by the Medical Plan, the Corporation shall promptly notify the affected Employee and the Alternate Recipient (or such recipient's designated representative) of the receipt of such order and the Medical Plan's procedures for determining the qualified status of such order under §609 of ERISA. For purposes of these notification requirements, notice to the designated representative of the Alternate Recipient shall be deemed to be notice to the Alternate Recipient. The Corporation shall then, within a reasonable period after receipt of such order, determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient (or such Alternate Recipient's designated representative) of its determination.

Notwithstanding any other provision of the Medical Plan, any payment for benefits made by the Plan pursuant to a Qualified Medical Child Support Order shall be made to the Alternate Recipient's custodial parent or legal guardian unless that individual authorizes payment to be made directly to the provider of services or supplies.

The term "Alternate Recipient" means any child of an Employee who is recognized under a Medical Child Support Order as having a right to enrollment under the Medical Plan.

The term "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which either:

Provides for child support with respect to a child of an Employee or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and which relates to benefits under the Plan; or

Enforces a law relating to medical child support described in 42 U.S.C. § 1396g-1, with respect to the Medical Plan.

The term "Qualified Medical Child Support Order" means a Medical Child Support Order or a properly completed National Medical Support Notice which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an Employee or beneficiary is eligible, and satisfies the requirements stated in (A) and (B) below:

A Qualified Medical Child Support Order must clearly specify:

(1) The name and last known mailing address of the Employee and of each Alternate Recipient (or the mailing address of such Alternate Recipient's designated representative); and

(2) A reasonable description of the type of coverage to be provided by the particular Plan to the Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(3) The period to which such order applies.

A Qualified Medical Child Support Order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Medical Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in 42 U.S.C. § 1396g-1.

Notwithstanding any other provision of this Plan, coverage for an Alternate Recipient will become effective on the first day of the calendar month following the date of receipt by the Plan of the Qualified Medical Child Support Order.

SECTION 14. ADMINISTRATION AND OPERATION OF THE PLAN

(a) Plan Administrator.

The Corporation is the "administrator" (also referred to as the "plan administrator") of the Medical Plan (including this Plan), as the term is used under ERISA. The Corporation may delegate plan administrator authority as permitted under ERISA.

(b) Administrative Power and Responsibility.

The Corporation is the named fiduciary that has the discretionary authority to control and manage the administration and operation of the Plan. The Corporation shall have the full, exclusive and discretionary authority to prescribe such forms, make such rules, regulations, interpretations and computations, construe the terms of the Plan and determine all issues relating to coverage and eligibility for benefits and take such other action to administer the Plan as it may deem appropriate in its sole discretion. The Corporation's rules, regulations, interpretations, computations and actions shall be final and binding on all persons.

SECTION 15. FUNDING POLICY AND PAYMENTS TO AND FROM MEDICAL PLAN

(a) Employee Contributions.

Employees or covered Dependents may be required to make monthly contributions to the Medical Plan. These contributions (which are referred to as "Employee Contributions") shall be determined from time to time by the Corporation in its sole discretion and may vary between different Employees and covered Dependents as determined by the Corporation in its sole discretion.

Any change in the rate of Employee Contributions due to a change in coverage will become effective on the first day of the calendar month coinciding with or next following the effective date of the change.

(b) Corporation Payments.

The Corporation will make payments to the Plan sufficient to meet current benefits and administrative expenses of the Plan to the extent such benefits and expenses exceed Employee Contributions. These payments are referred to as "Corporation Payments."

(c) Recovery of Overpayments.

An "Overpayment" is a payment made to any Employee (or elsewhere for the benefit of the Employee) in excess of the amount properly payable under the Plan with respect to the Employee.

Upon any Overpayment, the Plan will have a first right of reimbursement and restitution with an equitable lien by contract in such amount. Further, the holder of such Overpayment shall hold it as the Plan's constructive trustee.

If any Employee has cause to believe that an Overpayment may have been made, the Employee shall promptly notify the applicable Benefit Claims Administrator of the relevant facts. If the applicable Benefit Claims Administrator determines (on the basis of any relevant facts) that an Overpayment was made to any Employee (or any other person), it shall notify the Employee in writing and the Employee shall promptly pay (or cause another person to pay) the amount of such Overpayment to the applicable Benefit Claims Administrator.

If the applicable Benefit Claims Administrator has made a written demand for the repayment of an Overpayment and the Employee (or other person) has not repaid (or caused to be repaid) the Overpayment within 30 days following the date on which the demand was mailed to the Employee (or other person), then any amounts subsequently payable as benefits under this Plan with respect to the Employee may be reduced by the amount of the outstanding Overpayment or the applicable Benefit Claims Administrator may recover such Overpayment by any other appropriate method that the applicable Benefit Claims Administrator (or the Corporation) shall determine.

(d) Agreement Not to Alienate Rights or Property.

The Employee agrees that if such Overpayment is not in his or her possession (other than in possession by or on behalf of the Plan), to immediately take whatever steps possible to regain possession of the Overpayment or have it transferred to or on behalf of the Plan pursuant to its direction.

(e) Cooperation.

The Employee and/or covered Dependent hereby agrees to cooperate with the Plan and take any action that may be necessary to protect its interests herein.

SECTION 16. CLAIMS PROCEDURE

(a) Proof of Loss.

