SUMMARY

PLAN

DESCRIPTION

L-3 Communications Corporation

Aetna Choice POS II Medical Plan

Effective January 1, 2012

Benefits

L-3 COMMUNICATIONS

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The Aetna Choice POS II Medical Plan

L-3 Communications Corporation ("L-3") offers the Aetna Choice POS II Medical Plan (the "Plan") to eligible employees in certain business units of L-3. If you enroll in the Plan, you are enrolled automatically in the L-3 Communications Prescription Drug Plan (the "Drug Plan"). Please contact the L-3 Benefit Center to find out if the Plan and the Drug Plan are offered at your business unit. (Please see the *L-3 Communications Prescription Drug Plan SPD* for information on how that plan works.)

Before You Begin

This Summary Plan Description (SPD) describes the most important features of the Plan. We've tried to explain things in everyday language, but you will come across some words and phrases that have specific meanings within the context of the Plan. To help you understand them, they are *italicized* when first used and included in the *Glossary* that starts on page 69. Also be sure to read the *Other Information You Should Know* section of this SPD for important information and facts about your rights under the Plan.

If you enroll in the Plan, you are enrolled automatically in the L-3 Communications Prescription Drug Plan. (Please see the *L-3 Communications Prescription Drug Plan SPD* for information on how that plan works.)

Eligibility and Participation

Who's Eligible

You can enroll your eligible dependents in the Plan if you enroll, as long as you provide proper documentation (see *Enrolling your dependents for coverage,* page 4), including a Social Security number for each dependent.

Employees. You are eligible to participate in the Plan if it is offered at your business unit and you are:

- a U.S.-based employee working in the U.S. and regularly scheduled to work 20 hours or more per week;
- employed in a job classification designated as benefits-eligible; and/or
- on an approved leave of absence that allows for continuation of benefits.

If you are a collectively bargained employee, the terms of your collective bargaining agreement will govern your eligibility.

If you have any questions about your eligibility, contact the L-3 Benefit Center at 1-866-919-2424.

Dependents. You can enroll your eligible dependents in the Plan if you enroll, as long as you provide proper documentation (see *Enrolling your dependents for coverage,* page 4), including a Social Security number for each dependent. (If the dependent does not yet have a Social Security number, you must provide one within 60 days, unless the process is delayed for reasons beyond your control. You are not required to report a Social Security number for a dependent who is not a U.S. citizen (and therefore does not have a Social Security number nor is eligible for Medicare). If the dependent becomes eligible for a Social Security number, you must provide it as soon as it is received.) Your eligible dependents are your spouse and your children, defined as follows.

- *Spouse.* Your spouse is your lawfully married opposite-sex spouse. If the state where you live treats common-law marriage as legal marriage and you satisfy applicable state law requirements (including any documentation requirements), a common-law spouse of the opposite sex will also be considered a spouse for Plan purposes. Same-sex spouses are not treated as spouses under the Plan, even if the same-sex marriage is recognized in the state where you live. Domestic partners and civil union partners are not eligible for coverage, unless coverage is provided under an insured plan and required by law. Divorced or legally-separated spouses also are not eligible for coverage. **Please note that a decree of divorce or legal separation requiring you to provide health coverage for your ex-spouse does not make your ex-spouse eligible for coverage under the Plan** (see *COBRA Continuation Coverage,* page 50, for information about coverage that may be available to an ex-spouse).
- *Children.* Dependent children are your children under age 26 for whom proper documentation has been provided, including:
  - your biological children
  - your lawfully adopted children. If you have started legal adoption procedures, the child is considered a dependent if he/she lives with you full-time and depends on you for support. If you are adopting a child from birth, the child is considered a dependent from birth.

– your stepchildren

– any other child, including a grandchild, niece, nephew, etc. for whom you have proof of legal guardianship, as long as the child lives with you in a parent-child relationship and depends on you for support. If you have started legal guardianship procedures, coverage is effective with the filing of the application. For coverage to continue, you must be appointed a legal guardian within three months of filing your application.

You may also cover any other dependent children for whom Plan coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN). See page 7 for more information on QMCSOs and NMCSNs.

Continued coverage for handicapped children. While coverage normally ends on a dependent child's 26th birthday, you can apply for continued coverage for a *handicapped dependent child.* Children are considered handicapped when they are primarily dependent on you for financial support and maintenance because of a mental or physical condition that started before age 26. You must provide proof to Aetna that your child's handicap began before the child reached age 26, and you must do so within 60 days after the child's 26th birthday. Coverage stays in force for as long as dependent coverage under the Plan continues and the child remains handicapped, as defined above.

For all handicapped children age 26 and over, Aetna periodically requires substantiation of the child's continued handicap, which may include a physical exam. Without this proof, coverage will not be continued.

Please note: You are required to notify the L-3 Benefit Center within 60 days if your child is age 26 or over and no longer meets the criteria described above for continued coverage for handicapped children.

When family members work for L-3. An employee cannot be enrolled as both an employee and a dependent. Similarly, dependent children of married couples who both work for L-3 can be enrolled under only one parent's coverage. In addition, a person cannot be covered as both an employee and a retiree, or as a dependent of both an employee and a retiree. If a husband and wife work at different L-3 business units, the couple may choose family coverage at either business unit, and enroll either spouse's children.

Enrolling for Coverage

Participation in the Plan is not automatic; you must enroll to have coverage. You and your dependents can enroll:

- within 31 days of your eligibility date;
- during the annual enrollment period, which is held in the fall; or
- within 60 days of a "qualifying event" (see *Making changes mid-year,* page 5).

Most employees have the option of choosing a different L-3 Communications Medical Plan instead of the Aetna Choice POS II Medical Plan. Contact the L-3 Benefit Center to find out what other Medical Plan(s), if any, your business unit offers in your area.

When you enroll your dependents for coverage, you will be required to complete the *L-3 Dependent Eligibility Questionnaire* and provide certain documents to prove that your dependents are eligible. This requirement applies in **ALL** circumstances in which you may want to enroll a dependent.

HIPAA special enrollment rights. If you decline enrollment for yourself and/or your dependents (including your spouse) because you have other medical insurance or group health plan coverage and the other coverage ends, you may enroll yourself and/or your dependents in the Plan if you request enrollment within 60 days after your other coverage ends. To enroll for coverage, you must provide written proof that your other coverage has ended. Similarly, if you decline coverage because you have other employer-sponsored coverage (such as through your spouse's employer) and the employer stops contributing toward your or your dependents' other coverage, you may enroll yourself and/or your dependents in the Plan if you request enrollment within 60 days after employer contributions for your other coverage end. To enroll for coverage, you must provide written proof that employer contributions for your other coverage have ended.

In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) if you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption. You must provide documented proof that your dependents are eligible, as described below.

To request special enrollment or obtain more information, contact the L-3 Benefit Center.

Enrolling your dependents for coverage. When you enroll your dependents for coverage, you will be required to complete the *L-3 Dependent Eligibility Questionnaire* and provide certain documents to prove that your dependents are eligible. This requirement applies in **ALL** circumstances in which you may want to enroll a dependent, whether that's as a new hire, at annual enrollment, or when you have a "qualifying event" that allows you to add a dependent during the *Plan Year* (see *Making changes mid-year,* page 5).

L-3 reserves the right to confirm any dependent's eligibility at any time, including during annual enrollment or by conducting a formal dependent eligibility audit. Such an audit may be conducted by L-3 or by a third party authorized by L-3. If you do not respond to an audit request, coverage for your dependents will be terminated.

Please note: You are required to notify the L-3 Benefit Center within 60 days of any event that affects a dependent's eligibility.

Annual enrollment. L-3 holds an annual enrollment each fall during which you can:

- ❑ enroll for coverage;
- ❑ change your previous election;
- ❑ cancel your own and/or your dependents' coverage; or
- ❑ add dependent coverage (documentation will be required).

The election you make during annual enrollment takes effect on the next January 1 and stays in effect for that full Plan Year unless you have a qualifying event (see *Making changes mid-year,* page 5).

Choosing a coverage level. You may elect one of the following coverage levels:

- employee only
- employee and spouse
- employee and child(ren)
- employee and family.

Some collective bargaining agreements may provide for different coverage levels. You will be notified which coverage levels are available to you.

Making changes mid-year. The IRS requires that your election stays in effect throughout the full Plan Year unless you have a "qualifying event." L-3 abides by the IRS's definition of qualifying events, which includes:

- your legal marital status changes (e.g., through marriage, divorce, legal separation or annulment)
- the number of your dependents changes (e.g., through the birth or adoption of a child; a change in dependent status under the Internal Revenue Code; or the death of a child or spouse)
- you are required to cover a child pursuant to a Qualified Medical Child Support Order or a National Medical Child Support Notice
- your spouse or your dependent becomes employed or unemployed
- you, your spouse or your dependent takes or returns from an unpaid leave of absence
- your, your spouse's or your dependent's employment status changes from full-time to part-time (or vice versa) or from hourly to salaried (or vice versa)
- your dependent first meets or no longer satisfies the requirements for coverage because he/she reaches the limiting age, or any similar circumstance
- you, your spouse or your dependent goes on strike or is locked out, or returns from a strike or lockout
- the coverage options available to you change because you, your spouse or your dependent changes residences or work sites
- you previously waived participation because you were covered under your spouse's group medical plan and you subsequently lose coverage under that plan
- you, your spouse or your dependent either becomes eligible or loses eligibility for *Medicare* or *Medicaid* coverage
- according to Internal Revenue Service guidelines, there's a significant change in your, your spouse's or your dependent's medical coverage
- you, your spouse or your dependent makes a change (or a change is made) under another employer group health plan

You can't change your election during the Plan Year unless you have a "qualifying event." Generally if you have a qualifying event, you have 60 days from the event to change your coverage election. The change in your election must be due to and consistent with the qualifying event.

Contact the L-3 Benefit Center at 1-866-919-2424 as soon as you know that a qualifying event is about to take place (or immediately after it takes place) to make sure you allow yourself enough time to take the appropriate action.

- you or your dependent loses eligibility under a Medicaid plan or a state child health insurance plan (SCHIP)
- you or your dependent becomes eligible for government assistance under a Medicaid plan or an SCHIP designed to help you pay for Plan coverage.

If you have a qualifying event, you have 60 days from the event to change your coverage election. The change in your election must be due to and consistent with the qualifying event. (For example, if you are widowed mid-year, you could change from "employee and spouse" coverage to "employee only" coverage, but you couldn't drop your coverage.)

Effective date of election changes. The effective date of your election change is the date of the qualifying event. For example, if your election change is due to the birth of a child, the change is effective as of the child's date of birth.

An election change will not become effective until you provide the required enrollment materials, including appropriate written documentation of the reason for the change. Please note that you will need a dependent's Social Security number to enroll that dependent. (If the dependent does not yet have a Social Security number, you must provide one within 60 days, unless the process is delayed for reasons beyond your control. You are not required to report a Social Security number for a dependent who is not a U.S. citizen (and therefore does not have a Social Security number nor is eligible for Medicare). If the dependent becomes eligible for a Social Security number, you must provide it as soon as it is received.) You also will need to complete the *L-3 Dependent Eligibility Questionnaire* and provide certain documents to prove that the dependent is eligible.

Contact the L-3 Benefit Center at 1-866-919-2424 as soon as you know that an event is about to take place (or immediately after it takes place) to make sure you allow yourself enough time to take the appropriate action. The L-3 Benefit Center will explain the procedure to you.

When Coverage Begins

For you. If you enroll for coverage, it starts on your first day at work, unless otherwise specified in your collective bargaining agreement (if applicable).

For your dependents. If you enroll your eligible family members when you enroll, their coverage begins when yours does, as long as you have provided the required documentation, including a Social Security number for each dependent. If a dependent becomes eligible as a result of a qualifying event, coverage for that dependent starts on the date described above as long as you provide appropriate written documentation.

If you enroll during the annual enrollment period. If you enroll for coverage during the annual enrollment period held each fall, coverage for you and your enrolled dependents starts on the following January 1.

If you change your coverage because of a qualifying event. If a qualifying event occurs (as described above) and you change your coverage as a result of that event, your coverage is effective as described above as long as you provide appropriate written documentation.

Medical Child Support Orders

If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a Qualified Medical Child Support Order (QMCSO) or a properly completed National Medical Child Support Notice (NMCSN). A QMCSO is a judgment, decree or order issued by a state court or agency that creates or recognizes the existence of an eligible child's right to receive health care coverage. A NMCSN is a standardized medical child support notice that is used by state child support enforcement agencies to require children to be enrolled in an employer's group medical plan. The Order or Notice must comply with applicable law and must be approved and accepted as a QMCSO or a NMCSN by the Plan Administrator in accordance with Plan procedures.

If the Plan receives a QMCSO or a NMCSN requiring you to provide Plan coverage for an eligible child, deductions will be made automatically from your pay beginning as of the date specified in the QMCSO or the NMCSN. To get a free copy of the procedure followed by the Plan in determining whether an order is qualified, contact the L-3 Benefit Center or L-3's QMCSO administrator:

Aon Consulting, Inc.
ATTN: L-3 QMCSO Dept.
400 Atrium Drive, 5th Floor
Somerset, NJ 08873-4162
Phone: 1-732-537-4444
Fax: 1-312-381-9190

You and L-3 share the cost of your coverage. Your contributions are deducted from each paycheck on a pre-tax basis (before taxes are taken out). That means you pay less out of your pocket for coverage than if you were paying on an after-tax basis (after taxes are taken out).

Cost of Coverage

You and L-3 share the cost of coverage. Your contributions are deducted from your paycheck each pay period. Contact the L-3 Benefit Center to find out current contribution amounts.

Since your share of the cost is deducted from your paycheck on a pre-tax basis, L-3 does not withhold federal income taxes, state income taxes (for most states) or Social Security taxes on your contributions. However, keep in mind that, as a result of the tax savings, you may pay less into Social Security, which means your Social Security benefit could be slightly lower.

Waiving Medical Coverage

You also have the option of waiving participation. However, if you do so and want to enroll later, you will have to wait until the next annual enrollment or until you have a qualifying event, as described on page 5. Written proof of the qualifying event will be required.

What's Covered Under the Plan

While there is no overall lifetime maximum on Plan benefits, there are annual and lifetime limits for certain non-essential covered services.

Understanding What's Covered

It's very important that you understand that the Plan generally reimburses only specific medical expenses that result from a *non-occupational illness, injury* or *disease* or from conditions related to pregnancy. The Plan also reimburses specific covered preventive care expenses. As you read the following pages, you'll see that most *hospital,* surgical and medical services are considered covered expenses. But certain services are not covered, or are only partially covered, and some expenses may be covered only *In-Network.*

The Plan covers only those expenses Aetna determines to be *"medically necessary,"* and certain preventive services and supplies as described starting on page 12. "Medically necessary" is defined as services or supplies that are ordered by a *physician* and determined by Aetna as essential to the diagnosis, care or treatment of the physical or mental condition involved. The service also has to be widely accepted professionally in the United States as effective, appropriate and essential, based on recognized standards of the health care specialty involved.

In all circumstances, the Plan will cover treatment only if it meets the requirements of the Plan. Aetna has full discretionary authority to make all such determinations and to rely on its own materials, expertise and procedures, especially in determining issues concerning italicized words in this SPD. (Summary definitions of these terms are found in the *Glossary*.)

Lifetime Maximum Benefits

There is no overall *lifetime maximum* on benefits paid by the Plan. However, there are lifetime limits for certain non-essential covered services, as noted in the chart that begins on page 24.

Benefit Limits

You will note that limits apply on certain benefits. (These limits are spelled out in the charts found in this SPD.) It's important to understand that these limits apply to all related services received under the Plan.

The Plan Year

The Plan is administered on a calendar-year basis (January–December), so all references to a "Plan Year" mean a calendar year.

A Note About Maternity Admissions

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

Pre-certification of In-Network Care

If you go In-Network for care, **your *network provider*** will *pre-certify* any applicable medical services or supplies.

Out-of-Network Care That Requires Pre-certification

If you go Out-of-Network for care, **you** must pre-certify the following medical services or supplies by calling *Aetna Member Services* at 1-800-345-5839.

- all inpatient confinements, including admissions to a hospital, birthing center, skilled nursing facility, rehabilitation facility, *hospice facility,* mental health treatment facility or substance abuse treatment facility (for maternity confinements, please contact Aetna Member Services at 1-800-345-5839 after the first prenatal visit)
- the following outpatient mental health and substance abuse services and procedures:
  - intensive outpatient care
  - psychological testing
  - neuropsychological testing
  - outpatient electroconvulsive therapy (ECT)
  - biofeedback
  - Amytal interview
  - residential treatment
  - hypnosis
  - psychiatric home visits
  - outpatient detoxification

For a maternity admission, it's a good idea to call Aetna Member Services in advance of the admission in case there are unforeseen complications. Call Aetna at 1-800-345-5839 before the seventh month of pregnancy to provide notification of an anticipated maternity admission. Whether or not you call, the Plan will allow a minimum of 48 hours for normal deliveries and 96 hours for cesarean sections.