All claims for payment of Covered Charges under the Plan must be submitted to the Benefit Claims Administrator at the address specified in this document. All claims for payment of Covered Charges must be submitted in the form prescribed by the Benefit Claims Administrator and must include the required information and substantiation. The form must be filed within 24 months after the occurrence of the loss for which a claim for payment of Covered Charges is made, or as soon thereafter as reasonably possible. The Benefit Claims Administrator may require that itemized bills, receipts and other proof of the loss be submitted in addition to the claim form. No claim for payment of Covered Charges will be paid if complete proof of the claim is not furnished to the Benefit Claims Administrator within 24 months of when the Covered Charges were incurred.

(b) Payment of Claims.

The Benefit Claims Administrator will process a claim for payment of Covered Charges promptly after he or she receives complete proof of the claim. If the Benefit Claims Administrator finds that the claim is payable under the Plan, the Benefit Claims Administrator will send payment to the provider of services or supplies, or, in the case of a non-contracted provider, to the Employee, except in emergency situations. Notwithstanding the previous sentence, if the Plan has received a Qualified Medical Child Support Order, payment will be made to the Alternate Recipient's custodial parent or legal guardian, unless that individual authorizes payment to be made directly to the provider of services or supplies.

(c) Timing of Claims Decision.

The Benefit Claims Administrator will decide a claim for payment of Covered Charges in accordance with reasonable claims procedures, as required by ERISA. If the Benefit Claims Administrator denies a claim in whole or in part, a written notification setting forth the reason(s) for the denial will be provided.

If a claim is denied, an appeal may be submitted to the Benefit Claims Administrator for the Plan for a review of the denied claim. The Benefit Claims Administrator will decide the appeal in accordance with reasonable claims procedures, as required by

ERISA. If the appeal is not submitted on time, the right to file suit in a state or federal court may be lost. Appeals may be submitted by calling the number listed in the "Contact Information" section.

SECTION 17. REVIEW PROCEDURE

(a) Named Fiduciary.

The Benefit Claims Administrator shall be the named fiduciary with respect to the Plan that has the discretionary power and authority to act with respect to any appeal from a denial of a claim for payment of Covered Charges under the Plan by performing a full and fair review of the denial, and such actions shall be final and binding on all persons.

(b) Right of Appeal.

Any person whose claim for payment of Covered Charges is denied in whole or in part, or such person's duly authorized representative, may appeal from such denial by submitting to the Benefit Claims Administrator a written request for a review of the denial within 180 days after receiving written notice of such denial from the Benefit Claims Administrator.

(c) Request for a First Review.

The request for review must be in writing and shall be addressed to the Benefit Claims Administrator at the address specified in this document.

The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that the claimant deems pertinent. The Benefit Claims Administrator may require the claimant to submit (at the expense of the claimant) such additional facts, documents or other material as the Benefit Claims Administrator deems necessary or appropriate in making its review.

(d) Procedures on Review.

If the claimant (or the claimant's duly authorized representative) requests a review of a denied claim, the Benefit Claims Administrator shall apply the following procedures:

(i) The claimant (or the claimant's duly authorized representative) shall have the opportunity to review the claim file, submit written comments, documents, records, and other information or testimony pertinent to the claim to the Benefit Claims Administrator; and

(ii) The Benefit Claims Administrator shall provide to the claimant (or the claimant's duly authorized representative) upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for benefits (other than legally or medically privileged documents); and

(iii) 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 comments, documents, records, and other information were submitted or considered in the initial benefit determination; and

(iv) The review shall not afford deference to the initial claim denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual; in addition, the Benefit Claims Administrator shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision; and

(v) In deciding an appeal that is based in whole or in part on a medical judgment, including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such health care professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of such individual); and

(vi) The Benefit Claims Administrator shall, upon request, provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(vii) The Benefit Claims Administrator shall provide the claimant (or the claimant's duly authorized representative) with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, or any new or additional rationale for denying the claims as soon as possible and sufficiently in advance of the date the decision is due in order to give the claimant a reasonable opportunity to respond prior to decision due date.

(e) Decision on First Review.

The Benefit Claims Administrator shall act upon each request for a first review within the time frames established by law pursuant to ERISA and stated in the applicable documents relating to the Plan.

In the event the Benefit Claims Administrator determines on first review that benefits are payable under the Plan, he or she will process payment of the claim in accordance with the provisions of Section 9(b) above. In the event the Benefit Claims Administrator confirms the denial of the claim, in whole or in part, he or she shall notify

the claimant of such denial in writing. Such written notice shall set forth, in a manner calculated to be understood by the claimant, the following information:

(i) The specific reason(s) for the denial; and

(ii) Reference to the specific Plan provision(s) on which the denial is based; and

(iii) 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 (other than legally or medically privileged information) relevant to the claimant's claim for benefits; and

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring a civil action under §502(a) of ERISA following the completion of all levels of appeal required by the Plan; and

(v) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in denying the claim, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge upon request; and

(vi) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant free of charge upon request; and

(vii) Information sufficient to identify the claim involved and any other information required by the ERISA internal claims and appeals and external review processes regulations.

(f) Right to Second Review.

If on first review the Benefit Claims Administrator upholds the denial of a claimant's claim for benefits, the claimant, or the claimant's duly authorized representative, may, but is not required to, again appeal from such denial by submitting to the Benefit Claims Administrator a written request for a second review of the denial within 90 days after receiving the written notice described in Subsection (e) above.