If you go Out-of-Network for your care, you are responsible for pre-certifying required medical services.

- elective procedures and treatments, such as:
  - – allergy injections
  - – bunion removal
  - – carpal tunnel surgery
  - – colonoscopy
  - – computerized axial tomography (CAT) scan of the spine
  - – coronary angiography
  - – coronary angioplasty
  - – coronary artery bypass
  - – dilation/curettage
  - – gallbladder removal
  - – hemorrhoidectomy
  - – hip replacement
  - – hysterectomy
  - – in-hospital treatment of lower back pain
  - – knee arthroscopy
  - – knee replacement
  - – laminectomy
  - – magnetic resonance imaging (MRI) of the knee or spinal cord
  - – pelvic laparoscopy
  - – septorhinoplasty
  - – tubes surgically inserted in ears
  - – upper gastrointestinal endoscopy
- care in a *convalescent facility*
- hospice care
- home health care
- outpatient private duty nursing.

How to Pre-certify Out-of-Network Care

To get approval of Out-of-Network care that requires *pre-certification,* call Aetna Member Services at 1-800-345-5839, Monday through Friday, 8:00 a.m. to 6:00 p.m., local time zone.

A medical professional will work with you and your physician to review your condition and proposed treatment to ensure appropriate care. After Aetna has made its determination, it will send a "Notice of Certification" to you and your provider. Aetna's decision is valid for 60 days from the date you receive the notice. If the care is to be received after this 60-day period, or if the certified treatment plan changes, you will need a new certification.

Where certification of surgery is concerned, Aetna may require you to get a second surgical opinion, for which the Plan will pay the full negotiated charge or *reasonable and customary charge,* as applicable. Aetna will discuss this requirement with you when you call to pre-certify.

See page 36 to find out how benefits are paid if you don't pre-certify.

Hospital admissions. Inpatient hospital admissions must be pre-certified at least 14 calendar days before the patient is admitted for non-*emergency conditions* (or as soon as hospitalization has been suggested, if it is less than 14 calendar days before admission) and within two business days (excludes weekends and holidays) after admission for emergency conditions. Part of the approval process will be a determination of the necessity of the hospitalization and the appropriate length of stay for the medical condition being treated. In addition, a medical professional will monitor your progress to determine the need for additional days in the hospital. If your physician does not agree with the results of the approval process, he or she can request a review from Aetna.

All Out-of-Network inpatient confinements, including admissions to a hospital, skilled nursing facility, rehabilitation facility, hospice facility, mental health treatment facility or substance abuse treatment facility, require pre-certification. To pre-certify your care, call Aetna Member Services at 1-800-345-5839.

Lab tests and certain screenings, such as those for cholesterol and diabetes, may be covered as part of routine preventive care if they are ordered as part of your preventive care visit.

Covered Expenses

The following medical services and supplies are eligible under the Plan.

Preventive care. The Plan pays the full cost of the services and supplies listed below, as long as you go In-Network for your care. You are not required to meet the annual *deductible.* If you receive In-Network preventive care for eligible expenses that are **not** listed below, or you receive preventive care for eligible expenses from Out-of-Network providers, your expenses will be paid like any other eligible medical expense. (See the chart that begins on page 24 for details.)

Drugs prescribed for treating an ongoing condition are not considered preventive services or supplies and therefore are not covered at 100%, as required by law. For example, maintenance drugs taken for hypertension are treating an existing, ongoing condition, so they are not considered preventive services or supplies. (See the *L-3 Communications Prescription Drug Plan SPD* for information on prescription drug coverage.)

Well-child care, which includes office visits, routine immunizations, screenings and routine physical exams, is covered as follows:

Time Frame	Number of Office Visits
Birth to 1st birthday	7
Age 1 to 2nd birthday	3
Age 2 to 3rd birthday	3
Age 3 to 22nd birthday	one exam every 12 months

Well-adult care is also covered, as follows:

- annual physical exams for patients age 22 or older (exams include x-rays and lab tests performed in connection with the exam, and immunizations for infectious diseases)
- an annual gynecological exam, including routine lab work performed in connection with the exam
- approved preventive services and screening tests, subject to age and frequency guidelines as required under current Patient Protection and Affordable Care Act regulations, including:
  - mammograms
  - Pap tests
  - prostate-specific antigen (PSA) tests
  - colonoscopies
  - routine hearing exams
  - other preventive screenings and tests.

Please keep in mind that the only expenses for which the Plan pays 100% of the negotiated charge are In-Network preventive care expenses. If you have questions about whether a specific test, screening or procedure is considered "preventive," contact Aetna Member Services at 1-800-345-5839, from 8:00 a.m. to 6:00 p.m., local time zone. (Outside the U.S., call collect: 1-260-496-5400, 8:00 a.m. to 4:15 p.m., ET.)

Other covered expenses. The following medical services and supplies are also covered under the Plan.

The Plan covers a wide array of services and supplies, as shown on this and the following pages.

Abortion coverage is limited to abortions that are medically necessary because the life of the mother would be in danger if the fetus were carried to term, or because the woman's physician determines that either the pregnancy or the fetus is abnormal. A physician must perform the abortion.

Acupuncture therapy is covered when it is administered or directed by a physician and used as a form of anesthesia for a covered surgical procedure; or for treatment of certain covered conditions, including, but not limited to nausea of pregnancy and post-chemotherapy nausea.

Allergy testing and injections are covered when medically necessary and prescribed by a physician.

Ambulance services are covered when the patient's condition is such that use of any other means of transportation is not medically advisable. The ambulance service must be from the place where the patient becomes ill or injured to the nearest hospital or other facility that can provide the necessary care. (Air and water ambulance service is covered only when medically necessary.)

Anesthesia and its administration are covered in connection with a covered surgical, obstetrical or other medical procedure.

Chiropractic services, covered for spinal manipulation treatment only, are covered up to an annual maximum benefit of $1,000 per covered person (In- and Out-of-Network combined), as long as treatment results in demonstrable improvement of a specific condition. (Chiropractic services for maintenance purposes are not covered.)

Convalescent (skilled nursing) facility benefits are payable for up to 90 days per Plan Year in a convalescent facility. No benefits are payable for *custodial care,* care received in a non-approved facility or care that is not medically necessary. (Also see *What's Not Covered Under the Plan,* starting on page 37.)

Durable medical and surgical equipment (such as wheelchairs, crutches, hospital beds, insulin pumps and colostomy, ostomy and ileostomy supplies) is covered, including purchase, rental and repair. *Durable medical and surgical equipment* must be prescribed by a physician and be medically necessary to treat an illness or injury or to restore the use of a dysfunctional body part. The Plan will cover the cost of buying the equipment when the purchase price is expected to be less costly than long-term rental, or when the item is not available on a rental basis. (No benefits are payable for routine maintenance of rented equipment.)

Electrocardiograms are covered when prescribed by, and performed under the supervision of, a physician.

A hospital's emergency room is only for emergency medical conditions. An urgent care facility is for medical conditions that require immediate treatment but that are not serious or severe enough to require immediate hospital-level care.

Emergency and urgent care are covered in the appropriate facility. It's important to understand when it's appropriate to use a hospital's emergency room and when it's preferable to use an *urgent care* facility, since use of an emergency room for non-emergency care may result in denial of benefits under the Plan.

- **A hospital's emergency room is only for emergency medical conditions.** An emergency is a medical condition whose symptoms are so severe that a prudent layperson, who has average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the patient's health or, if the patient is a pregnant woman, the health of the woman and her unborn child. Severe chest pains, prolonged bleeding and seizures are examples of emergency conditions.
- **An urgent care facility is for medical conditions that require immediate treatment but that are not serious or severe enough to require immediate hospital-level care.** Sudden conditions that require immediate—but not hospital-level—care include broken bones, deep cuts and chronic earaches.

Also see page 33 for an explanation of what to do in a mental health emergency.

Hearing aids, including fitting and repairs, are covered for up to $5,000 per three Plan Years.

Hemodialysis benefits are payable for hemodialysis equipment in the home, and equipment and other professional services required in connection with approved outpatient treatment furnished and/or prescribed by a physician.

Home health care benefits are available for up to 120 visits each Plan Year, as long as:

- the care is provided by a licensed *home health care agency*
- a *home health care program* is established and approved by the attending physician
- home health care is required for the same condition as the one that required hospitalization, or for a related condition
- the attending physician certifies that without home health care the patient would have to be hospitalized.

Four hours of home health aide services are considered the same as one home health care visit or one home visit by a member of a home health care team to provide nursing care or physical, occupational or speech therapy.

Hospice care, which provides counseling and pain relief for terminally ill patients, defined as those with a life expectancy of six months or less, is covered. The aim of a hospice is to keep the family involved in caring for the terminally ill patient, while providing the support necessary to help the family cope with the stress involved in caring for the patient and adjusting to death. Up to $25,000 in benefits per lifetime for the following hospice services are covered: room and board at a hospice facility, medical supplies, nursing services, psychological and dietary counseling, home health aide services and physical therapy. These must be furnished by, or provided under arrangements made by, an accredited *hospice care agency* under a written plan of care that is established and periodically reviewed by its medical director. (Also see *What's Not Covered Under the Plan,* starting on page 37.)

Hospital care is covered on both an inpatient and outpatient basis.

- **Inpatient.** Inpatient room and board charges are covered throughout a hospitalization. Benefits are based on the hospital's *semiprivate room rate.* However, benefits for a private room may be payable if Aetna determines that confinement in a private room is medically necessary.

  Medically necessary hospital services and supplies are also covered, including the following:

  – administration of blood and blood plasma, including the cost of blood

  – anesthesia and its administration

  – general inpatient nursing services by an on-staff registered graduate nurse (RN) or licensed practical nurse (LPN)

  – staff physicians' visits for treatment of a medical condition

  – intravenous injections and solutions

  – oxygen and other gas therapy

  – use of hospital equipment (such as incubators, oxygen tents and hemodialysis machines), operating, delivery and treatment rooms, and special or intensive care units

  – routine nursery care of a newborn child before discharge from the hospital

  – diagnostic services (x-rays, laboratory, pathology, radiology, EKG, EEG and other diagnostic procedures), including pre-admission testing

  – any additional covered medical services and supplies if Aetna determines they are customarily provided to treat the medical condition that resulted in the hospitalization.

  Services received in a licensed birthing center are covered as if they were received in a hospital.

  Also see page 33 for information on inpatient mental health and substance abuse treatment.

- **Outpatient.** The services described above are also covered on an outpatient basis when they are prescribed by the attending physician and received in a hospital's outpatient department or emergency room.

Infertility diagnosis is covered. (Infertility treatment is not covered, nor are assisted reproductive technology treatments.)

Magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), PET and CAT scans are covered when medically necessary and performed as part of a diagnostic examination.

Medically necessary hospital services and supplies are covered on an outpatient as well as an inpatient basis.

The *National Medical Excellence (NME) Program* provides treatment of certain medical conditions that call for care in a highly specialized "Institutes of Excellence" facility, including medically necessary care to treat heart, lung, liver, kidney, pancreas or bone marrow transplants. The Plan may also help pay certain travel charges for a companion traveling with the individual receiving treatment.

Mental health and substance abuse treatment is covered on both an inpatient and outpatient basis. Inpatient benefits cover care received at a hospital, a *mental disorder treatment facility* or a *substance abuse treatment facility.* Benefits are payable for room, board and other services or supplies necessary for the effective treatment of *substance abuse* or *mental disorders.* (Detoxification—treating the aftereffects of a specific episode of alcoholism or drug abuse—and maintenance care—providing an environment free of alcohol or drugs—are not by themselves considered effective treatment. They are not covered unless they are received as part of the prescribed *course of treatment.*)

The National Medical Excellence (NME) Program works with hospitals that have contracted with Aetna to furnish services or supplies to an NME patient in connection with specific procedures or treatments. The NME Program provides treatment of certain medical conditions that call for care in a highly specialized "Institutes of Excellence" (IOE) facility. Should Aetna determine that care in an IOE facility is medically necessary to treat a heart, lung, liver, kidney, pancreas or bone marrow transplant, in addition to covering the eligible expenses related to the treatment itself, the Plan will also help pay certain travel (from the patient's home to the facility) and lodging expenses you have in connection with the stay. All travel and lodging expenses must be approved in advance by Aetna. (A companion's expenses will be approved only when the companion's presence is essential to the patient's receiving NME services on either an inpatient or outpatient basis.) The Plan will pay up to $50 per person per night toward lodging in connection with any one NME treatment. The maximum reimbursement for covered non-medical IOE expenses you have in connection with any one type of procedure is $10,000 per family. The period over which benefits are payable begins on the day a covered person becomes an NME patient, and ends on the earlier of one year after the day the procedure is performed or the date the NME patient ceases to receive any services from the IOE facility in connection with the procedure. If Aetna determines that care in an IOE facility is medically necessary and you instead receive care in a non-IOE facility, expenses related to your care in a non-IOE facility will be covered on an Out-of-Network basis—**even if the facility is an In-Network facility for non-IOE care.**

Nutritional counseling is covered when prescribed by a physician as medically necessary for the treatment of certain chronic conditions for which dietary adjustments have a therapeutic role (e.g., diabetes, obesity and eating disorders).

Oral surgery is covered for services that are medical in nature. Dental treatment for accidental injury to sound, natural teeth is also covered.

Outpatient chemotherapy, including a physician's charges to administer U.S. Food and Drug Administration (FDA)-approved chemotherapy drugs, is covered. (Experimental or research chemotherapy is not covered.)

Outpatient nursing care, including private duty and visiting nurse services provided by a registered graduate nurse (RN) or licensed practical nurse (LPN), is covered for up to 70 eight-hour shifts per Plan Year. Benefits are available when Aetna determines that private duty nursing is medically necessary. (Inpatient private duty nursing is not covered.)

Physicians' services received at home, in the hospital or in a physician's office are covered, as are physicians' charges to treat a specific illness or injury. Emergency care, including physicians' charges to treat an emergency condition, is covered. Preventive care services, as described on page 12, are also covered.

Prosthetics (such as artificial limbs and eyes) are covered, including replacement, repair, fitting and adjustment. The appliance must be medically necessary and prescribed by a physician, and it must replace all or part of a permanently inoperative or malfunctioning part of the body. (Routine maintenance is not covered.)

Radiological therapy (such as x-ray, radium and radioactive isotope therapy), including a physician's charges, is covered when prescribed by a physician to treat a covered illness or accidental injury.

Reconstructive surgery is considered a covered expense when the procedure is to correct conditions, functional problems or deformities that result from accidental injuries, traumatic scars, disease or congenital anomalies. Surgery necessary to correct deformities due to malignancy is also covered, as is surgery to reconstruct a breast after a medically necessary mastectomy. Mastectomy expenses include reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedemas. (Surgery performed primarily for cosmetic or beautifying purposes, as determined by Aetna, is not covered.)

Short-term rehabilitation, which includes physical, occupational and speech therapy,* is covered when the treatment plan is expected to improve or restore a bodily function that has been lost or impaired due to an injury, disease or congenital defect, within a short period of time—usually within 60 days from when therapy begins. Benefits are payable only for outpatient treatment by a physician or a licensed or certified physical, occupational or speech therapist working under the direct supervision of a physician. Please see the chart on page 27 for limits on short-term rehabilitation expenses.

Surgery-related expenses are covered on both an inpatient and outpatient basis, including pre- and post-operative care. Eligible expenses include:

- the surgeon's and *assistant surgeon's* charges for surgery (an assistant surgeon's charges are reimbursed as a percentage of the surgeon's charges)
- anesthesiologist's charges
- drugs administered for consumption on the premises
- lab tests
- medical and surgical supplies.

Certain Out-of-Network surgical procedures require pre-certification. For details, see page 9.

X-ray and lab services directly related to and necessary for a diagnosis, including pathology services, are covered.

*Speech therapy benefits are limited to charges made by a physician or a licensed or certified speech therapist to restore the level of an existing speech function (that is, the loss of the ability to speak normally) that has been lost or impaired due to an injury or disease. Therapies for the treatment of delays in development, unless development delays result from an acute illness or injury, or congenital defects amenable to surgical repair (e.g., cleft lip/palate), are not covered. Pervasive developmental disorders (e.g., autism, Down syndrome and cerebral palsy) are not covered, as these are considered developmental and/or chronic in nature.

Short-term rehabilitation, including physical, occupational and speech therapy, is covered when the treatment plan is expected to improve or restore a bodily function that has been lost or impaired due to an injury, disease or congenital defect, within a short period of time.

Special Aetna Programs

If you or one of your enrolled dependents have asthma, diabetes, a heart condition, lung cancer, migraines or certain other chronic illnesses or conditions, you may receive a call, letter or e-mail from ActiveHealth, L-3's health and disease management program partner.

ActiveHealth Management

If you or one of your covered dependents have asthma, diabetes, a heart condition, lung cancer, migraines or certain other chronic illnesses or conditions (ActiveHealth covers over 30 conditions), you may receive a call, letter or e-mail from ActiveHealth, L-3's health and disease management program partner. Through this program, ActiveHealth reaches out to participants who stand to gain the most from early and active intervention and offers a variety of services and assistance in managing chronic conditions. By reaching out to you, the program helps you:

- get the most appropriate treatment and preventive care for your individual needs
- understand how to follow your doctor's treatment plan
- take charge of your own health and manage your chronic conditions well
- make the changes necessary to reach your personal health goals
- identify and manage your risks for other conditions.

If you are already managing a chronic condition, or if you think you are at risk for one, you do not have to wait for ActiveHealth to contact you; call ActiveHealth at 1-866-606-6539.

CareEngine Program. To help ensure that Plan participants receive the best possible care, ActiveHealth uses its *CareEngine* treatment review program. *CareEngine* is ActiveHealth's computerized system that is used to analyze participants' medical, lab and prescription drug claims, and to compare the treatment provided to established medical protocols. Whenever the *CareEngine* program identifies a claim that falls outside the guidelines or that offers an opportunity for improving care, the claim is referred to ActiveHealth's medical staff for further review and follow up. ActiveHealth may then contact the patient's personal physician about this finding.

If an ActiveHealth doctor contacts your doctor, he/she does so by sending a notice called a "Care Consideration." (You will receive notification, too.) This does not necessarily mean there is a reason for concern or that you did not receive the proper care. In fact, the system may have picked up something as simple as insufficient information or an oversight.

As with all of your individual claims-related information, the *CareEngine* is completely confidential. If you have any questions about the *CareEngine* program, please contact ActiveHealth at 1-866-606-6539.

Beginning Right® Maternity Program

If you or a covered dependent is expecting a baby, you are eligible to participate in Aetna's Beginning Right® Maternity Program. The program, which is free to all eligible pregnant members, provides information and services to help give your baby a healthy start, including:

- Aetna's *Healthy Pregnancy Handbook,* which contains practical and helpful information and tips ranging from proper prenatal care and what to expect in each trimester, to the actual delivery process and taking care of your newborn
- access to a toll-free telephone line staffed by specially trained nurses who can answer your questions and address any concerns you have about your pregnancy
- access to the Beginning Right® Pregnancy Risk Survey, the results of which will determine whether you are placed in the normal-risk or more intensive high-risk program (see below for a description of high-risk pregnancy factors)
- educational materials (available in English and Spanish) on topics such as prenatal care, newborn care and breastfeeding
- participation in the Smoke-Free Moms-to-Be™ behavior-modification smoking-cessation program
- special information and support for members with high-risk pregnancies
- information for dads-to-be.

Once you enroll in Beginning Right®, complete the online Pregnancy Risk Survey, if you have internet access. (Visit www.aetna.com and log into the Aetna Navigator™ website, click on "Benefits, Health Programs" and select "Pregnancy Risk Survey.") The results of this survey will determine the level of support Aetna will provide during your pregnancy. If Aetna identifies your pregnancy as high-risk (see below) and you choose to participate, you will receive a phone call from an Aetna nurse who will work with you and your obstetrician to coordinate any specialty care that may be needed.

To participate in the Beginning Right® Maternity Program, you may enroll by phone at 1-800-CRADLE-1 (1-800-272-3531). Or, log on to the Beginning Right® website on Aetna's Women's Health Online at http://womenshealth.aetna.com and click on "Beginning Right®/Pregnancy Resouces."

High-risk pregnancies. High-risk members are those who have one or more of the following risk factors:

- history of preterm birth, or any factor that predisposes the member to preterm labor and/or delivery
- multiple gestation (pregnant with more than one baby)
- diabetes
- hypertension (high blood pressure)
- hyperemesis (severe and persistent nausea and vomiting)

If you or a covered dependent is expecting a baby, you are eligible to participate in Aetna's Beginning Right® Maternity Program.

VSP Vision Care Plan participation is not automatic when you enroll in the Aetna Choice POS II Medical Plan. If you want L-3-sponsored vision coverage, you must elect the Vision Care Plan.

- cigarette smoking habit
- advanced maternal age (usually age 40 or older)
- age 19 or under
- African-American descent
- previous intrauterine fetal surgery.

Rx Check[sm]

Aetna's Rx Check[sm] is an Aetna Pharmacy Management program that helps doctors improve health outcomes and reduce medication errors by identifying certain situations, such as the following, and then notifying your doctor and you, by mail:

- simultaneous use of two medications that serve the same purpose
- severe drug-to-drug interactions
- multiple prescriptions and/or prescribers for certain medications with the potential for misuse
- money-saving opportunities when generic equivalent medications are available.

Aetna Vision

Under the Plan, vision expenses are covered through Aetna Vision. Aetna Vision provides point-of-purchase discounts on a wide array of eye care services and supplies.

- You can save on frames, lenses, contacts, and on non-prescription items such as contact lens solutions and sunglasses.
- To get your discount, go to an Aetna Vision provider and show your Aetna ID card.
- You can use Aetna Vision as often as you like. There are no claims to file.

While there's no dispensing fee for contacts, there is a fee for fitting and dispensing eyeglasses, including unlimited eyeglass adjustments. For more details or store locations, call Aetna Vision at 1-800-793-8616 between 9:00 a.m. and 9:00 p.m., Eastern Time, Monday through Friday, or between 9:00 a.m. and 5:00 p.m., Eastern Time, Saturdays. Or, visit www.aetna.com.

Please note: Aetna Vision is separate from the Aetna Choice POS II Medical Plan. Aetna Vision has no effect on the benefits the Plan pays, and is not subject to pre-certification or other requirements that apply to services and supplies for which benefits are payable. You pay the full discounted cost of any expenses you have under Aetna Vision.

In addition to Aetna Vision, L-3 makes available the VSP Vision Care Plan. (VSP Vision Care Plan participation is optional; you must enroll to have coverage.) You can use both VSP and Aetna Vision together. For example, you can use a VSP provider for eye exams and an Aetna Vision provider to purchase eyeglasses. For more information about the VSP Vision Care Plan, see the *Vision Care Plan SPD.*

Other Aetna Discount Programs

Medical Plan participants also have access to the following Aetna discount programs.

- **Natural Products and Services Program,** a special discount program, through which you may be able to take advantage of many alternative, health-related services from chiropractors, acupuncturists, massage therapists and nutritional counselors.
- **Fitness Program,** which gives you access to discounts on membership rates at independent health clubs that have contracted with GlobalFit™—a national network of fitness clubs—and discounts on certain home exercise equipment.
- **Weight Management Program,** which provides discounts on eDiets meal plans and customized menus, Jenny Craig weight-loss programs and Nutrisystem food deliveries.

These discount programs are separate from the Plan. They have no effect on the benefits the Plan pays, and are not subject to pre-certification or other requirements that apply to services and supplies for which benefits under the Plan are payable. You pay the full cost of any expenses you have under these discount programs.

For more information on these discount programs, contact Aetna Member Services by phone at 1-800-345-5839 or online at www.aetna.com.

Aetna's Discount Programs are separate from the Medical Plan and have no effect on Plan benefits.

Generally, the Plan pays a higher level of benefits for care received from In-Network providers. You don't need to see a Primary Care Physician before receiving In-Network care.

How the Plan Works

The Plan gives you direct access to a network of doctors and hospitals that charge lower fees for services they provide to eligible participants. You can see any physician/specialist in the network at any time without a referral. Benefits depend on whether you go In-Network or Out-of-Network for your care, as explained starting on page 29.

Comparing how expenses are reimbursed In- and Out-of-Network will give you the best sense of your potential out-of-pocket costs, which is why we have included the following charts.

Medical Expense Coverage—General Provisions

Plan Provision	How It Works	
	In-Network	**Out-of-Network**
How You Access Care	Go to any network provider.	Go to any licensed/certified provider.
Basis for Reimbursement	In most cases, In-Network reimbursements are based on the **negotiated charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** where required. Reimbursements for preventive care are also based on the negotiated charge.	In most cases, Out-of-Network reimbursements are based on the **reasonable and customary charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Reimbursements for preventive care are also based on the reasonable and customary charge.
Annual Deductible		
– individual	$200	$500
– family	$600	$1,500
	Amounts you pay toward meeting the In-Network annual deductible apply toward meeting the Out-of-Network annual deductible, and vice versa.	
Copays (where applicable)		
– generalist (general practitioner, family practitioner, internist, pediatrician)	$25/visit	N/A
– specialist	$40/visit	N/A
– inpatient facility care	$100/day (limited to first 5 days of admission/Plan Year)	N/A
– urgent care	$40/visit	N/A
– emergency room care	$200/visit (waived if admitted within 24 hours)	$200/visit (waived if admitted within 24 hours)
– outpatient mental health and substance abuse treatment (received in provider's office)	$25/visit	N/A

Plan Provision	How It Works	
	In-Network	**Out-of-Network**
Coinsurance (where applicable)	Plan pays 90% after the annual deductible (where required).	Plan pays 70% after the annual deductible.
Annual *Out-of-Pocket Maximum* – individual – family	$2,000 $4,000	$4,500 $9,000
	Amounts you pay toward meeting the In-Network annual out-of-pocket maximum apply toward meeting the Out-of-Network annual out-of-pocket maximum, and vice versa. **Please note** that the following do not apply to the annual out-of-pocket maximum: copays for In-Network expenses; amounts you pay toward the annual deductible; amounts above the reasonable and customary charge; and amounts you pay because you don't pre-certify the Out-of-Network services and supplies listed starting on page 9. You are responsible for paying these amounts in full.	
Penalty for Not Pre-certifying	N/A	If you don't pre-certify the services and supplies listed starting on page 9, the Plan will pay related eligible expenses at 50% after the deductible (if applicable). The 50% you pay is limited to $5,000 per event, and it does not count toward your annual out-of-pocket maximum. When your 50% coinsurance reaches $5,000, the Plan pays 70% of eligible expenses up to the annual out-of-pocket maximum. (See page 35.)
Lifetime Maximum Benefit	Unlimited	

All Out-of-Network reimbursements are based on the reasonable and customary charge for eligible expenses. You will be responsible for paying any difference between the reasonable and customary charge and a non-Choice POS II provider's actual charge.

Medical Expense Coverage—Specific Provisions

This chart shows how In-Network and Out-of-Network benefits compare.

Expense	What the Plan Pays	
	In-Network	Out-of-Network
Hospital Services Inpatient care (semiprivate room and board)	90% after $100/day copay. (Copay limited to first 5 days of hospital admission/Plan Year.) Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Outpatient care	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Emergency room care	For a true emergency, 90% after $200/visit copay for facility charge and 90% after annual deductible for physician services. (The emergency room copay is waived if the patient is admitted to the hospital within 24 hours, but then the standard hospital provisions—e.g., $100 per day copay—apply.) No benefits are payable if you use the emergency room for non-emergency care. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay and deductible do not. **Note:** An "emergency" is a medical condition whose symptoms are so severe that a prudent layperson, who has average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the patient's health or, if the patient is a pregnant woman, the health of the woman and her unborn child.	
Routine nursery care	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Ambulance service	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	**Emergency:** 90% after annual deductible. **Non-emergency:** 70% after annual deductible. Your 10% or 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Diagnostic radiology, laboratory and pathology	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not. Reimbursements for services received in a Choice POS II hospital from non-Choice POS II radiologists, anesthesiologists or pathologists will be at 90% of the reasonable and customary charge.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Physician services	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Surgery	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.

*Must be pre-certified, as described on page 9.

Expense	What the Plan Pays	
	In-Network	**Out-of-Network**
Urgent Care Facility	100% after $40/visit copay. Your copay does not apply toward the annual out-of-pocket maximum.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Doctors' Office Visits (including diagnostic x-rays and tests performed in the doctor's office)		
General practitioner, family practitioner, internist or pediatrician	100% after $25/visit copay. Your copay does not apply toward the annual out-of-pocket maximum.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Specialist	100% after $40/visit copay. Your copay does not apply toward the annual out-of-pocket maximum.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Prenatal and postnatal care	100% after $40 copay for first visit. 90% after deductible for additional visits. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay and deductible do not.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Chiropractic care	100% after $40/visit copay, up to $1,000 annual maximum benefit. Your copay does not apply toward the annual out-of-pocket maximum.	70% after annual deductible, up to $750 annual maximum benefit. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
	Benefits paid under the In-Network portion of the Plan are also applied against the Out-of-Network annual benefit maximum, and vice versa.	
Allergy treatment	100% after $25/visit (generalist) or $40/visit (specialist) copay, if billed with office visit. 90% after deductible (no copay) for injection only. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay and deductible do not.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Mental Health/Substance Abuse Treatment		
Inpatient care	90% after $100/day copay. (Copay limited to first 5 days of hospital admission/Plan Year.) Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Outpatient care	100% after $25/visit copay at provider's office. 90% after annual deductible at outpatient facility. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay and deductible do not.	70% after annual deductible.** Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.

*Must be pre-certified, as described on page 9.

**Certain outpatient mental health and substance abuse services and procedures must be pre-certified. See page 9.

Out-of-Network services and supplies listed on pages 9 and 10 that are not pre-certified will be covered at 50% after the annual deductible (if applicable). The 50% you pay will be limited to $5,000 per event but will not count toward the annual out-of-pocket maximum.

If you are on temporary assignment outside the U.S. (that is, assignment outside the U.S. for less than six months) and receive medical care, benefits for covered expenses will be paid on an Out-of-Network basis. You will need to pay the full cost of your care at the time care is received and then file a claim for reimbursement.

Expense	What the Plan Pays	
	In-Network	**Out-of-Network**
Preventive Care Well-child care and immunizations (see page 12 for frequency guidelines)	100% (no copay or deductible).	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Annual physical (one exam/Plan Year for patients age 19 or older)	100% (no copay or deductible).	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Annual gynecological exam	100% (no copay or deductible).	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Preventive and Diagnostic Tests (lab fees only; subject to age and frequency guidelines) – routine mammography – Pap test – prostate-specific antigen (PSA) test – colonoscopy – other preventive screenings and tests	100% (no copay or deductible) if considered preventive, based on age and frequency guidelines. 90% after deductible (no copay) if considered diagnostic. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Other Covered Services Outpatient (private duty) nursing care	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
	Combined maximum of 70 eight-hour shifts/Plan Year.	
Convalescent (skilled nursing) facility	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
	Combined maximum of 90 days/Plan Year.	
Home health care	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
	Combined maximum of 120 visits/Plan Year.	

*Must be pre-certified, as described on page 9.

Expense	What the Plan Pays	
	In-Network	**Out-of-Network**
Other Covered Services (cont'd) Hospice care	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
	5 bereavement counseling visits/Plan Year; a $25,000 lifetime maximum applies to combined inpatient and outpatient hospice care.	
Infertility (diagnosis only)	100% after $40/visit copay. Your copay does not apply toward the annual out-of-pocket maximum.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Abortions (covered only if medically necessary)	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Tubal ligation/vasectomy (Plan excludes reversal of tubal ligation/ vasectomy)	**Inpatient care:** 90% after $100/ day copay. (Copay limited to first 5 days of inpatient hospital admission/PlanYear.) **Outpatient surgery:** 90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay and deductible do not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Durable medical equipment	90% after annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.	70% after annual deductible.* Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
Short-term rehabilitation (physical, occupational and speech therapy)	100% after $25/visit copay, if provided by a family practitioner, general practitioner, pediatrician or internist. 90% after annual deductible if provided by physical, occupational or speech therapist in therapist's office. Your 10% coinsurance applies toward the annual out-of-pocket maximum but your copay and deductible do not.	70% after annual deductible. Your 30% coinsurance applies toward the annual out-of-pocket maximum but your deductible does not.
	Combined maximum of 60 visits/Plan Year.	
Hearing aids (hardware, fitting and repairs only)	90%, no annual deductible. Your 10% coinsurance applies toward the annual out-of-pocket maximum. Benefits are limited to a combined maximum of $5,000 per three Plan Years.	

*Must be pre-certified, as described on page 9.

This chart shows how In-Network and Out-of-Network benefits compare.

Incentive Credits

You and your spouse have up to three opportunities each year to earn incentive credits:

Healthy Behavior	Incentive Credit
Take an online Health Assessment through ActiveHealth	$75 per person
Get an *annual physical*	$125 per person
Complete a four-call telephonic engagement with ActiveHealth (if eligible for disease management)	$200 per person

If you are not eligible for disease management, the maximum incentive reward you can earn is $200 ($400 if both you and your spouse participate). If you are eligible for disease management, you can earn up to $400 ($800 if your spouse is also eligible for disease management).