A request for a second review must set forth all of the grounds upon which it is based, all facts in support thereof, and any other matters that the claimant deems pertinent. The procedures set forth in Subsection (d) above shall apply to the second review.

(g) Decision on Second Review.

The Benefit Claims Administrator shall act upon each request for a second review within the time frames indicated below.

For Pre-Service Claims, not later than 30 days after receiving the second appeal.

For Post-Service Claims, not later than 45 days after receiving the second appeal.

Notwithstanding anything in the Plan to the contrary, there shall be no second appeal with respect to an Urgent Care Claim.

In the event the Benefit Claims Administrator determines on second review that benefits are payable under the Plan, the Benefit Claims Administrator will process payment of the claim in accordance with the provisions of Section 9(b) above. In the event the Benefit Claims Administrator confirms the denial of the claim, in whole or in part, the Benefit Claims Administrator shall notify the claimant of such denial in writing. Such written notice shall set forth, in a manner calculated to be understood by the claimant, the information specified in Subsection (e).

(h) Voluntary External Review.

The Benefit Claims Administrator shall provide an external review procedure that complies with the ERISA internal claims and appeals and external review processes regulations and related guidance issued from time to time ("External Review Guidance") upon request by the claimant. A claimant need not seek a second review in order to request a voluntary external review. External Review Guidance shall provide for referral to an independent review organization upon request for external review filed by a claimant (or the claimant's duly authorized representative) as required by the External Review Guidance when:

(i) the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(ii) the adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) the adverse benefit determination or final adverse benefit determination involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational), as determined by the external reviewer; or the matter is a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time);

(iv) the claimant has exhausted the Plan's internal appeal process; provided that a de minimis deviation from strict adherence of the internal claims and appeals procedures that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and

review procedure. The Benefit Claims Administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is rejected on the basis of the failure to exhaust internal claims and review procedures when a de minimis deviation is involved, the claimant will have opportunity to pursue the internal appeal of the claim. The Benefit Claims Administrator shall provide notice of such opportunity within 10 days of the external reviewer's rejection of the request, and the time period for filing the appeal shall start upon claimant's receipt of such notice.

Such procedure shall provide for an expedited review for the following situations:

(i) an adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or

(ii) a final decision on review if the claimant has a medical condition where:

(A) the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or

(B) in the opinion of a physician with knowledge of the claimant's medical condition, the would subject the claimant to severe pain that cannot be adequately managed without the care or treatment made subject of the claim; or

(C) the final internal decision on review 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.

A claimant must submit a written request for External Review within 30 days following an adverse benefit determination, or within 15 days after receiving the External Review Guidance (following a request), whichever is later. Any verbal request or any written request submitted after such deadlines will not be considered.

(i) Benefit Claims Administrator Rules and Procedures.

The Benefit Claims Administrator shall have the discretionary power and authority to establish such rules and procedures, consistent with the Plan, and with ERISA, as it may deem necessary or appropriate in carrying out its responsibilities.

SECTION 18. REVIEW PROCEDURES REGARDING ELIGIBILITY TO PARTICIPATE IN THE MEDICAL PLAN

(a) Claims Procedure.

Any person who has a question regarding eligibility to participate in the Plan should contact the Employee Benefits Service Center. If the person is not satisfied with the outcome, they can file a request for an eligibility determination. Note that a request for an eligibility determination is not a claim for benefits for purposes of ERISA and is not subject to the Claims and review provisions under the Plan.

(b) Eligibility Determinations.

If a person has been denied participation in the Plan the person can file a written request for an eligibility determination with the Plan Administrator. The writing should include the grounds on which the request is based and any documents, records, written comments or other information that will support the request. The Plan Administrator shall make a determination on the request within 90 days after the request is received. However, if there are special circumstances that require additional time, the administrator will provide written notice of the extension prior to the termination of the initial 90-day period. In such case, the administrator shall make a determination within 180 days after the request is received.

SECTION 19. AMENDMENT AND TERMINATION OF THE MEDICAL PLAN

(a) Right to Amend or Terminate.

The Corporation reserves the right to amend or to terminate the Plan at any time, by action of its board of directors or by action of a committee or individual(s) acting pursuant to a valid delegation of authority by the board of directors.

(b) Effect of Amendment or Termination.

Any amendment or termination of the Plan will not affect any payment of a Covered Charge incurred by an Employee or a covered Dependent before the amendment or termination. Notwithstanding the foregoing, any amendment that pertains to matters involving the processing of claims for the payment of such Covered Charges under the Plan (and not the calculation of the amount of such Covered Charges that may be payable under the Plan) shall be effective as of the date specified by the board of directors of the Corporation or its delegate at the time of adopting the amendment and shall apply with respect to all pending claims and reviews without regard to the date the Covered Charge was incurred.

SECTION 20. GENERAL PROVISIONS

(a) Payment of Claims to Others.

If any payment for Covered Charges with respect to the Plan would be payable to the estate of any person, or to any person who is a minor or otherwise not competent to give a valid release, the Benefit Claims Administrator (to the extent permitted by law) may distribute this benefit to any relative of the person by blood or marriage (or to any other person who can demonstrate that the person paid the Employee's or Dependent's health care expenses and is entitled to reimbursement) whom it deems to be entitled to

the benefit. Any payment made by the Benefit Claims Administrator in good faith pursuant to this Section will discharge the Plan and the Corporation from all liability to such person to the extent of the payment.

(b) Exhaustion of Remedies.

No action at law or in equity shall be brought to recover benefits under the Plan unless the action is commenced within the lesser of the applicable statute of limitations period or one year after the occurrence of the loss for which a claim is made. No legal action for benefits under the Plan shall be brought unless and until the claimant:

(i) Has submitted a written application for benefits in accordance with the provisions of the Plan; and

(ii) Has been notified by the Benefit Claims Administrator that the application is denied; and

(iii) Has filed a written request for a first review of the application in accordance with this document; and

(iv) Has been notified in writing that the Benefit Claims Administrator has affirmed the denial of the application on first review;

(v) Has filed a written request for a second review of the application; and

(vi) Has been notified in writing that the Benefit Claims Administrator has affirmed the denial of the application on second review;

provided that legal action may be brought after the Benefit Claims Administrator has failed to take any action on the claim within the time prescribed herein. Notwithstanding the foregoing, in the event that the Benefit Claims Administrator fails to provide timely notice of its decision in accordance with the terms and provisions herein. The Plan Administrator reserves the right to contend that the Employee may not file a legal or equitable action until the Employee files a timely written request for a review of the claim and that review is completed.

(c) Proof of Age, Financial Support and Marital or Same Sex Domestic Partnership Status.

The Corporation may require Employees and Dependents to furnish satisfactory proof of age and financial support of Dependents and may require Employees and their Spouses or Same Sex Domestic Partners to furnish satisfactory proof of marital or Same Sex Domestic Partnership status (as applicable) as a condition of maintaining coverage of such Dependents under the Plan.

(d) Workers' Compensation.

The Plan is not in lieu of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

(e) Employment Rights.

Nothing in the Plan shall be deemed to constitute a contract between any person and the Company, or to give any person any right to remain in the employ of the Company nor to affect the right of the Company to terminate the employment of any person at any time with or without cause, which right is hereby reserved.

SECTION 21. THIRD PARTY RESPONSIBILITY

(a) Payment of Certain Benefits Subject to Full Right to Subrogation and Reimbursement, and Restitution.

If any Employee or covered Dependent receives benefits under the Plan related to either a) injuries, illnesses or conditions resulting from the act or omission of any third person, or b) any matter reimbursable under a contract of no fault automobile insurance, any benefits paid under this Plan that are related to such matters shall only be paid subject to the Plan's full rights of subrogation, reimbursement, and restitution for the payment of such benefits.

(b) Granting of First Right of Subrogation, Reimbursement, and Restitution.

As a condition of receiving the Plan benefits described in Subsection (a), the Employee and/or covered Dependent grant specific and first rights of subrogation, reimbursement, and restitution to the Plan.

Such rights shall come first and are not adversely impacted in any way by:

(i) the extent to which the Employee or covered Dependent recovers his or her full damages and/or attorneys' fees; or

(ii) how such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses.

Such rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits described in Subsection (a). Such rights shall be without regard to the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Employee and/or covered Dependent, no-fault coverage, uninsured and/or underinsured motorist coverage).

(c) Agreement Not to Alienate Rights or Property.

The Employee and/or covered Dependent agree:

(i) not to assign any rights or causes of action he or she may have against others (including those under insurance policies) related to this Section without the express written consent of the Plan;

(ii) to take possession of any property subject to the Plan's equitable lien by contract in his or her own name, place it in a segregated account within his or her control (at least in the amount of the equitable lien by contract), and not to alienate it or otherwise take any action so that it is not in his or her possession prior to the satisfaction of such equitable lien by contract; and

(iii) that if such property is not in his or her possession (other than in possession by or on behalf of the Plan), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the Plan pursuant to its direction.

(d) Cooperation.

The Employee and/or covered Dependent hereby agrees to cooperate with the Plan and take any action that may be necessary to protect its interests herein.

(e) Notice Obligation.

The Employee or covered Dependent shall timely notify the Plan of:

(i) the possibility that benefits paid by the Plan may be subject to Subsection (a);

(ii) the submission of any claim or demand letter regarding property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust;

(iii) the filing of any legal action regarding any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust;

(iv) the request for any alternative dispute resolution process regarding any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust;

(v) the commencement date of any trial or alternative dispute resolution process related to any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust (at least 30 days in advance); and

(vi) any agreement that any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust will be paid to or on behalf of the Employee

and/or covered Dependent (whether pursuant to resolution of a claim, legal action, alternative dispute resolution proceeding, or otherwise).

SECTION 22. DEFINITIONS

(a) "Alternate Recipient"

means an alternate recipient as that term is defined in ERISA § 609(a)(2)(C).

(b) "Benefit Claims Administrator"

means the claims administrator appointed by the Corporation to assist it in processing and reviewing claims with respect to the Plan. The Benefit Claims Administrator shall not be deemed to be the "administrator" of the Plan as defined in ERISA.

(c) "Calendar Year"

means a period commencing January 1 and ending at 12 o'clock midnight on the next succeeding December 31.

(d) "Casual Employee"

means an Employee who normally works fewer than 20 hours a week on a non-continuous, irregular, infrequent, and unscheduled basis.

(e) "Claims Administrator"

means an entity appointed by the Corporation to assist it in processing and reviewing claims. A Claims Administrator shall not be deemed to be the "administrator" of the Plan as defined in ERISA.