Please note the following about earning incentive credits:

- **Health Assessment:** To access the Health Assessment, log on to www.myactivehealth.com/l-3com. (Please note that you must complete the Health Assessment within the allotted time period to receive incentive credits; contact the L-3 Benefit Center for more information.) You may save your answers at any time and return later, but you will not receive incentive credits until you have completed and submitted the Health Assessment. If you previously submitted a Health Assessment through ActiveHealth, you must update your assessment within the allotted time period to receive incentive credits.
- **Annual physical:** It is important that your doctor's office code your visit as "preventive" to get credit for an annual physical. When you schedule your annual physical, be sure to inform the office your visit should be coded as preventive.
- **Working with ActiveHealth:** Please note that this incentive is for employees/spouses who have been invited to participate in the Disease Management Program only. A "telephone session" is a 15-20 minute phone call in which you and a nurse coach address existing or potential issues related to your chronic condition(s) and set health-related goals. Please note that just scheduling an appointment with a nurse coach does not count as a session.

How incentives work. Your incentive credits are added automatically to an Incentive Credit Account the Company establishes on your behalf with WageWorks. Your incentive credits are available as soon as administratively possible after you complete the applicable task, and WageWorks automatically sends you a reimbursement check as soon as administratively possible after you incur eligible out-of-pocket health care expenses. There is no action required on your part: no forms to complete and no claim forms to file. Please note that incentive credits cannot be used to reimburse claims processed before the date the reward is credited to your Incentive Credit Account.

Incentive balances roll over from year to year. Any incentive credits remaining in your Incentive Credit Account at the end of the Plan Year will be available in the following Plan Year. Credits are never paid out in cash, nor do they become payable when your L-3 coverage ends. If you have unspent credits when your coverage ends, you forfeit them. However, if you elect COBRA, unspent credits remain available to you for as long as your COBRA coverage continues.

How In-Network Expenses Are Reimbursed

In-Network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a Choice POS II network provider. The network provider will assess your medical needs and advise you on appropriate care, as well as take care of any necessary tests, pre-certifications or inpatient hospital admissions. When you use a doctor, hospital or other provider in the Choice POS II network, the Plan generally will pay 90% for most charges, after the annual deductible. (See page 16 for special provisions that apply to hospital care under the National Medical Excellence Program and page 30 for special provisions that apply when *Choice POS II providers* refer you to, or use, non-Choice POS II providers.) For other charges, such as doctor's visits, the Plan pays either 90% or 100% after you pay a $25 (generalist) or $40 (specialist) copay. For inpatient hospitalization, the Plan pays 90% after you pay a $100 copay per day (limited to the first five days of inpatient hospital admission per Plan Year). The Plan also pays 90% after a $200 copay for emergency room visits. (The emergency room copay is waived if the patient is admitted to the hospital within 24 hours.)

When you enroll in the Plan, your eligible expenses are reimbursed based on whether your care is considered "In-Network" or "Out-of-Network."

Annual deductible. The individual annual deductible for In-Network care is $200. If you have family coverage, the $600 family annual deductible is considered met once the family's combined deductible expenses reach the family limit. However, in determining whether the family deductible has been satisfied, the Plan will not count more than $200 per person. Amounts you pay toward meeting the Out-of-Network annual deductible apply toward meeting the In-Network annual deductible.

Please note that the In-Network annual deductible generally applies only to services and supplies other than those for which a copay applies. See the chart that begins on page 24 for details.

Expenses that don't count toward the annual deductible. The following expenses are not applied toward the In-Network annual deductible:

- copays; and
- charges excluded or limited by the Plan. (See *What's Not Covered Under the Plan,* starting on page 37.)

Annual out-of-pocket maximum. The annual out-of-pocket maximum puts a cap on the amount each participant has to pay in coinsurance toward his/her covered expenses in a given Plan Year. The In-Network individual annual out-of-pocket maximum is $2,000. It applies to each enrolled person and also includes amounts paid toward meeting the Out-of-Network annual out-of-pocket maximum. If you have family coverage, the $4,000 family annual out-of-pocket maximum is considered met once the family's combined In-Network and Out-of-Network annual out-of-pocket expenses reach the family maximum. Eligible expenses submitted for reimbursement after the annual out-of-pocket maximum is reached are paid at 100% of the negotiated charge.

Expenses that don't count toward the annual out-of-pocket maximum. The following expenses are not applied to the annual out-of-pocket maximum:

- annual deductible;
- copays; and
- charges excluded or limited by the Plan. (See *What's Not Covered Under the Plan,* starting on page 37.)

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Your Choice POS II provider may be part of a group practice that includes non-Choice POS II providers. Verify that the provider from whom you receive care participates in the Choice POS II network.

If you move* out of *a network area. If you move out of a network service area during the Plan Year, contact the L-3 Benefit Center to discuss your Medical Plan options. If you change your coverage to the Aetna Out-of-Area Medical Plan, contact Aetna Member Services at 1-800-345-5839 so that any deductibles and/or coinsurance you've paid under the Choice POS II Medical Plan can be applied to your annual deductible and annual out-of-pocket maximum under the Aetna Out-of-Area Medical Plan. Likewise, any benefits you receive from the Choice POS II Medical Plan for which specific Plan Year or dollar limits apply will be carried over and applied toward the limits under the Out-of-Area Medical Plan.

If you move* into *a network area. If you move into a network service area during the Plan Year, contact the L-3 Benefit Center to discuss your Medical Plan options. If you change your coverage to the Choice POS II Medical Plan, contact Aetna Member Services at 1-800-345-5839 so that any deductibles and coinsurance you've already paid under the Out-of-Area Medical Plan will count toward your annual deductibles and annual out-of-pocket maximum under the Choice POS II Medical Plan. Likewise, any benefits you receive from the Out-of-Area Medical Plan for which specific Plan Year or dollar limits apply will be carried over and applied toward the limits under the Choice POS II Medical Plan, if you choose coverage under that Plan.

The Choice POS II network. Aetna has carefully selected the physicians, hospitals and other providers who participate in the Choice POS II network. Each physician in the network holds a current, unrestricted license from the appropriate state and federal authorities; has admitting privileges and is a member in good standing at a network hospital; is Board-certified or Board-eligible; and provides proof of sufficient malpractice insurance and a satisfactory malpractice history.

Using Choice POS II providers. When you visit the provider you've selected, show him/her your Aetna Medical Plan ID card. When you identify yourself to Choice POS II providers with your ID card, they will file all claims for you and the Plan will pay them directly. Here are some additional considerations to keep in mind about Choice POS II providers:

- **Your Choice POS II provider may be part of a group practice that includes non-Choice POS II providers.** Verify that the provider from whom you receive care participates in the Choice POS II network.
- **Providers perform a variety of medical services, some of which they may not perform at Choice POS II facilities.** Reimbursements in "mixed" situations—that is, when a Choice POS II provider performs services at a non-Choice POS II facility, or vice versa—are based on Choice POS II participation. For example, when you use a Choice POS II surgeon to perform surgery at a non-Choice POS II facility, the surgeon is reimbursed at the In-Network level while the facility is reimbursed at the Out-of-Network level. Likewise, when you use a non-Choice POS II surgeon to perform surgery at a Choice POS II facility, the surgeon is reimbursed at the Out-of-Network level while the facility is reimbursed at the In-Network level.
- **Some Choice POS II providers may refer you to non-Choice POS II providers.** Care you receive from non-Choice POS II providers is reimbursed at the Out-of-Network level. Verify that the provider you're being referred to participates in the Choice POS II network.

- **Some Choice POS II providers may use non-Choice POS II radiologists, anesthesiologists or pathologists.** Just because you are in a Choice POS II hospital doesn't mean that all care you receive will come from Choice POS II providers. There may be some radiologists, anesthesiologists or pathologists who are not in the Choice POS II network but who provide services to you while you are confined in a Choice POS II hospital. Covered services received in a Choice POS II hospital from these non-Choice POS II providers will be subject to the annual deductible and reimbursed at 90% of reimbursement rate based at 125% of the Medicare fee schedule, which may be lower than the provider's actual charge. You will be responsible only for your In-Network coinsurance. You are not responsible for any additional charges. If a provider bills you for anything more, contact Aetna Member Services at 1-800-345-5839 for assistance.

- **All health care services and supplies furnished by a Choice POS II provider are subject to the provisions of the Plan.** Just because a provider is a Choice POS II provider does not mean that all services and supplies the provider furnishes are eligible expenses under the Plan. Contact Aetna Member Services at 1-800-345-5839 if you have questions about what is and is not covered.

Specialists. In the unlikely event that there's no specialist in the network who can provide the care you need, contact Aetna Member Services at 1-800-345-5839. If appropriate, they will refer you to an Out-of-Network specialist. As long as that referral is approved by Aetna prior to the service being rendered, it's treated as In-Network care. However, since the specialist is not in the network, you may have to pay for your treatment when you receive it and then file a claim with Aetna for reimbursement. (See page 41 for an explanation of the claims procedure.) Your reimbursement will be based on the provider's reasonable and customary charge. You will be responsible for paying any difference between the reasonable and customary charge and the provider's actual charge, and for calling Aetna to pre-certify your care, if required.

Insufficient network providers. Some networks may not have as wide a selection of providers as other networks. (For example, in some parts of the country there may not be an adequate selection of ancillary providers such as x-ray and lab facilities, home health care agencies, skilled nursing facilities, ambulance services, etc.) When this is the case, your primary care physician must contact Aetna Member Services for authorization prior to the service being rendered so that your eligible expenses can be approved for coverage at the In-Network level. Otherwise, your eligible expenses will be paid at the Out-of-Network level. If they are paid at the Out-of-Network level, you will be responsible for paying any difference between the reasonable and customary charge and the provider's actual charge, and for calling Aetna to pre-certify your care, if required. Keep in mind that since the specialist is not in the network, you may have to pay for your treatment when you receive it and then file a claim with Aetna for reimbursement. (See page 41 for an explanation of the claims procedure.) If you have questions about whether there is a sufficient number of network providers in your area, please call Aetna Member Services at 1-800-345-5839.

Aetna Member Services. Contact Aetna Member Services if you want more information regarding a particular Choice POS II provider. Member Services also can answer questions about your benefits, claim status and Choice POS II network service areas. To reach Member Services, call 1-800-345-5839, Monday through Friday, 8:00 a.m. to 6:00 p.m., local time zone.

You can find out about physicians and providers who participate in the Choice POS II network by logging in to Aetna Navigator, which you can do from Aetna's website (www.aetna.com). In addition to customized provider searches, Navigator makes it easy for you to view Plan facts, check the status of a claim or print forms.

When you receive preventive care from a network provider, your care is covered at 100% with no copay required, subject to age and frequency guidelines. Pap tests, routine mammography exams and certain other preventive services are also covered at 100% with no copay, subject to age and frequency guidelines.

Aetna Member Services for the hearing-impaired. If you need to contact Aetna Member Services from a TDD (Telecommunications Device for the Deaf) telephone, call 1-800-325-2285. This line is staffed Monday through Friday, 8:30 a.m. to 4:30 p.m., Eastern Time. At other times, callers will receive this message: "The office is now closed. Please type your name, Social Security number and TDD telephone number and a representative will get back to you the next business day."

Aetna online. You can find out about physicians and providers who participate in the Choice POS II network by logging in to Aetna Navigator, which you can do from Aetna's website (www.aetna.com). In addition to customized provider searches, Navigator makes it easy for you to view Plan facts, check the status of a claim or print forms. Online directories are updated continually and are available 24 hours a day, seven days a week.

Your ID card. You will receive one Plan ID card to access medical and prescription drug services and supplies. If you have family coverage, you will receive two Plan ID cards: one for you and one for your spouse. Each ID card will list all of your enrolled dependents. If you have an enrolled child who is away at school and you need an additional ID card for him or her, contact Aetna Member Services at 1-800-345-5839.

Keep your ID card with you at all times. If you lose or damage your ID card, contact Aetna Member Services at 1-800-345-5839. You also may be able to get a temporary ID card online at www.aetna.com.

Hospital Care

After you pay a $100 copay per day (limited to the first five days of hospital admission per Plan Year), In-Network hospital care is paid at 90% as long as hospitalization is authorized in advance by you or a network provider. Physician services are covered at 90% after the annual deductible.

Aetna will send you a "Notice of Certification" to confirm that your hospital admission has been approved. Present your ID card upon admission; the hospital should take care of all the paperwork.

Please note: If a hospital stay extends from one Plan Year to the next, the maximum hospital copay for that continuous stay is $500; you will not have to meet a new $500 copay for that continuous hospital stay.

Urgent Care

Urgent care is covered in full after a $40 copay per visit.

Preventive Care

When you receive preventive care from a network provider, your care is covered at 100% with no copay required, subject to age and frequency guidelines. Pap tests, routine mammography exams and certain other preventive services are also covered at 100% with no copay, subject to age and frequency guidelines.

Maternity Care

The first prenatal visit to an In-Network doctor's office is covered at 100% after a $40 copay. Subsequent prenatal and postnatal In-Network doctor's office visits are covered at 90% after the annual deductible.

For In-Network maternity hospital admissions, doctor's services are covered at 90% after the annual deductible. In-Network hospital expenses for the mother are covered at 90% after a $100 copay per day (limited to the first five days of inpatient hospital admission per Plan Year) as long as hospitalization is authorized in advance by you or a network provider. For a newborn child, routine nursery expenses are covered at 90% after the annual deductible. However, if the newborn requires a longer-than-normal hospital stay, a $100 copay per day (limited to the first five days of inpatient hospital admission per Plan Year) will also apply to the newborn's stay.

Mental Health and Substance Abuse Treatment

Treatment of mental health and substance abuse problems will be provided by providers in a network established and managed by *Aetna Behavioral Health (ABH),* Aetna's resource for mental health and substance abuse care. Call ABH at 1-800-424-4047 to arrange treatment. Benefits are paid only for treatment that ABH determines is medically necessary.

Inpatient care. If hospitalization is required and you go to a network facility, benefits are paid at 90% after a $100 copay per day (limited to the first five days of inpatient hospital admission per Plan Year).

In an emergency. A mental health emergency is when someone presents a real and present danger to themselves (or to others) or suffers an immediate and severe medical complication as a consequence of a psychiatric illness (such as a drug overdose). In an emergency, the patient should first go to the nearest emergency room, then contact ABH at 1-800-424-4047. As long as ABH is contacted within two business days (excludes weekends and holidays) after admission, In-Network benefits are payable for charges that are determined to be emergency care charges. If the facility is not part of the ABH provider network, the patient may be transferred to a network facility once the emergency has passed.

Outpatient care. If outpatient mental health or substance abuse treatment is required and you receive care from a network provider in the provider's office, benefits are paid at 100%, subject to a $25 per visit copay. For care provided at an outpatient facility, benefits are paid at 90% after the annual deductible.

Treatment alternatives. Once a condition has been reviewed and evaluated, ABH may recommend treatment alternatives. If you're not familiar with an alternative treatment or a provider ABH recommends, one of their clinicians will explain why a specific provider was recommended and what kind of treatment you can expect.

Outpatient mental health or substance abuse treatment provided by a network provider in the provider's office is paid at 100%, after a $25 per visit copay.

If You Go Out of the Network

Your eligible medical expenses are reimbursable when your care is received "Out-of-Network." These expenses are paid at a lower level, which means you pay more out of your pocket. Out-of-Network care is defined as care that is not provided by a Choice POS II network provider (or, for mental health and substance abuse treatment, from any provider without a referral from ABH).

Once the annual deductible is met, the Plan pays 70% of reasonable and customary charges for most eligible Out-of-Network expenses.

How Out-of-Network Expenses Are Reimbursed

Deductibles and coinsurance apply to eligible Out-of-Network medical expenses.

Annual deductible. The individual annual deductible for Out-of-Network care is $500. If you have family coverage, the $1,500 family annual deductible is considered met once the family's combined deductible expenses reach the family limit. However, in determining whether the family deductible has been satisfied, the Plan will not count more than $500 per person.

Expenses that don't count toward the annual deductible. The following expenses are not applied toward the Out-of-Network annual deductible:

- copays;
- Out-of-Network expenses that are over the reasonable and customary charge;
- Out-of-Network prescription drug expenses that are covered under the Plan (see page 36);
- amounts you pay because you do not pre-certify a hospital stay or meet any other similar Plan requirements; or
- charges excluded or limited by the Plan. (See *What's Not Covered Under the Plan,* starting on page 37.)