(f) "COBRA"

means the Consolidated Medical Budget Reconciliation Act of 1985, as amended from time to time.

(g) "Code"

means the Internal Revenue Code of 1986, as amended from time to time.

(h) "Company"

means the Aerospace Corporation. Such designation may include a limitation as to the classes or groups of Employees that may participate in the Medical Plan.

(i) "Concurrent Care Claim"

means any claim for a benefit regarding an on-going course of treatment that was previously approved by the Plan for a specific period of time or number of treatments.

(j) "Continuation Coverage"

means the coverage provided under the COBRA provisions of the Plan and not the Regular Coverage provisions of the Plan.

(k) "Continuation Coverage Election Period" means the period described in Section 4.

(l) "Copayment" means the flat-dollar amount that a Covered Individual must pay for certain Covered Services. Covered Services subject to a Copayment and the amounts are listed in the summary of benefits or in the PPO Plan Benefit Booklet.

(m) "Corporation" means the Aerospace Corporation.

(n) "Corporation Payments"

mean payments by the Corporation.

(o) "Covered Charge"

means a covered charge or covered medical care as defined herein.

(p) "Covered Individual"

means an Eligible Employee or Dependent who is receiving benefits under the Plan.

(q) "Dependent"

means the following:

An Employee's Spouse or Surviving Spouse; or

An Employee's Same Sex Domestic Partner or Surviving Same Sex Domestic Partner; or

A Dependent Child or Surviving Dependent Child.

(r) "Dependent Child"

means an Employee's Dependent Child or a Same Sex Domestic Partner's Dependent Child.

(s) "Disability Leave"

means a leave of absence without pay that is designated as a leave on account of a disability by the Company in accordance with the Leave of Absence Policy.

(t) "Eligible Employee"

Means the following

(i) an employee who is a Regular Employee who has elected and commenced coverage under the Medical Plan and whose coverage has not terminated under the Medical Plan. In the event of a Regular Employee's death, a Surviving Spouse or Surviving Same Sex Domestic Partner, as applicable, or a Surviving Dependent Child who is not covered as a Dependent of a Surviving Spouse or Surviving Same Sex Domestic Partner, shall be treated as a Regular Employee; or

(ii) a Tier A Retiree; or

(iii) a Tier B Retiree

(iv) who is otherwise eligible to participate in the Medical Plan.

(u) "Employee"

means any individual who is employed as a common law employee of the Company, either on a full or a part-time basis. However, "Employee" does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or individual classified by the Employer as an independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; and (c) Casual Employees. Temporary Employees who work for the Employer for less than 12 months. The term Employee does include Temporary Employees who work for the Company for less than 12 months for the limited purpose of allowing eligibility solely for group medical benefits. Additionally, the term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Company, but only to the extent specifically provided elsewhere under the Plan.

(v) "Employee Contributions"

mean such contributions by Employees as described in Section 7.

(w) "Employee's Dependent Child"

means:

(i) The Employee's natural child, stepchild, legally adopted child (including a child Placed for Adoption with the Employee prior to the date of adoption) or a foster child who is either under the age of 26 or an Incapacitated Child.

(ii) An unmarried child who is an Employee of the Employee's household and for whom the Employee or the Employee's Spouse acts as a guardian if the child is either:

(iii) Under the age of 26, if more than one-half of his or her financial support is derived from the Employee or the Employee and the Employee's Spouse; or

(iv) An Incapacitated Child who is the Employee's "qualifying child" (as defined in Section 152(c) of the Code) if more than one-half of his or her financial support is derived from the Employee or the Employee and the Employee's Spouse.

(x) "ERISA"

means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(y) "Family Leave"

means a leave of absence designated as a family leave by the Company in accordance with the Leave of Absence Policy or a leave necessary to comply with any applicable family leave law.

(z) "Incapacitated Child"

means a Dependent Child who:

(i) Is incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician);

(ii) Is dependent for more than half of their support on the:

(iii) Employee

(iv) The Employee together with the Employee's Spouse or Same Sex Domestic Partner; or

(v) The Employee's Surviving Spouse or Surviving Same Sex Domestic Partner if the Employee is deceased and the Surviving Spouse or Same Sex Domestic Partner is covered by the Medical Plan; and

(vi) Is incapacitated (i.e., meets the requirements of Subsection (i) above):

(A) Immediately prior to turning age 26 while being covered under the Plan; or

(B) By age 26 when the Employee becomes an Eligible Employee, and the Dependent Child:

(1) Had other health care coverage immediately before the Employee becomes an Eligible Employee; and

(2) Is enrolled in the Plan within 31 days after the Employee becomes an Eligible Employee; or

(C) By age 26 when the Employee is an Eligible Employee, and the Dependent Child:

(1) Had other health care coverage immediately before he or she is enrolled in the Plan; and

(2) Is enrolled in the Plan during an Open Enrollment Period or Special Enrollment Period; and

(3) Has proof of such incapacity and dependency furnished to the Corporation:

(a) In the case of Subsection (v)(iii)(A), within 31 days after the date when the Dependent Child's Regular Coverage would terminate but for the incapacity; or

(b) In the case of Subsection (v)(iii)(B), within 31 days after the Employee becomes an Eligible Employee.

Notwithstanding the foregoing, an Incapacitated Child will cease to be so if proof of such incapacity and dependency is not furnished to the Corporation on such subsequent occasions as may be required by the Corporation, but not earlier than two years after commencing Incapacitated Child status (but no more frequently than annually); or if his or her Regular Coverage is terminated after becoming an Incapacitated Child.