Coinsurance. Once the annual deductible is met, the Plan pays 70% of the reasonable and customary charge for eligible Out-of-Network expenses. You pay the remaining 30%, which is your coinsurance, plus any amounts over what Aetna determines is the reasonable and customary charge.

How the reasonable and customary charge is determined. You are responsible for any amounts over the reasonable and customary charge for a covered service or supply. The reasonable and customary charge is the reasonable amount charged for a service or supply that is the lowest of: the provider's usual charge for providing the service or supply; the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the way in which charges for the service or supply are made; or the charge Aetna determines to be the prevailing charge level made for the service or supply in the geographic area where it is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual, not often provided in the area or provided by only a small number of providers in the area, Aetna may take into account:

- the complexity;
- the degree of skill needed;
- the provider's specialty;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Annual out-of-pocket maximum. The annual out-of-pocket maximum puts a cap on the amount each participant has to pay in coinsurance toward covered expenses each Plan Year. The Out-of-Network individual annual out-of-pocket maximum is $4,500. It applies to each enrolled person and also includes amounts paid toward meeting the In-Network out-of-pocket maximum. If you have family coverage, the $9,000 family annual out-of-pocket maximum is considered met once the family's combined In-Network and Out-of-Network annual out-of-pocket expenses reach the family maximum. Any eligible expenses submitted for reimbursement after the annual out-of-pocket maximum is reached are paid at 100% of the reasonable and customary charge.

Eligible expenses submitted for reimbursement after the annual out-of-pocket maximum is reached are paid at 100% of the reasonable and customary charge.

Expenses that don't count toward the annual out-of-pocket maximum. The following expenses are not applied to the annual out-of-pocket maximum:

- annual deductible;
- copays;
- expenses over the reasonable and customary charge;
- amounts you pay because you do not pre-certify an Out-of-Network hospital stay or meet any other similar Plan requirements; and
- charges excluded or limited by the Plan. (See *What's Not Covered Under the Plan,* starting on page 37.)

If you move out of a network area. If you move out of a network service area during the Plan Year, contact the L-3 Benefit Center to discuss your medical plan options. If you change your coverage to the Out-of-Area Medical Plan, contact Aetna Member Services at 1-800-345-5839 so that any deductibles and/or coinsurance you've paid under the Choice POS II Medical Plan can be applied to your annual deductible and annual out-of-pocket maximum under the Out-of-Area Medical Plan. Likewise, any benefits you receive from the Choice POS II Medical Plan for which specific Plan Year or dollar limits apply will be carried over and applied toward the limits under the Out-of-Area Medical Plan.

If you move **into** *a network area.* If you move into a network service area during the Plan Year, contact the L-3 Benefit Center to discuss your medical plan options. If you change your coverage to the Choice POS II Medical Plan, contact Aetna Member Services at 1-800-345-5839 so that any deductibles and coinsurance you've already paid under the Out-of-Area Medical Plan will count toward your annual deductibles and annual out-of-pocket maximum under the Choice POS II Medical Plan. Likewise, any benefits you receive from the Out-of-Area Medical Plan for which specific Plan Year or dollar limits apply will be carried over and applied toward the limits under the Choice POS II Medical Plan, if you choose coverage under that Plan.

If you do not pre-certify the services and supplies listed starting on page 9, the Plan will pay related eligible expenses at 50% (instead of 70%) of the reasonable and customary charge after the annual deductible.

Hospital care. Inpatient hospital admissions must be pre-certified by Aetna. (See *How to Pre-certify Out-of-Network Care,* on page 11.) As long as the stay is approved by Aetna, the eligible charges related to the hospitalization are reimbursed at 70% of the reasonable and customary charge subject to the annual deductible.

Please note: If a hospital stay extends from one Plan Year to the next, any amounts for hospital expenses paid toward meeting the annual deductible in the initial Plan Year will carry over to the following Plan Year; you will not have to meet a new deductible for that continuous hospital stay.

Mental health and substance abuse treatment. All mental health and substance abuse benefits are coordinated through Aetna Behavioral Health (ABH). If you use a *non-network* facility and the stay has been certified, benefits are paid at 70% after the annual deductible. If care is rendered by providers not referred or pre-certified by ABH, your eligible expenses will be reimbursed as described below.

Retail prescription drugs. As a Plan participant, you are enrolled automatically in the L-3 Communications Prescription Drug Plan. (See the *L-3 Communications Prescription Drug Plan SPD* for information about that Plan.) If you fill or refill a prescription at an Out-of-Network (non-Aetna) retail pharmacy, your eligible prescription drug expenses will be covered under the Out-of-Network portion of the Aetna Choice POS II Medical Plan. Benefits for eligible prescription drug expenses will be paid at 70% of the pharmacy's charge after the annual deductible. Your 30% coinsurance will apply to the annual out-of-pocket maximum. To receive benefits for prescription drugs filled at an Out-of-Network retail pharmacy, you must file a claim with the Aetna Choice POS II Medical Plan, as explained on page 41.

How Out-of-Network Benefits Are Paid if You Don't Pre-certify

If you do not pre-certify the inpatient services and supplies listed starting on page 9, the Plan will pay related eligible expenses at 50% (instead of 70%) of the reasonable and customary charge after the annual deductible. You pay the annual deductible (if it has not already been satisfied for the Plan Year) plus 50% coinsurance, which is limited to $5,000 per event. When your 50% coinsurance reaches $5,000, the Plan pays 70% of eligible expenses up to the annual out-of-pocket maximum. However, the 50% that you pay does not count toward your annual out-of-pocket maximum. This provision applies to all expenses related to the hospitalization, procedure or treatment.

If you don't pre-certify the outpatient services and procedures listed on page 9, your expenses will not be covered under the Plan.

If you have any questions on how benefits are paid under this portion of the Plan, call Aetna Member Services at 1-800-345-5839.

What's Not Covered Under the Plan

It's important for you to know what expenses are not covered under the Choice POS II Medical Plan. The following expenses are not covered.

- services, supplies and treatment that are not medically necessary (except for preventive care, as defined on page 12). In no event will any of the following services or supplies be considered medically necessary:
  - those that do not require the technical skills of a medical, mental health or dental professional
  - those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or any health care facility
  - those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined
  - those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or *dentist's* office or other less costly setting
- services rendered by a provider that do not require that particular provider's technical skills
- inpatient hospital services and supplies when hospitalization is not medically necessary
- charges made by any provider who is a family member
- charges over the amount that Aetna determines is the reasonable and customary charge
- any work-related injury, sickness or medical expenses covered under Workers' Compensation or any state or federal law
- charges that would not have been made if you didn't have this coverage
- services and supplies any school system is required by law to provide
- care, treatment, services or supplies that are not prescribed, recommended or approved by the patient's attending physician
- replacement of lost or stolen durable medical equipment or prescription drugs
- experimental services, drugs and other supplies
- procedures that are experimental or still under clinical investigation by health professionals. The only exception to this rule applies when Aetna determines that denying treatment will lead to the patient's death within one year. However, the treatment for the disease in question must be demonstrated by scientific data as being effective for that disease. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. The panel will be selected by Aetna and will include professionals who treat the type of disease involved

Contact Aetna Member Services at 1-800-345-5839 if you have a question about what is and isn't covered under the Plan.

Services and supplies furnished or paid for because the patient was or is in the armed forces of a government are not covered.

- services of a resident physician or intern billed separately from a hospital bill
- services and supplies furnished or paid for because the patient was or is in the armed forces of a government
- services and supplies furnished or paid for under any government law (This does not include a plan established by a government for its own employees or their dependents, or Medicaid.)
- eye surgery, mainly to correct refractive errors
- education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment
- plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies that improve, alter or enhance appearance, except when it is to:
  - improve the function of a part of the body that is not a tooth or structure that supports the teeth
  - improve the function of a part of the body that is malformed as a result of a severe birth defect or a direct result of a disease or surgery performed to treat a disease or injury
  - repair an injury, as long as the surgery is performed within two Plan Years of the accident or injury
- vision aids and communication aids
- hearing aid batteries and supplies
- orthopedic shoes, foot orthotics and other devices to support the feet
- the following physical, occupational or speech therapy services:
  - speech therapy for a child whose speech development was delayed or suppressed because of a disease or injury before the child was born or developed any functional speech
  - services covered elsewhere under the Plan
  - services received while the patient is confined to a hospital or other facility for medical care
  - services not performed by a physician or under a physician's direct supervision
  - services that don't follow a specific treatment plan that details the treatment, its frequency and its duration
  - services rendered by a therapist living in the patient's home, or who is related to either the patient or the patient's spouse
  - treatment of delayed speech development, unless it results from disease or injury
  - special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired

- therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- sex change surgery or treatment of gender identity disorders
- artificial insemination, in-vitro fertilization or embryo transfer procedures
- reversal of a sterilization procedure
- routine eye examinations (see the *Vision Care Plan SPD* for information about vision care benefits)
- marriage, family, child, career, social adjustment, pastoral or financial counseling
- acupuncture therapy, except when it is performed by a physician and is used as a form of anesthesia in connection with a covered surgical procedure or for treatment of a covered condition (see page 13)
- non-emergency treatment in an emergency room
- orthognathic surgery procedures
- treatment of temporomandibular joint syndrome (TMJ) or any similar disorder of the jaw joint
- dental implants and oral appliances, except for treatment of Obstructive Sleep Apnea (OSA)
- tattoo removal, revision or application
- physicians' services in connection with weak, strained or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion, unless the charges are for an open cutting operation or for services prescribed by a physician
- physicians' services in connection with corns, calluses or toenails, unless the charges are for the partial or complete removal of nail roots or for services prescribed by a physician who is treating the patient for a metabolic or peripheral vascular disease
- expenses you are not legally obligated to pay
- expenses you have before coverage was in place
- custodial and/or maintenance care, defined as services and supplies furnished to a person mainly to help him or her in the activities of daily life, including room, board and other institutional care
- personal comfort items (such as a television or telephone while hospitalized)
- expenses payable under any other L-3-sponsored plan
- home health care services or supplies that are not a part of a home health care program

Non-emergency treatment in an emergency room is not covered.

Services, treatment, education, testing or training related to learning disabilities or developmental delays are not covered.

- transportation, except as specified under the National Medical Excellence Program (see page 16)
- prescription drugs and related supplies for which benefits are payable under the Drug Plan
- convalescent care for drug addiction, chronic brain syndrome, alcoholism, mental retardation, senility or mental disorder
- the following hospice care expenses: funeral arrangements; religious counseling; financial or legal counseling (including estate planning or the drafting of a will); homemaker or caretaker services; and respite care
- expenses for or related to the following types of treatment: primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy
- expenses for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field
- applied behavioral analysis
- services, treatment, education, testing or training related to learning disabilities or developmental delays, unless developmental delays result from an acute illness or injury, or congenital defects amenable to surgical repair (e.g., cleft lip/palate). Non-covered diagnoses include pervasive developmental disorders (e.g., autism, Down syndrome and cerebral palsy), as these are considered developmental and/or chronic in nature
- care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury
- any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition.

Any questions about excluded expenses should be directed to Aetna Member Services at 1-800-345-5839.

How to Claim Benefits

When to File Claims

Claim forms are not required for most In-Network services and supplies under the Plan, including services and supplies pre-certified by Aetna Behavioral Health. However, to be reimbursed for your eligible Out-of-Network expenses, including prescriptions filled or refilled at an Out-of-Network (non-Aetna) retail pharmacy under the L-3 Communications Prescription Drug Plan, you must file a claim with Aetna. You can expedite the claims process by properly completing your claim form. Forms are available from the L-3 Benefit Center or on Aetna's website, www.aetna.com.

Claims must be submitted within 24 months after you have an eligible expense; otherwise you will not receive payment.

If you have any questions about the claims procedure, contact Aetna Member Services at 1-800-345-5839.

Claiming Out-of-Network Medical Benefits

To be reimbursed for your eligible Out-of-Network expenses, including prescriptions filled or refilled at an Out-of-Network (non-Aetna) retail pharmacy, you must file a claim with the Aetna Choice POS II Medical Plan.

1. Get a claim form from the L-3 Benefit Center or by logging in to Aetna Navigator, which you can do from Aetna's website, www.aetna.com.

2. Follow the instructions printed on the form. Complete the form and answer all questions, even if the answer is "none" or "N/A" (not applicable). If you leave out any information, benefit payment could be delayed. Separate forms must be submitted for you and for each covered dependent. You can attach any related bills to the claim form. (Make sure your Aetna member ID number is on all bills in case they get separated from your claim form.) If another plan is the primary payer (that is, you have already received benefits from another plan for the same treatment), you should attach the Explanation of Benefits you received from the other plan.

3. Provide proof of your expense. Original bills from providers will be accepted if they have all of the following information:

   - ❑ Employee's name and Aetna member ID number
   - ❑ Patient's name (if a dependent), age and relationship to you

To be reimbursed for your eligible Out-of-Network expenses, including prescriptions filled or refilled at an Out-of-Network (non-Aetna) retail pharmacy, you must file a claim with the Aetna Choice POS II Medical Plan.

If you have any questions about claims procedures, contact Aetna Member Services at 1-800-345-5839.

- ❑ An itemized bill from your provider that includes:
  - – Patient diagnosis
  - – Date(s) of service
  - – Procedure code(s) and descriptions of service(s) rendered
  - – Charge for each service rendered
  - – Name, address and tax identification number of service provider
  - – The date the injury or sickness began
  - – A statement indicating either that you are or you are not enrolled for coverage under any other medical insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

4. Submit your claim to Aetna at the address shown on your ID card.
5. Keep a copy of your claim for your files.

Assignment of Benefits

When you receive In-Network medical care for covered services, all you need to pay is the applicable copay, deductible and coinsurance. If you receive covered Out-of-Network medical care and your physician accepts an assignment of benefits, you can ask Aetna to pay your physician directly. Aetna will choose the method of payment to your provider. If you want Aetna to pay your physician directly, be sure to complete the appropriate section on the claim form. Forward the claim to Aetna, along with the itemized bill. Keep in mind that if you assign benefits, you are still responsible for satisfying any applicable deductible and for paying any applicable coinsurance amounts, which you would have to pay directly to your physician.

Filing Claims When You Are Covered by More Than One Plan

The claims procedure for participants who also have coverage under another group medical plan depends on whether our Plan is "primary" or "secondary." (See *How Benefits Are Coordinated With Other Coverage,* on page 43.)

When our Plan is primary. When our Plan is your primary coverage, send your original bills with your claim form to Aetna. Be sure to keep copies of the bills. After your claim is processed, send a copy of the Explanation of Benefits you receive from Aetna, and copies of the bills, to the secondary plan.

When our Plan is secondary. If our Plan is your secondary coverage, file a claim with your primary medical plan first. After you have received written notification of payment (or denial) from your primary plan, make a copy of it and submit it with your claim to Aetna.

Other Information You Should Know

This Summary Plan Description (SPD) describes the benefits that are offered under the Aetna Choice POS II Medical Plan (the "Plan") and the steps you must follow to take full advantage of the Plan. The previous sections describe the most important features of the Plan; what you'll find here is important administrative information and facts about your rights as a participant in this Plan.

This section contains important administrative information and facts about your rights as a participant in the Plan.

This booklet is the SPD for the Aetna Choice POS II Medical Plan. It provides a complete description of the medical benefits offered under the Plan. The Plan is part of the L-3 Communications Group Health Plan and the L-3 Communications Funded Group Health & Welfare Plan ("Group Health Plan"). There is an official Plan document for the Group Health Plan. If the terms of this SPD conflict with the terms of the official Plan document for the Group Health Plan, the terms of the Group Health Plan document will govern.

Your Rights as a Patient

You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any provider in terms that you or your authorized representative easily understands. You also have the right to all information necessary for you to give informed consent before undergoing any procedure or treatment. And you have the right to refuse treatment to the extent the law allows, in which case you will be advised of the medical consequences of doing so.

How Benefits Are Coordinated With Other Coverage

If you or your dependents are covered under the Plan and are also covered by another group medical plan or governmental program, benefits will be coordinated between the plans on what is known as a "non-duplication" basis. Non-duplication means that when the Plan is the secondary payer, the total benefits paid for a *single processed claims transaction* will never be more than the amount the Plan would have paid as the primary payer. (For example, if the total covered expense is $200 and the Out-of-Network portion of the Plan would have paid 70%, or $140, and another employer is primary and pays 60% [$120], the Plan, as secondary coverage, would make up the $20 difference after any annual deductible is met.)

Please note: The Plan **always** is the secondary payer to any motor vehicle policy that may be available to you, including MedPay, Personal Injury Protection (PIP) or no-fault coverage. You may wish to review your automobile insurance policy to ensure that you have responded correctly to any questions about the order of payment for medical benefits.

When the Plan is primary, the benefits paid under the secondary plan will be disregarded in determining the benefits the Plan pays.