(aa) "Leave of Absence Policy"

means the Corporation's applicable leave of absence policy as set forth in Practice HR 3-15, as amended from time to time.

(bb) "Leave with Pay"

means a leave of absence with pay that is designated as such by the Company in accordance with the Leave of Absence Policy.

(cc) "Medicare"

means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged Act), as amended from time to time.

(dd) "Military Service Leave"

means a leave of absence for the purpose of allowing an Eligible Employee to serve voluntarily or involuntarily as an Employee of the uniformed services of the United States when such military service is subject to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and that is designated as a Military Service Leave by the Company in accordance with the Leave of Absence Policy.

(ee) "Misconduct"

(i) means that an individual:

(ii) Has committed an act of embezzlement, fraud or theft with respect to the property of the Company or any person with whom the Company does business; or

(iii) Has deliberately disregarded the rules of the Company in such a manner as to cause material loss, damage or injury to or otherwise endanger the property or employees of the Company; or

(iv) Has made any unauthorized disclosure of any of the secrets or classified information of the Company; or

(v) Has engaged in any conduct that constitutes unfair competition with the Company; or

(vi) Has induced any customers of the Company to breach any contracts with the Company.

(ff) "Open Enrollment Period"

means the period once a year when Employees or Eligible Employees may (for themselves and/or their Dependents) elect to commence coverage under the Medical Plan, to change existing coverage to another health care plan to which the Corporation contributes (if available), or to cease such coverage.

(gg) "Open Enrollment Period Effective Date"

means the first of January following the end of the Open Enrollment Period.

(hh) "Placed for Adoption" or "Placement for Adoption"

means that a child has been placed with an Eligible Employee and/or his or her Spouse or Same Sex Domestic Partner and such individual(s) has assumed a legal obligation for more than one-half of the child's financial support in anticipation of the adoption of such child. Whether a child has been "Placed for Adoption" within the meaning of this provision shall be determined by the Benefit Claims Administrator in its sole discretion based on objective evidence supplied by the Employee.

(ii) "Post-Service Claim"

means any claim for benefits that is not a Pre-Service Claim or an Urgent Care Claim.

(jj) "Pre-Service Claim"

means any claim for benefits with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval by the Plan of the benefit in advance of obtaining medical care.

(kk) "Qualified Beneficiary"

means a Qualified Beneficiary as described in Section 4(a)(2).

(ll) "Qualifying Event"

means:

(i) With respect to an Employee, the Employee's failure to qualify as an Eligible Employee due to termination of employment for reasons other than "gross misconduct" or a reduction in hours of the Employee's Regular Work Schedule or the expiration of a Disability Leave, Family Leave, or Military Service Leave for reasons other than "gross misconduct." Notwithstanding the foregoing, the Employee's failure to qualify as an Eligible Employee due to termination of employment following a leave of absence for which Continuation Coverage has been provided shall not be considered Qualifying Event.

(ii) With respect to a covered Dependent of an Employee:

(iii) The Qualifying Event of the Employee; or

(iv) The death of the Employee; or

(v) The loss of status as a Dependent for any reason, including age, marriage, cessation of financial dependence on the Employee, divorce from the Employee or termination of a Same Sex Domestic Partnership.

(mm) "Regular Coverage"

means coverage under the Medical Plan.

(nn) "Regular Employee"

means an Employee who works on a regularly scheduled and assigned basis, either full or part time.

(oo) "Relevant"

means a document, record, or other information regarding a claimant's claim for a benefit if such document, record, or other information:

(i) Was relied upon in making the benefit determination; or

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to the ERISA claims regulations; or

(iv) Constitutes a statement of policy or guidance with respect to the Medical Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(pp) "Same Sex Domestic Partner"

means a person who meets all of the following conditions of either Subsection (i) or Subsection (ii):

(i) A person who meets and continues to meet all of the criteria detailed in the Corporation's policies regarding the establishment of Same Sex Domestic Partnership for benefits purposes and the Same Sex Domestic Partnership has been internally registered with the Corporation by filing an original, properly completed, notarized affidavit of Same Sex Domestic Partnership that has been accepted by the Corporation; or

(ii) A person who is married to an Eligible Employee or who has entered into a civil union with an Eligible Employee when the Eligible Employee resides in a jurisdiction where that marriage or civil union is not recognized.

(qq) "Same Sex Domestic Partner's Dependent Child"

means:

A Same Sex Domestic Partner's natural child, stepchild, legally adopted child (including a child Placed for Adoption with the Same Sex Domestic Partner prior to the date of adoption), or foster child who is either under the age of 26 or an Incapacitated Child, if the child does not qualify as the Employee's Dependent Child.

An unmarried child who is a member of the Same Sex Domestic Partner's household and for whom the Same Sex Domestic Partner acts as a guardian if the unmarried child is either:

(A) Under the age of 26, if more than one-half of his or her financial support is derived from the Same Sex Domestic Partner or the Employee and the Same Sex Domestic Partner; or

(B) An Incapacitated Child who is the Same Sex Domestic Partner's "qualifying child" (as defined in Section 152(c) of the Code), if more than one-half of his or her financial support is derived from the Same Sex Domestic Partner or the Employee and the Same Sex Domestic Partner.