Benefits are coordinated on a non-duplication basis.

Determining when our Plan is primary. The Plan is always primary for you while you are an active employee. The Plan is also primary if:

- the expenses are for your enrolled child and your birth date occurs earlier in the Plan Year than the birth date of the child's other parent. If both parents have the same birth date, then the primary plan is the one that has been in effect the longest. This rule applies only if the parents are married to each other; or
- the expenses are for your enrolled spouse who is either disabled or at least age 65 and eligible for Medicare; or
- your enrolled dependents have no other coverage.

If your enrolled dependent has his or her own employer-sponsored coverage as an employee, that coverage is primary and L-3's Plan is secondary.

How the primary plan is determined in other instances. If one of the other group plans that covers you coordinates benefits based on gender, its provisions prevail. This means that such a plan covering the male spouse would be primary for any enrolled dependent children.

When a child is claimed as a dependent by separated or divorced parents, the primary plan is determined in the following order.

1. The plan of the parent who has been charged with financial responsibility for the dependent child's health care expenses by a court; if there is no court order, then
2. The plan of the parent who has custody of the child; if the parent who has custody of the child does not have coverage, then
3. The plan of the stepparent who is married to the parent with custody of the child, if the stepparent claims the child as a dependent; if this is inapplicable, then
4. The plan of the parent who does not have custody; if the parent who does not have custody of the child does not have coverage, then
5. The plan of the stepparent who is married to the parent who does not have custody of the child.

If these rules do not establish which plan is primary, the plan that has covered the person for the longest period of time becomes primary. If the other group plan(s) does not have a coordination of benefits provision (for example, an HMO), the plan without the coordination provision becomes the primary plan.

Subrogation and Reimbursement

Subrogation and reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you, your representative or any agreements characterize the money you receive as a recovery, it shall be subject to these provisions.

Subrogation. The Plan has the right to recover payments it makes on your behalf from you or any party responsible for compensating you for your illnesses or injuries. The legal term for this right of recovery is "subrogation." The following provisions will apply:

- You must assign to the Plan all rights of recovery to the extent of the reasonable value of services and benefits provided by the Plan, plus reasonable costs of collection.
- The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan, including filing suit in your name.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement. If you obtain a recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any recovery. Further, the Plan's rights will not be reduced due to your negligence.

Aetna, on behalf of the Plan, has a legal right to reimbursement of benefits paid to you or your enrolled dependents if someone else (e.g., an insurance company) is legally responsible for your or your enrolled dependents covered medical expenses.

The Plan has the right to recover payments it makes on your behalf from you or any party responsible for compensating you for your illnesses or injuries. The legal term for this right of recovery is "subrogation."

- You and your legal representative must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your recovery, whichever is less, from any future benefit under the Plan if:

  1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or

  2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your recovery, whichever is less, directly from the providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.

- The Plan is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your duties. Your duties consist of the following:

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and you must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

- You must assign to the Plan all rights of recovery to the extent of the reasonable value of services and benefits provided by the Plan, plus reasonable costs of collection.
- You must not accept any settlement that does not fully compensate or reimburse the Plan without its prior written approval.

The Plan sponsor has sole discretion to interpret the terms of the subrogation and reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any recovery because of injuries sustained by the covered person, that recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing these provisions.

These provisions apply to the participant, his or her enrolled spouse and enrolled dependents in the same manner.

Claim Fraud

Aetna regularly evaluates claims to detect fraud or false statements and will notify L-3 about these matters. Aetna must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds copays, deductibles or coinsurance is entering into a discount arrangement with you. Aetna calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers or refunds of copays, deductibles or coinsurance you receive. Failure to notify Aetna or the Plan Administrator of such price adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan.

Aetna regularly evaluates claims to detect fraud or false statements and will notify L-3 about these matters.

Overpayment of Benefits

If Aetna mistakenly pays more for your claim than you're entitled to, it has the right to recover the excess. You must give Aetna any documents or paperwork it asks for, and you must return any benefit payments that were made in error.

How Benefits Can Be Forfeited or Delayed

Benefits can be forfeited or delayed under certain situations. Most of these circumstances are described in the previous sections. However, benefit payments also may be forfeited or delayed if:

- you or your beneficiary does not properly file an application for benefits within the time periods required;
- you do not furnish information required by Aetna to complete or verify your claim; or
- your current address is not on file with your business unit or with Aetna.

You should know that benefits are not payable for expenses that dependents may have after they become ineligible due to age or divorce.

Under the federal Family and Medical Leave Act (FMLA), you may continue to participate in the Plan if you take a family and/or medical leave.

What Happens When You Become Entitled to Medicare

If you're still an active L-3 employee when you reach age 65, the Plan in which you are enrolled will generally continue to be your primary coverage, with Medicare secondary. If you have an enrolled dependent who is eligible for Medicare, the Plan generally is the primary plan unless the dependent waives coverage under the Plan. In cases where the Plan is your primary coverage, you or your enrolled dependent(s) will be entitled to the same benefits under the Plan as those persons who do not have Medicare. (Rules governing the coordination of Medicare are complex, and this is only a brief summary. Contact Aetna at 1-800-345-5839 if you need additional information.)

Continued Coverage Under the Federal Family and Medical Leave Act

If you take a leave that qualifies under the federal Family and Medical Leave Act (FMLA), you may continue or stop your participation in the Plan, according to the procedures established by your business unit. You will be subject to the same rules regarding deductibles, copays, coinsurance and contributions as an active employee. Contact the L-3 Benefit Center for further information.

When Coverage Ends

Unless otherwise specified in a collective bargaining agreement (if applicable), your coverage ends at midnight on your last day at work. Coverage would also end at midnight on the date L-3 or your business unit stops offering the Plan to employees.

Dependent coverage ends when your coverage ends, when a dependent is no longer considered an eligible dependent (as defined on page 2) or if L-3 or your business unit stops offering the Plan to dependents. Specifically, dependent coverage ends at midnight of the day of the event that disqualifies the individual for coverage, as follows:

- **spouse:** at midnight on the date a divorce or legal separation becomes effective
- **children who are not handicapped:** at midnight on the child's 26th birthday
- **children who are handicapped:** the date the child is declared to be no longer handicapped or the date you fail to provide Aetna with required proof of the child's continued handicap, whichever happens first.

You can't convert this group coverage to an individual policy, but you and/or your enrolled dependent(s) may be eligible for continued coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). (See page 50.)

If you are rehired. If you leave L-3 and are rehired within 30 days of your termination, your election that was in effect before your termination will be reinstated; you may not make a new election. If you are rehired more than 30 days after your termination, you may make a new election as a new hire; your prior election will not be reinstated automatically.

Dependent coverage ends when your coverage ends, a dependent is no longer considered an eligible dependent (as defined on page 2) or if L-3 or your business unit stops offering the Plan to dependents.

Extended Coverage

In certain circumstances, your or your dependents' coverage under the Plan may be extended by L-3 past the date it otherwise would end. For example, if you die and have coverage for your dependents, your dependents' coverage may be continued for a limited period after your death. Similarly, if your employment ends because you become disabled, you may be able to continue your and your dependents' coverage for a limited period. Any period of coverage continued due to your death or disability will be included as part of the total period of coverage under COBRA. The L-3 Benefit Center can give you more information about available coverage extensions.

COBRA Continuation Coverage

Under COBRA, you and your enrolled dependents have the right to elect to continue coverage under the Plan if you (or your enrolled dependents) would otherwise lose coverage because of a qualifying event (as shown in the chart below). Each qualified beneficiary has the independent right to elect COBRA coverage. A qualified beneficiary means each person (you, your spouse and your dependents) covered by the Plan on the day before a qualifying event, and any child born to you (the employee) or placed for adoption with you while you are covered by COBRA. COBRA coverage is identical to the coverage provided to similarly situated active employees. You may elect (but you may not waive) COBRA continuation on behalf of your spouse, as long as your spouse is a qualified beneficiary. Parents may elect COBRA continuation coverage on behalf of their dependent children, as long as the dependent children are qualified beneficiaries.

Under COBRA, you and your enrolled dependents have the right to elect coverage continuation under the Plan if you (or your enrolled dependents) would otherwise lose coverage because of a qualifying event.

Please note: The explanation of COBRA in this section is not intended to give you or your enrolled dependents any rights to COBRA that are not otherwise required by law.

The following chart shows the qualifying events and the periods of eligibility for COBRA continuation coverage:

If You Lose Coverage Because...	These People Would Be Eligible for COBRA Coverage...	For up to...
Your employment terminates for reasons other than gross misconduct	You and your eligible dependents	18 months*
You become ineligible due to reduced work hours	You and your eligible dependents	18 months*
You die	Your eligible dependents	36 months
You divorce or legally separate	Your eligible dependents	36 months
Your dependent children no longer qualify as dependents	Your eligible dependent children	36 months
You become entitled to Medicare	Your eligible dependents	36 months

*Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. These additional 11 months are available to employees and enrolled dependents if notice of disability is provided to SHPS, the COBRA Administrator, before the 18-month continuation period runs out and within 60 days of the date of the Social Security Administration's determination notice (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest).

Please note that entitlement to Medicare means you are eligible for and enrolled in Medicare. Also note that if you are entitled to Medicare at the time that your employment terminates or you become ineligible due to a reduction in hours and your Medicare entitlement began less than 18 months before the applicable qualifying event, your dependents will be eligible for up to 36 months of COBRA after the date of Medicare entitlement.

Please note: If you are age 65 or older, or otherwise eligible for Medicare, you are urged to elect Medicare Part A and Part B, since Medicare will be your primary coverage; your L-3 COBRA coverage will be secondary. ***This means that L-3 COBRA coverage will NOT pay for those services normally covered by Medicare, regardless of whether you enroll for Medicare Part A and Part B.***

If you or your dependents receive an L-3-subsidized extension of coverage after you terminate employment, the coverage extension will be credited against the applicable COBRA coverage period (18, 29 or 36 months) shown in the chart on page 50.

Extension of 18-month COBRA coverage period for disability. If you're a qualified beneficiary who has COBRA continuation coverage because of termination of employment or reduction in hours, you and each enrolled member of your family can get an extra 11 months of COBRA coverage if you become disabled. (That is, you can get up to a total of 29 months of COBRA coverage.) To qualify for additional months of COBRA coverage, you must have a Notice of Award from the Social Security Administration that your disability began before the 61st day after your termination of employment or reduction in hours, and your disability must last at least until the end of the COBRA coverage period that would have been available without the extension.

To elect extended COBRA coverage, you must send a copy of the Social Security Administration's determination to SHPS, the COBRA Administrator, within 60 days of the date of the Social Security Administration's determination notice (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest). In addition, your notification to SHPS must occur within 18 months after your termination of employment or reduction in hours. If you do not notify SHPS in writing within the 60-day (and 18-month) period, you will lose your right to elect extended COBRA continuation coverage.

Extension of 18-month COBRA coverage period for your spouse or dependent children due to a second qualifying event. If your spouse or dependent children have COBRA continuation coverage because of your termination of employment or reduction in hours, they can get up to an extra 18 months of COBRA coverage if they have a second qualifying event. (That is, they can get up to a total of 36 months of COBRA coverage.) This extended COBRA coverage is available to your spouse and dependent children if the second qualifying event is your death, divorce or legal separation. The extension is also available to a dependent child whose second qualifying event occurs when he or she stops being eligible under the Plan as a dependent child.

To elect extended COBRA coverage in all of these cases, you must notify SHPS of the second qualifying event within 60 days after the second qualifying event (or the date that benefits would end under the Plan as a result of the first qualifying event, if later). If you do not notify SHPS in writing within the 60-day period, you will lose your right to elect additional COBRA continuation coverage.

Your COBRA coverage may be extended beyond 18 months (up to 36 months) if you become disabled or have a second qualifying event.

Within 14 days after SHPS is notified that a qualifying event has occurred, they will send you an election form and a notice of your right to elect COBRA. (If you do not receive this notification, please contact the L-3 Benefit Center.)

Notification. In general, the L-3 Benefit Center is responsible for notifying SHPS if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment, reduction in hours of employment or Medicare entitlement. The notification must be made within 30 days after the qualifying event.

Under the law, you or your enrolled dependent is responsible for notifying SHPS in writing of your divorce, your legal separation or a child's loss of dependent status. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later).

A disabled qualified beneficiary must notify SHPS in writing of a disability determination by Social Security within 60 days after such determination (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest) and within the initial 18 months of COBRA coverage.

You or your family member can provide notice on behalf of yourself as well as other family members affected by the qualifying event. The written notice of the qualifying event should be sent to SHPS, at the address shown on page 55, and should include the following:

- ❑ Date written notice is submitted (month/day/year)
- ❑ Employee's name
- ❑ Employee's Social Security number/ ID number
- ❑ Reason for loss of coverage
- ❑ Loss of coverage date (month/day/year)
- ❑ Spouse/dependent's name
- ❑ Spouse's Social Security number/ ID number
- ❑ Spouse/dependent's address
- ❑ Spouse/dependent's telephone number
- ❑ Spouse/dependent's gender
- ❑ Spouse/dependent's date of birth (month/day/year)
- ❑ Spouse/dependent's relationship to employee
- ❑ Spouse/dependent's employer's name.

If you do not notify SHPS in writing within the applicable 60-day period or you do not follow the procedures prescribed for notifying SHPS, you will lose your right to elect COBRA continuation coverage.

COBRA enrollment. Within 14 days after SHPS is notified that a qualifying event has occurred, they will send you an election form and a notice of your right to elect COBRA. (If you do not receive this notification, please contact the L-3 Benefit Center.) To receive COBRA continuation coverage, you must elect it by returning a completed COBRA election form to SHPS within 60 days after the date of the notice of your right to elect COBRA (or within 60 days after the date you would lose coverage, if later).

If you make this election and pay the required premium within the required deadlines, COBRA coverage will become effective on the day after coverage under the Plan would otherwise end. If you do not elect COBRA, your coverage under the Plan will end in accordance with the provisions listed under *When Coverage Ends,* page 49.

In considering whether to elect COBRA coverage, please note that if you decline COBRA coverage, it will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Keep in mind that under federal law, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in the chart on page 50. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Adding a dependent after COBRA coverage begins. If a child is born to you (the employee) or placed for adoption with you while you are covered by COBRA, you can add the child to your coverage as a qualified beneficiary with independent COBRA rights. In addition, each qualified beneficiary covered by COBRA may add dependents in the same manner as an active employee, but such dependents are not qualified beneficiaries.

Cost of coverage. As provided by law, you and/or your enrolled dependents must pay the full cost of coverage plus 2% for administrative expenses for the full 18- or 36-month period. For a disabled person who extends coverage for more than 18 months, the cost for months 19–29 is 150% of L-3's cost for the coverage. When two or more family members elect COBRA coverage, the family coverage cost under the Plan will apply. Since the cost to L-3 may change during the period of your continuation coverage, the amount charged to you may also change annually during this period.

Time for payment. You must send the initial payment for COBRA coverage to SHPS within 45 days of the date you first notify SHPS that you choose COBRA coverage. (A U.S. Post Office postmark will serve as proof of the date you sent your payment.) You must submit payment to cover the number of months from the date of regular coverage termination to the time of payment (or to the time you wish to have COBRA coverage end).

After your initial payment, all payments are due on the first of the month. You have a 30-day grace period from the due date to pay your premium. If you fail to pay by the end of the grace period, your coverage will end as of the last day of the last fully paid period. Once coverage ends, it cannot be reinstated. To avoid cancellation, you must send your payment on or before the last day of the grace period. (Again, a U.S. Post Office postmark will serve as proof.) Please note that if your check is returned unpaid from the bank for any reason, that may prevent your COBRA premiums from being paid on time and may result in cancellation of coverage.

As provided by law, you and/or your enrolled dependents must pay the full cost of COBRA coverage plus 2% for administrative expenses for the full 18- or 36-month COBRA continuation-of-coverage period.

COBRA continuation coverage cannot under any circumstances extend beyond 36 months from the date of the qualifying event that originally made you or a dependent eligible to elect COBRA.

When COBRA continuation coverage ends. COBRA continuation coverage ends automatically on the last day of the month in which the earliest of the following dates falls:

- the date the maximum coverage period ends
- the last day of the period for which the person covered under COBRA made a required premium payment on time
- the date after the election of COBRA that the person covered under COBRA first becomes covered under another group medical plan. If the other plan limits coverage because of the person's pre-existing condition, COBRA coverage will end after the pre-existing condition no longer applies
- the first of the month that begins more than 30 days after the date the person whose disability caused the extension of coverage to 29 months is no longer disabled (based on a final determination from the Social Security Administration)
- the date the Plan is terminated and L-3 and all of its business units provide no other medical coverage.