(rr) "Same Sex Domestic Partnership"

means a relationship between an Eligible Employee and a Same Sex Domestic Partner that meets and continues to meet all of the criteria for a Same Sex Domestic Partnership detailed in Corporation's policies when the Same Sex Domestic Partnership has been internally registered with the Corporation by filing an original, properly completed, notarized affidavit of Same Sex Domestic Partnership that has been accepted by the Corporation.

(ss) "Special Enrollment Period"

means a period during the Plan Year in which Eligible Employees who fail to timely enroll themselves and/or certain of their Dependents for coverage under the Medical Plan may so enroll, provided that all of the applicable requirements described under the Plan's special enrollment provisions are met.

(tt) "Special Enrollment Period Eligible Individuals"

means individuals described in the special enrollment sections of the Plan.

(uu) "Spouse"

means a person to whom the Employee is legally married under the law of a state or other jurisdiction where the marriage took place.

(vv) "Survivor"

means a Surviving Spouse, Surviving Same Sex Domestic Partner or a Surviving Dependent Child of a deceased Former Eligible Employee (provided that such Dependent Child is not a Dependent of a Surviving Spouse or a Surviving Same Sex Domestic Partner).

(ww) "Surviving Dependent Child"

means an individual who qualifies as a Dependent Child as of the date of death of an Employee when the Employee dies and does not otherwise cease to be a Dependent Child.

(xx) "Surviving Same Sex Domestic Partner"

means a Same Sex Domestic Partner whose Same Sex Domestic Partnership with an Employee terminates because of the death of the Employee.

(yy) "Surviving Spouse"

means a Spouse whose marriage to an Employee terminates because of the death of the Employee.

(zz) "Temporary Employee"

means an Employee who works for a period of not more than 12 months.

(aaa) "Tier A Retiree"

Means a retiree from the Company who is

(i) between the ages of 55 and 65; and

(ii) was hired (or rehired) by the Company as a Regular Employee before July 1, 1987; and

(iii) has at least 10 years of service with the Company; and

(iv) has at least 5 consecutive years of service with the Company as of the effective date of his or her retirement; and

(v) was an Eligible Employee on the date prior to the effective date of his or her retirement.

(bbb) "Tier B Retiree"

A Tier B Retiree means a retiree from the Company who is

(i) between the ages of 55 and 65; and

(ii) was hired (or rehired) by the Company as a Regular Employee on or after July 1, 1987; and

(iii) has at least 10 years of service with the Company; and

(iv) has at least 5 years of consecutive service with the Company as of the effective date of his or her retirement; and

(v) was an Eligible Employee on the date prior to the effective date of his or her retirement.

(ccc) "Urgent Care Claim"

means any claim for a Plan benefit with respect to which the application of the time periods for making non-urgent care claim determinations either:

(i) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ddd) "USERRA"

means the Uniformed Services Employment and Reemployment Rights Act of 1994.

SECTION 23. PLAN INFORMATION

Plan Name: Group Hospital Medical Plan of The Aerospace Corporation - PPO Option (the "Plan")

Effective Date: January 1, 2018

Employer / Plan Sponsor: The Aerospace Corporation

Employer / Plan Sponsor Tax ID: 95-2102389

Plan Number: 502

Plan Year: For purposes of operating the Plan, the plan year is January 1 through December 31.

Plan Type: The Plan provides medical, behavioral health, and prescription drug benefits to eligible employees of the Company (and its subsidiaries) and their eligible dependents.

Plan Administrator: The Aerospace Corporation, Principal Director Total Rewards
2310 East El Segundo Blvd M1/064
El Segundo, CA 90245

Benefit Claims Administrator: Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street Woodland Hills, CA 91367

Plan Funding: A combination of Company and employee contributions provides the funding for the Plan. The Company uses its general assets to pay for the Plan's benefits and expenses.

SECTION 24. CONTACT INFORMATION

See the attached PPO Plan Benefit Booklet for telephone numbers and additional contact information.

Plan Administrator	The Aerospace Corporation c/o Principal Director, Total Rewards 2310 East El Segundo Blvd M1/064 El Segundo, CA 90245
Benefit Claims Administrator	Anthem Blue Cross Life and Health Insurance Company 21555 Oxnard Street Woodland Hills, CA 91367
Privacy Official	Principal Director Total Rewards 2310 East El Segundo Blvd M1/064 El Segundo, CA 90245
COBRA Information	(Contact the Plan Administrator)

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

- Continue healthcare coverage for yourself, Spouse or dependents if you lose coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Note: The Plan does not have any pre-existing condition exclusions.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your local telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

AEROSPACE
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APPENDIX A

TO THE
GROUP HOSPITAL MEDICAL PLAN OF THE AEROSPACE CORPORATION

SUMMARY PLAN DESCRIPTION FOR THE PPO PLAN OPTION
HIPAA PRIVACY APPENDIX

I. Disclosure of Protected Health Information to The Aerospace Corporation ("Corporation").

The Medical Plan shall provide Individually Identifiable Health Information ("IIHI") as defined in 45 C.F.R. § 160.103 (including the subcategory of Protected Health Information ("PHI") thereunder, as defined in 45 C.F.R. § 164.501) to the Corporation only if the following requirements are met:

A. The Corporation shall use or disclose such IIHI only for such purposes as would be permitted under the HIPAA Privacy Regulations (Subparts A – C of 45 C.F.R. Part 160 and Subparts A and E of 45 C.F.R. § 164) if the Corporation were a Covered Entity as defined in 45 C.F.R. § 160.103, provided that the Corporation is not otherwise assuming the responsibility of a Covered Entity.