In addition, COBRA continuation coverage normally will end when the person covered under COBRA first becomes entitled to Medicare.

If continuation coverage ends before the end of the maximum coverage period, SHPS will send you a written notice as soon as practicable following their determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

COBRA continuation coverage cannot under any circumstances extend beyond 36 months from the date of the qualifying event that originally made you or a dependent eligible to elect COBRA.

Once COBRA continuation coverage ends for any reason, it cannot be reinstated.

You must notify SHPS if:

- you have a divorce or legal separation
- you, your spouse or an eligible enrolled dependent has a change of address
- you, your spouse or your dependent becomes entitled to Medicare
- your dependent child is no longer eligible
- you or a dependent ceases to be disabled, as determined by the Social Security Administration.

If you don't notify SHPS in a timely manner that any of the above events has occurred, you may lose COBRA coverage.

COBRA Administrator. The COBRA Administrator for the Plan is:

SHPS, Inc. COBRA Administration
11405 Bluegrass Parkway
Louisville, KY 40299
Phone: 1-877-324-4644

All notices to SHPS must be in writing and sent to SHPS at this address. Any notice that you send must be postmarked by the U.S. Post Office no later than the last day of the required notice period. The notice must state the name of the Plan under which you request COBRA continuation coverage, your name and address, the name and address of each qualifying beneficiary, the qualifying event and the date it happened. If the qualifying event is a divorce or legal separation, you must include a copy of the divorce decree or legal documentation of the legal separation. Other applicable documentation (such as birth certificates or adoption papers) may also be required.

Unavailability of coverage. If you or your enrolled dependent has notified SHPS in writing of your divorce, your legal separation or a child's loss of dependent status, or a second qualifying event, but you or your enrolled dependent is not entitled to COBRA, SHPS will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same time frame the Plan follows for election notices.

Additional COBRA election period under the Trade Act. If the U.S. Department of Labor (DOL) certifies you as eligible for benefits under the Trade Act of 2002, you may be eligible for both an additional 60-day COBRA election period and an individual health insurance tax credit. For more information about COBRA and the Trade Act, go to www.irs.gov and enter "HCTC" in the "Search" box on the home page, or call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. (TTD/TTY callers may call toll-free at 1-866-626-4282.) SHPS may also be able to assist you with your questions.

If you have questions. If you have any questions about your COBRA continuation coverage, contact SHPS or the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Addresses and phone numbers of EBSA offices are available at www.dol.gov/ebsa.

To protect your family's rights to COBRA coverage, keep the L-3 Benefit Center informed of any changes of address for you and your family members.

Continued Coverage During a Military Leave of Absence

If you are on a military leave of absence, your and your dependents' coverage under the Plan will continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may request a copy of L-3's USERRA policy from the L-3 Benefit Center.

If you are on a military leave of absence, your and your dependents' coverage under the Plan will continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Ownership of Benefits

The benefits described here are exclusively for Plan participants and, if applicable, their eligible enrolled dependents. These benefits cannot be sold, transferred or assigned for any reason (except as provided by law).

If there is a conflict between the information you receive from Aetna, the L-3 Benefit Center or L-3's Human Resources Department and the terms of the Plan documents, the terms of the Plan documents will prevail.

Plan Administration

L-3 Communications Corporation, as the Plan Administrator, is responsible for the administration of the Plan. The L-3 Benefit Center and L-3's Human Resources Department act on behalf of the Plan Administrator and are responsible for routine Plan administration and answering questions about eligibility and coverage. The Plan Administrator has the full and complete discretionary authority and responsibility to administer the Plan and may delegate any or all of its authority and responsibility to any individuals or entities.

The Plan Administrator has delegated to Aetna the discretionary authority and responsibility to determine claims for benefits under the Plan. Aetna has the full and complete discretionary authority and responsibility to decide whether you are entitled to benefits under the Plan. However, if Aetna denies your appeals, you may request that your claim be submitted for external review, as described on page 61. If you request external review, the decision of the independent review organization (IRO) conducting the external review will be final and binding on all persons, to the full extent permitted by law, unless you decide to further appeal any adverse decision of the IRO to the *Health Claims Appeals Committee.* Procedures for appealing to the Health Claims Appeal Committee are described in greater detail on page 62.

If conflicts arise. The L-3 Benefit Center, the L-3 Human Resources Department and Aetna will always try to give you the most complete and accurate information regarding the Plan. If there is a conflict between the information you receive from Aetna, the L-3 Benefit Center or L-3's Human Resources Department and the terms of this Summary Plan Description, the terms of this Summary Plan Description will prevail. If there is a conflict between the information in this Summary Plan Description and the Plan document, the terms of the Plan document will prevail.

Compliance With Federal Law

As a group health plan, the Plan is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Internal Revenue Code (the "Code") and certain other federal law. In general, ERISA preempts state law that relates to group medical plans subject to ERISA.

The Plan will be construed and administered in accordance with ERISA, the Code and other applicable federal law, in all respects. In the event that there is no controlling federal law, the law of New York will apply (including its statute of limitations and all substantive and procedural law, and without regard to its conflict of laws provision).

Claims Procedures

To receive the benefits for which you may be eligible under the Plan, you or your beneficiary may first be required to file a claim with Aetna, as described on page 41. Below is a summary of how the claims for benefits will be handled.

Timing of Initial Claim Approval or Denial

Action	Urgent Care Claim	Pre-service ("Pre-certification") Claim	All Other Claims
Aetna will notify you of claim approval or denial	Within 24 hours after claim is received	Within 15 days after claim is received	Within 30 days after claim is received
Aetna will notify you if your claim didn't include enough information	Within 24 hours after claim is received	Within 15 days after claim is received	Within 30 days after claim is received
You must provide more information to Aetna, if necessary	48 hours from the date you are notified	At least 45 days from the date you are notified	At least 45 days from the date you are notified

Timing of Appeal Decision

Action	Urgent Care Claim	Pre-service ("Pre-certification") Claim	All Other Claims
You must provide more information to Aetna, in writing (for an urgent care claim: orally *or* in writing)	Within 180 days after the date you were notified	Within 180 days after the date you were notified	Within 180 days after the date you were notified
Aetna will notify you about the appeal decision	Within 36 hours after appeal is received	Within 15 days after appeal is received	Within 30 days after appeal is received
You can make a *second* appeal to Aetna, in writing (for an urgent care claim: orally *or* in writing)	Within 60 days after appeal denial is received	Within 60 days after appeal denial is received	Within 60 days after appeal denial is received
Aetna will notify you about the *second* appeal decision	Within 36 hours after appeal is received	Within 15 days after appeal is received	Within 30 days after appeal is received
You can seek review from an independent review organization (IRO)	Expedited external IRO review is available following any denial by Aetna, as described on page 62	Within 123 days after *second* appeal denial is received	Within 123 days after *second* appeal denial is received
The IRO will notify you of its final decision, in writing	Within 72 hours after the IRO receives the request for expedited review (however if the notice by the IRO is not in writing, the IRO will provide written confirmation within 48 hours after the notice)	Within 45 days after the IRO receives the request for external review	Within 45 days after the IRO receives the request for external review

cont'd

If the appeal of a claim other than an urgent care claim is denied by the independent review organization (IRO), you can make a final appeal to the Health Claims Appeals Committee.

The time within which your claim must be approved or denied will depend on the type of claim you file.

Action	Urgent Care Claim	Pre-service ("Pre-certification") Claim	All Other Claims
You may appeal to the Health Claims Appeals Committee, in writing, in the case of a denial by the IRO or a determination that you are not eligible for IRO review	Not permitted	Within 60 days after denial of appeal by IRO or determination that appeal is not eligible for IRO review	Within 60 days after denial of apeal by IRO or determination that appeal is not eligible for IRO review
The Health Claims Appeals Committee will notify you of its decision, in writing	N/A	As soon as administratively feasible	As soon as administratively feasible

Timing of initial claim approval or denial. The time within which your claim will be approved or denied will depend on the type of claim you file.

- **For claims involving urgent care,** you will be notified of the approval or denial no later than 24 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Aetna receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life, health or the ability to regain maximum function, or that must, in the opinion of a physician, be provided without delay to adequately manage severe pain.

- **For medical care requiring pre-certification approval (called a "pre-service claim"),** you will be notified of the approval or denial of your claim no later than 15 days after your claim is received. Aetna may extend this 15-day period to 30 days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-day period of the reasons for the extension and the date by which a decision will be made. If your claim did not include enough information to reach a decision, you will be notified by Aetna within five days after receiving your claim of the specific information that is necessary. You will have at least 45 days from receipt of the notice to provide the specified information.

- **For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions"),** you will be notified in advance of any decision by Aetna to reduce or terminate the course of treatment that would be covered, so that you will have enough time to appeal the decision and receive a determination before the treatment is reduced or terminated. If you request an extension of the course of treatment and the treatment involves urgent care, you will be notified within 24 hours after your request is received, as long as you make your request at least 24 hours before the approved course of treatment is scheduled to end.

- **For all other care (e.g., reimbursement for medical services already received),** you will be notified of the approval or denial of your claim no later than 30 days after your claim is received. Aetna may extend this 30-day period to 45 days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 30-day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 days from receipt of the notice to provide the specified information.

Contents of claim denial notice. If you receive notice that your claim has been denied, either in full or in part, the claim denial notice will include:

- the specific reasons for the denial
- reference to the specific Plan provisions on which the denial is based
- a description of any additional material or information Aetna requires and an explanation of why it is necessary
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action under Section 502(a) of ERISA but only after you have followed the Plan's claims procedures
- if an internal rule, guideline or protocol was relied on in making the adverse determination, a statement that a copy of the specific rule, guideline or protocol will be provided on request, free of charge
- if the denial is based on a medical necessity exclusion, *experimental treatment* exclusion or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge
- sufficient information to identify the claim involved, including the date of service, the health care provider and, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- any denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.

First appeal to Aetna. You have 180 days after receipt of the denial to file an appeal with Aetna. Your appeal must be in writing, except that an appeal of an urgent care claim may be made orally or in writing. Be sure to explain why you think you are entitled to benefits, and attach any documentation that will support your claim. You have the right to review your claim file and to present evidence and testimony as part of the appeals process. Specifically, you have the right to receive, free of charge, any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of approval or denial is required to be provided to give you a reasonable opportunity to respond prior to that date.

In addition, before Aetna can issue a final determination on an appeal based on a new or additional rationale, you must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of determination of appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

If you are appealing a claim denial in writing, be sure to explain why you think you are entitled to benefits, and attach any documentation that will support your claim.

You must follow all claims procedures completely before you can take legal action.

Approval or denial of appeal. Aetna will send you its decision within the following deadlines: 36 hours for urgent care claims; 15 days for pre-service claims; and 30 days for all other claims.

If your claim is based on a medical judgment, in reviewing your appeal, Aetna will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and will provide you with the name of the health care professional, upon request.

If Aetna denies your appeal, the denial notice will include:

- the specific reasons for the denial
- reference to the specific Plan provisions on which the denial is based
- a statement that you have the right to bring a civil action under Section 502(a) of ERISA after you have followed the Plan's claims procedures and received an adverse decision on your second appeal
- if an internal rule, guideline or protocol was relied on in making the adverse determination, a statement that a copy of the specific rule, guideline or protocol will be provided on request, free of charge
- if the denial is based on a medical necessity exclusion, experimental treatment exclusion or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge
- sufficient information to identify the claim involved, including the date of service, the health care provider and, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- any denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.

Second appeal to Aetna. If Aetna denies your appeal, you have 60 days from receiving the appeal denial to send a second appeal to Aetna. Your appeal must be in writing. Aetna will send you its written decision within 36 hours for urgent care claims, 15 days for pre-service claims and 30 days for all other claims.

Authorized representative. If you appeal an adverse decision to Aetna, an independent review organization (IRO) or the Health Claims Appeals Committee, you may have an authorized person represent you (at your own expense). You have the right to examine the relevant portions of any documents that Aetna referred to in its review.

Legal action. You must follow these claims procedures completely, which require two appeals to Aetna before you can take legal action.

Effect of appeal decision. Aetna, the IRO and the Health Claims Appeals Committee, in their respective roles, have absolute and discretionary authority to interpret the terms of the Plan. Decisions on appeal will be made at the sole discretion of Aetna, the IRO and the Health Claims Appeals Committee, in their respective roles, and will be final and binding on all persons.

External review process. Effective January 1, 2011, the Plan is also providing an external review process. The external review process applies to any second denial by Aetna, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

You may file a request for an external review with Aetna if the request is filed within 123 days after the date of receipt of a notice of denial of a second appeal by Aetna.

You may file a request for an external review with Aetna if the request is filed within 123 days after the date of receipt of a notice of denial of a second appeal.

Within five business days following the date of receipt of the external review request, Aetna will complete a preliminary review of the request to determine whether:

- you are or were covered under the Plan at the time the health care item or service was requested or provided;
- the denial does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- you have exhausted the Plan's internal appeal process; and
- you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, Aetna will notify you in writing. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the U.S. Department of Labor Employee Benefits Security Administration (toll-free number: 1-866-444-EBSA (3272)), as well as information explaining how to appeal your claim to the Health Claims Appeals Committee. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow you to perfect the request for external review within the 123-day filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Aetna has contracted with an accredited independent review organization (IRO) to conduct the external review.

The IRO will notify you in a timely manner, in writing, of the eligibility of the request and acceptance for external review. This notice will include a statement that you may submit in writing to the IRO, within ten business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Aetna will provide to the IRO the documents and any information considered in making the benefit determination within five business days following assignment of the claim to the IRO. The IRO will review all of the information and documents received in a timely manner.

Upon receipt of any information submitted by you, the IRO will forward the information to Aetna within one business day. Upon receipt of this information, Aetna may reconsider its prior determination. Reconsideration by the Plan will not delay the external review. If Aetna reverses its earlier denial as a result, the external review process will terminate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO's written notice will include:

- a general description of the reason for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for the previous denial
- the date the IRO received the assignment and the date of the decision
- reference to the evidence or documentation considered in reaching the decision
- discussion of the principal reason for reaching the decision
- a statement that the determination is binding except to the extent that the parties have a right to seek judicial review to overturn the decision or review by the Health Claims Appeals Committee
- current contact information for any applicable ombudsman established under federal law.

You have the right to make a request for an expedited external review if you have a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your ability to regain maximum function and you have filed a request for expedited internal review.

Expedited external review. You also have the right to make a request for an expedited external review if you have a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your ability to regain maximum function and you have filed a request for expedited internal review, or if you received a denial from Aetna concerning an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility.

Voluntary request for review by the Health Claims Appeals Committee. If the IRO denies your external appeal or it is determined that you are not eligible for external appeal, you may request that the Health Claims Appeals Committee review your claim. The Health Claims Appeals Committee may be reached at the following address and phone number:

L-3 Communications Corporation
c/o Director, Health Claims Appeals Committee
600 Third Avenue
New York, NY 10016
1-212-697-1111

Appeal to the Health Claims Appeals Committee is available for any denial by the IRO other than an appeal for expedited external review. You must follow the appeals process described above before you may submit a request for review to the Health Claims Appeals Committee. This means that you must file two appeals with Aetna and an appeal with the IRO, unless it is determined that your appeal is ineligible for IRO review. You have 60 days from receiving the IRO's final denial or the determination that your appeal is not eligible for IRO review to send a written request to the Health Claims Appeals Committee. The Health Claims Appeals Committee will send you its final written decision as soon as administratively feasible.

If you choose to appeal to the Health Claims Appeals Committee, you must do so in writing, and you should send the following information:

- the specific reason(s) for the appeal;
- copies of all past correspondence with Aetna or the IRO (including any EOBs); and
- any applicable information that you have not yet sent to Aetna and the IRO.

If you appeal to the Health Claims Appeals Committee, you will be deemed to authorize the Health Claims Appeals Committee or its designee to obtain information from Aetna relevant to your claim.

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that all group medical plans that provide medical and surgical benefits with respect to a mastectomy must provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, coinsurance and copay provisions applicable to other such medical and surgical benefits provided under the Plan.

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

Confidentiality of Health Care Information

L-3's Medical Plans are required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official *HIPAA Privacy Notice,* which is distributed to all Plan participants, is summarized here.

The intent of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as "protected health information" (PHI). The Plan will not use or disclose your PHI without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with benefits under another employee benefit plan.

The Plan also hires professionals and other companies to advise the Plan and help administer and provide health care benefits. The Plan requires these individuals and organizations, called "Business Associates," to comply with HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates (for example, Aetna, the Plan's Claims Administrator). That notice will describe your rights with respect to benefits administered by that individual/organization.

Under federal law, you have certain rights where your PHI is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services, if you believe your rights have been violated.

If you have questions about the privacy of your health information or if you would like a copy of the official *HIPAA Privacy Notice,* please contact the L-3 Benefit Center.