B. The Corporation certifies to the Medical Plan that the Medical Plan has been amended as required by 45 C.F.R. § 164.504(f)(2) to provide and that the Corporation agrees to:

1. Not use or further disclose the IIHI other than as permitted or required by the Medical Plan text or as required by law;

2. Ensure that any agents (including any Employee of the Corporation's controlled group of companies, any subcontractor, and any of their employees) to whom it provides IIHI received from the Medical Plan agrees to the same restrictions and conditions that apply to the Corporation;

3. Not use or disclose the IIHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan except to the extent that such plans are Affiliated Covered Entities (as defined in 45 C.F.R. § 164.504(d)(1)) or part of an Organized Health Care Arrangement (as defined in 45 C.F.R. § 164.501).

4. Report to the Medical Plan any use or disclosure of the IIHI that is inconsistent with the use or disclosure for which it becomes aware;

5. Make available IIHI to an individual to whom it concerns as described in 45 C.F.R. § 164.524.

6. Make available IIHI for amendment and incorporate any amendments as described in 45 C.F.R. § 164.526.

7. Make available to the Medical Plan the information required for it to provide an accounting of disclosures as described in 45 C.F.R. § 164.528.

8. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary of Health and Human Services for purposes of determining compliance by the group health plan with the HIPAA Privacy Regulations.

9. If feasible, return or destroy all IIHI received from the Medical Plan (that exists in any form) and retain no copies when it is no longer needed for the purpose for which the 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 infeasible.

10. Ensure that adequate separation exists between the Medical Plan and the Corporation.

    a) The Corporation will restrict the access and use of such IIHI without an authorization to those Employees of its workforce, and any entity within the Corporation controlled group of companies (including their workforce), and the Medical Plan's Business Associates (including their workforce) that are directly involved with providing services with respect to the design, administration, or legal defense of the Medical Plan and only to the extent necessary for such purposes. This shall include individuals from such entities as human resources, finance, payroll, information technology, or legal functions that are involved in functions related to such purposes.

    b) Any issue of non-compliance with this adequate separation requirement will be referred to the Medical Plan's Privacy and Compliance Official. He or she is authorized to make findings with respect to whether the adequate separation requirement has been violated or whether a particular disclosure or use is consistent with adequate separation. If he or she determines that the adequate separation requirement has been or would be violated, the Medical Plan's Privacy and Compliance Official may take such action as he or she deems appropriate – including forbidding any further disclosure of IIHI from the Medical Plan to the Corporation, request the Corporation to have corrected any action taken based on the improper use of the IIHI, and notifying the Secretary of Health and Human Services.

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APPENDIX B

TO THE
GROUP HOSPITAL MEDICAL PLAN OF THE AEROSPACE CORPORATION

SUMMARY PLAN DESCRIPTION FOR THE PPO PLAN
HIPAA SECURITY APPENDIX

A. Introduction.

The Medical Plan shall protect Electronic Protected Health Information in accordance with the requirements of the HIPAA Security Rule as set forth at 45 C.F.R. Parts 160 and 164, and specifically in accordance with 45 C.F.R. §164.314(b)(2) and as set forth below.

B. Definitions.

1. Electronic Protected Health Information. The term "Electronic Protected Health Information" will have the meaning set forth in 45 C.F.R. §160.103.

2. HIPAA Security Rule. The term "HIPAA Security Rule" will mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. §§160 and 164, Subparts A and C.

C. HIPAA Security Rule Requirements.

The Plan Sponsor will reasonably and appropriately safeguard Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Medical Plan, other than Electronic Protected Health Information that is summary health information disclosed pursuant to 45 C.F.R. §164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. §164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. §164.508. In implementing such safeguards, the Plan Sponsor is required to do the following:

1. Safeguards. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Medical Plan.

2. Adequate Separation. The Plan Sponsor will ensure that the adequate separation between the Medical Plan and the Plan Sponsor as required by 45 C.F.R. §164.504(f)(2)(iii) of the HIPAA Security Rule is supported by reasonable and appropriate security measures.

3. Agents. The Plan Sponsor will ensure that any agent (including any subcontractor) to whom it provides Electronic Protected Health Information received from the Plan agrees to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

4. Reporting Obligation. The Plan Sponsor will report to the Medical Plan any security incident (as defined by 45 C.F.R. §164.304) of which it becomes aware.

D. Miscellaneous.

1. Rights. This Amendment shall not be construed to establish requirements or obligations beyond those required by the HIPAA Security Rule. Any portion of this Amendment that appears to grant any additional rights not required by the HIPAA Security Rule shall not be binding upon the Plan Sponsor.

2. Amendment. The Plan Sponsor reserves the right to amend or terminate any and all provisions set forth in this Amendment at any time to the extent permitted under the HIPAA Security Rule.

3. Construction. The terms of this Amendment shall be construed in accordance with the requirements of the HIPAA Security Rule and in accordance with any applicable guidance on the HIPAA Security Rule issued by the Department of Health and Human Services.

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SUPPLEMENT A

THE AEROSPACE CORPORATION ANTHEM BLUE CROSS PPO PLAN BOOKLET, WHICH IS INCORPORATED INTO AND MADE PART OF THIS DOCUMENT