No Right to Continued Employment

Your eligibility or right to benefits under the Plan does not confer any legal right to continued employment by L-3 or any of its business units. L-3 and each business unit at all times retain the right to discharge any employee at any time, for any reason.

Your eligibility or right to benefits under the Plan does not confer any legal right to continued employment by L-3 or any of its business units.

Future of the Plan

L-3 intends to continue the Plan indefinitely, but reserves the right to change, terminate, suspend, withdraw, amend or modify the Plan at any time, in any manner, at L-3's sole discretion, by action of the Vice President, Human Resources of L-3 Communications Corporation, subject to applicable collective bargaining agreements. Any change, termination, suspension, withdrawal, amendment or modification of benefits will be based solely on the decisions of L-3 and may apply to active employees, employees covered through COBRA, future retirees and current retirees as either separate groups or as one group. You will be notified of any change; however, the change may be effective before any notice is given to you.

Contribution rates are established by the Vice President, Human Resources of L-3 Communications Corporation and may change each Plan Year, subject to applicable collective bargaining agreements.

Contribution rates may change each Plan Year, subject to applicable collective bargaining agreements.

Under ERISA, you have the right to obtain copies of documents governing the operations of the Plan.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

ERISA provides that you will be entitled to receive information about your Plan and benefits, as follows:

- ❑ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description (SPD). 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.

ERISA also provides that you will be entitled to continue group health plan coverage for yourself, your spouse and your dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. You should review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

In addition, ERISA provides that you should be given a certificate of creditable coverage, free of charge, from your group medical plan or medical insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, and 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.

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 Plan. The people who operate the 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 benefit or exercising your rights under ERISA.

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 after you have followed the Plan's claim procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You can get publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. To visit the Department of Labor's website, go to www.dol.gov.

Contact the nearest area office of the Employee Benefits Security Administration if you have questions about ERISA. You can get publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Facts

Plan Name	L-3 Communications Group Health Plan (501) L-3 Communications Funded Group Health & Welfare Plan (503)
Employer and Plan Sponsor	L-3 Communications Corporation 600 Third Avenue New York, NY 10016 1-212-697-1111
Employer Identification Number	13-3937436
Plan Number	501 (503 for employees whose coverage is funded through the L-3 SCA VEBA trust)
Plan Administrator and Named Fiduciary	L-3 Communications Corporation c/o Vice President, Human Resources 600 Third Avenue New York, NY 10016 1-212-697-1111
Agent for Service of Legal Process	Process may be served upon the Plan Administrator at the address indicated above.
Plan Year	January 1–December 31
Type of Plan	Group Health Plan
Type of Administration	The Plan includes self-insured and insured programs. This summary describes the self-insured Aetna Choice POS II Medical Plan program, administered under an administrative services contract with: Aetna, Inc. 151 Farmington Avenue Hartford, CT 06156 1-800-345-5839 www.aetna.com
Plan Records	The records of the Plan are maintained on a calendar-year basis.
Plan Funding	L-3 and employees contribute toward the cost of coverage. For certain employees subject to the provisions of the Service Contract Act, employer contributions are deposited irrevocably to the L-3 SCA VEBA trust, the sole purpose of which is to provide medical or other acceptable benefits to these employees.

Glossary

This Glossary is provided to help you understand the Plan by summarizing several of its key terms. However, any questions about Plan coverage that concern these terms will be answered by Aetna, which has full discretionary authority to use its own materials, procedures and expertise to define these terms. Aetna is not limited to the summary definitions provided in this Glossary.

Aetna Behavioral Health (ABH) is Aetna's resource for pre-certifying certain inpatient and outpatient mental health and substance abuse care (listed on page 9), and for recommending mental health and substance abuse care providers.

Aetna Member Services is Aetna's service center that provides you with information about providers in their network; answers questions about what is and isn't covered under the Plan; tells you about the status of a claim; and provides pre-certification of required medical services and supplies.

Annual physical is, for incentive credit purposes, a once yearly examination by your family physician (or a "well-woman exam" by an ob-gyn physician). The physician's exam usually will include a medical history review, a physical examination and basic lab tests (for example, for cholesterol or diabetes). An annual physical is designed to assess overall health and screen for possible chronic conditions and generally is not performed solely for the purpose of addressing an already diagnosed medical condition.

Assistant surgeon is a licensed physician who actively assists the operating surgeon.

Choice POS II provider. See *Network (or "Choice POS II") provider.*

Coinsurance is:

- the percentage of a covered In-Network expense you pay under the Plan after the deductible (if applicable) and before the Plan starts paying benefits; or
- the percentage of a covered Out-of-Network expense you pay under the Plan after the deductible.

Convalescent facility is an institution that:

- is licensed to provide the following inpatient care to patients convalescing from disease or injury: professional nursing care by an RN, or by an LPN directed by a full-time RN; and physical restoration services that help patients restore their ability to care for themselves
- provides 24-hour nursing care by licensed nurses directed by a full-time RN
- is supervised full-time by a physician or RN
- keeps a complete medical record on each patient
- has a utilization review plan
- is not mainly a place for rest; for the aged, drug addicts, alcoholics or the mentally retarded; for custodial or educational care; or for care of mental disorders
- charges for its services.

Copay is a fee charged for covered medical services and supplies received under the In-Network portion of the Plan.

Course of treatment is a planned program of services or supplies furnished by a health care provider in connection with the diagnosis and treatment of an injury or disease of a definite duration.

Custodial care is services and supplies furnished to a person mainly to help him or her in the activities of daily life. Services include room and board, and other institutional care. To receive custodial services, a covered person does not have to be disabled. Services and supplies are considered "custodial care" regardless of:

- who prescribes the care;
- who recommends the care; or
- the person or institution that provides the care.

Deductible is the amount you pay each Plan Year before the Plan pays a portion of your covered expenses.

Dentist is a legally licensed dentist practicing within the scope of his or her license, or a legally licensed physician authorized by his or her license to perform the particular dental services rendered.

Disease means any condition of abnormal function involving any structure, part, or system of the body, or a specific illness or disorder marked by a specific set of signs and symptoms.

Durable medical and surgical equipment is equipment that is made to withstand prolonged use, made for and mainly used in the treatment of a disease or injury, suited for use in the home, not normally of use to persons who do not have a disease or injury, not for use in altering air quality or temperature, and not for exercise or training.

Emergency condition is a sudden and unexpected change in a person's physical or mental condition that, as confirmed by Aetna, is severe enough to require immediate hospital-level care. (Also see *Urgent care.*)

Experimental treatment, as used here, is a procedure, service, drug or other supply that, as determined by Aetna, falls into any of the following categories:

- there are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- if required by the FDA, approval has not been granted for marketing;
- a recognized national medical or dental society, or regulatory agency, has determined, in writing, that it is experimental, investigational or for research purposes; or
- the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Handicapped dependent child is a dependent child who depends chiefly on you for support and maintenance and is not able to earn his or her own living because of a mental or a physical condition which began prior to age 26. Proof of the child's handicap must be submitted to Aetna within 60 days after the child's 26th birthday. Aetna has the right to require proof of the continuation of the handicap, including examining the child as often as needed while the handicap continues, at Aetna's own expense. Please note, however, that an exam will not be required more often than once each year after two years following the child's 26th birthday. Coverage for a handicapped dependent child will end when the child is no longer handicapped, when you fail to provide proof of the continued handicap, when you fail to submit to any required exam, or if L-3 stops offering the Plan to dependents, whichever happens first.

Health Claims Appeals Committee is a committee appointed by L-3 to review appeals of health care claims.

Home health care agency is an agency that:

- mainly provides skilled nursing and other therapeutic services
- is associated with a professional policy-making group that has at least one physician and one RN
- is supervised full-time by a physician or RN
- keeps complete medical records on each patient
- has a full-time administrator
- meets licensing standards.

Home health care program is a program that provides for care and treatment of a disease or injury. The care and treatment must be prescribed in writing by the attending physician and must be an alternative to confinement in a hospital or convalescent facility.

Hospice care agency is an agency or organization that:

- has 24-hour hospice care available
- meets the licensing or certification standards of its jurisdiction
- provides bereavement counseling for the immediate family, skilled nursing services, medical social services and psychological and dietary counseling
- provides or arranges for other services that include:
  - the services of a physician
  - physical or occupational therapy
  - part-time home health aide services that mainly consist of caring for patients
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management
- is staffed with at least one physician, one RN, one licensed or certified social worker employed by the agency and one pastoral or other religious counselor
- has policies governing the provision of hospice care

- assesses the patient's medical and social needs
- develops a hospice care program to meet those needs
- provides an ongoing quality assurance program that includes reviews by physicians other than those who own or direct the agency
- permits all area medical personnel to use its services for their patients
- keeps a medical record on each patient
- uses volunteers trained in providing services for non-medical needs
- has a full-time administrator.

Hospice facility is a facility, or distinct part of one, that:

- mainly provides inpatient hospice care to the terminally ill
- charges for its services
- meets the licensing or certification standards of its jurisdiction
- keeps a medical record on each patient
- provides an ongoing quality assurance program that includes reviews by physicians other than those who own or direct the facility
- is run by a staff of physicians and has at least one of them on call at all times
- provides 24-hour nursing services under the direction of an RN
- has a full-time administrator.

Hospital (including a birthing center) is defined as an institution that:

- mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of the injured and sick
- is supervised by a staff of physicians
- provides 24-hour RN service
- is not mainly a place for rest or a nursing home for the aged, drug addicts or alcoholics
- charges for its services.

In-Network refers to a health care service or supply furnished by:

- a network provider
- an Out-of-Network provider approved by Aetna
- any health care provider in an emergency when travel to an In-Network provider prior to treatment is not feasible.

Lifetime maximum is the most the Plan will pay in benefits for each covered person for his or her lifetime.

Medicaid is a state program of medical aid for needy individuals, established under Title XIX of the Social Security Act of 1965, as amended.

Medically necessary means that when a particular provider furnishes a service or supply, Aetna determines that it is appropriate for the diagnosis, care or treatment of the disease or injury involved.

To be appropriate, the service or supply must be:

- considered care or treatment;
- as likely to produce a significant positive outcome as it is to produce a negative outcome when compared with any alternative service or supply, taking into account the disease or injury involved and the person's overall health condition;
- a diagnostic procedure, indicated by the health status of the person, and be as likely to result in information that could positively affect the course of treatment as it is to produce a negative outcome when compared with any alternative diagnostic procedure, taking into account the disease or injury involved and the person's overall health condition; and
- no more costly (taking into account all health expenses you have in connection with the service or supply) than any alternative service or supply to meet the above criteria regarding diagnosis, care and treatment.

In determining if a service or supply is appropriate under the circumstances, Aetna will consider:

- information provided on the affected person's health status;
- reports in peer-reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

The following services or supplies are never considered necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional;
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or any health care facility;

- those provided solely because the person is an inpatient on any day when the person's disease or injury could safely and adequately be diagnosed or treated while he or she is not an inpatient; or

- those provided solely because of the setting, if the service or supply could safely and adequately be provided in a physician's or a dentist's office, or other less costly setting.

Medicare is the federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Mental disorder is an illness, whether or not it has a physiological basis, for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, psychologist or psychiatric social worker. Any one of the following conditions is considered a mental disorder under the Plan: anorexia/bulimia nervosa, bipolar disorder, major depressive disorder, obsessive compulsive disorder, panic disorder, pervasive mental developmental disorder (including autism), psychotic disorders/delusional disorder, schizo-affective disorder and schizophrenia.

Mental disorder treatment facility is an institution that:

- has an onsite licensed behavioral health provider 24 hours per day/7 days a week

- provides a comprehensive patient assessment (preferably before admission, but at least upon admission)

- has a physician perform admissions

- has access to necessary medical services 24 hours per day/7 days a week

- provides living arrangements that foster community living and peer interaction that are consistent with developmental needs

- offers group therapy sessions with at least an RN or Masters-level health professional

- has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults)

- provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy

- has peer-oriented activities

- has services that are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director)

- has an individualized active treatment plan directed toward the alleviation of the impairment that caused the admission

- provides a level of skilled intervention consistent with patient risk

- meets any and all applicable licensing standards established by the jurisdiction in which it is located

- is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

National Medical Excellence (NME) Program arranges for treatment of certain medical conditions (such as heart, lung, liver, kidney, pancreas or bone marrow transplants) that call for care in a highly specialized "Institutes of Excellence" (IOE) facility. For NME benefit purposes, an NME patient is a member of the Plan who requires any of the specific NME procedures and treatments for which the charges are a covered medical expense, contacts Aetna and is approved by Aetna as an NME patient, and agrees to have the procedure or treatment performed in any hospital designated by Aetna as the closest and most appropriate IOE facility. A companion is a person whose presence as a companion or caregiver is necessary to enable an NME patient to receive services in connection with any of the specified NME procedures and treatments on an inpatient or outpatient basis, or to travel to and from an IOE facility.

Network (or "Choice POS II") provider refers to a health care provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna's consent, included in its directory as an In-Network care provider for the service or supply involved.

Non-network refers to care received from providers not affiliated with Aetna's Choice POS II network.

Non-occupational illness or disease is an illness or disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does. A disease is considered non-occupational regardless of its cause if proof is furnished that the person is covered under any type of Workers' Compensation law, and not covered for that disease under such law.

Non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit or result in any way from an injury that does.

Out-of-pocket maximum is the most you pay out of your pocket in coinsurance each Plan Year under the Plan. For covered In-Network expenses under the Plan, the annual out-of-pocket maximum does not include the annual deductible; copays; and any amounts you may pay because you don't pre-certify the services and supplies listed starting on page 9. For covered Out-of-Network expenses under the Plan, the annual out-of-pocket maximum does not include the annual deductible; any amounts above reasonable and customary limits; and any amounts you may pay because you don't pre-certify the services and supplies listed starting on page 9.

Physician is a legally qualified, licensed practitioner of medicine, acting within the scope of that license and includes, but is not limited to, doctors of medicine and dental surgery, chiropractors, osteopaths and podiatrists.

Plan Year is the 12-month period from January 1 through December 31 during which the Plan is administered and during which the annual deductible, annual out-of-pocket maximum and annual benefit limits are recorded.

Pre-certification (or "pre-certify") means to get advance approval for medical services or supplies under the Plan. Pre-certification is required only for certain services and supplies, as shown starting on page 9.

Reasonable and customary charge (or "recognized charge") is the recognized amount charged for a service or supply that is the lowest of:

- the provider's usual charge for furnishing the service or supply;
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
- the charge Aetna determines to be the prevailing charge level made for the service or supply in the geographic area where it is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual, not often provided in the geographic area or provided by only a small number of providers in the geographic area, Aetna may take into account:

- the complexity;
- the degree of skill needed;
- the provider's specialty;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate Aetna will pay for a service or supply. In these instances, the reasonable and customary charge is the rate established in the agreement.

Semiprivate room rate is the charge for room and board that an institution applies to most beds in its semiprivate rooms with two or more beds. If there are no such rooms, Aetna will figure the rate, which will be the rate most commonly charged by similar institutions in the same geographic area.

Single processed claims transaction is a group of actual or prospective charges submitted to Aetna for consideration that have been grouped together for administrative purposes as a claims transaction.

Substance abuse is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association that is current as of the date services are rendered to you or your covered dependents.) Substance abuse does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM) or an addiction to nicotine products, food or caffeine intoxication.

Substance abuse treatment facility is an institution that:

- has an onsite licensed behavioral health provider 24 hours per day/7 days a week
- provides a comprehensive patient assessment (preferably before admission, but at least upon admission)

- has a physician perform admissions
- has, for patients who require detoxification services, the availability of onsite medical treatment 24 hours per day/7days a week, actively supervised by an attending physician
- has access to necessary medical services 24 hours per day/7 days a week
- provides living arrangements that foster community living and peer interaction that are consistent with developmental needs
- offers group therapy sessions with at least an RN or Masters-level health professional
- has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults)
- provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy
- has peer-oriented activities
- has services that are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director)
- has an individualized active treatment plan directed toward the alleviation of the impairment that caused the admission
- provides a level of skilled intervention consistent with patient risk
- meets any and all applicable licensing standards established by the jurisdiction in which it is located
- is not a Wilderness Treatment Program or any such related or similar program, school and/or education service
- has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally
- has 24 hours per day/7 days a week supervision by a physician with evidence of close and frequent observation
- has onsite, licensed behavioral health provider, medical or substance abuse professionals 24 hours per day/7 days a week.

Urgent care is medical care given to treat an injury or disease that, while not an emergency, is severe enough to require immediate care. Examples of situations that require urgent (but not emergency) care are broken limbs, acute bronchitis, first-degree burns and chronic earache.

Mixed Sources
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