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Introduction

This benefits Summary Plan Description contains detailed information on the Medical, Dental, Mental Health, Counseling and Postdoctoral Services Program, Prescription, Vision, and Dependent Care Spending Account Plans. Each section includes plan options, a schedule of benefits, eligibility requirements, coverage information, general provisions and easy-to-reference definitions. This Summary Plan Description may be used to answer specific questions about your benefits as they arise throughout the year.

Benefits Overview

This benefits Summary Plan Description begins with an overview that describes the Benefit Options, eligibility requirements, Premiums, enrollment information, and qualified status changes and terms you should know.

Benefits Overview

Under Section 125 of the Internal Revenue Code, you may choose between after-tax and pre-tax benefits. With certain exceptions, Premiums may be deducted from your pay on a pre-tax basis. Those individuals who are not required to pay federal and state income taxes are not eligible to have their Premiums deducted on a pre-tax basis.

Flexible Benefits include:

- Three Medical Plan Options (Two plan options for Graduate Students (External));
- One Dental Plan Option;
- Dependent Care Spending Account (some exceptions apply; see the section below titled “General Enrollment Provisions” for further information.)

Miscellaneous Benefits

Other benefits programs you may be eligible for include: Retirement Plans, Voluntary Life Insurance Plan, Transit Reimbursement Program, Participant Discounts, Direct Deposit, Fitness Benefit Discount and other miscellaneous benefits are not described in this document. For information regarding these benefits, please visit the Human Resources website or the applicable Retirement Summary Plan Description.

Benefit Premiums

Deductions for your benefit choices, if any, may be taken from your paycheck before taxes are deducted if you are eligible or pre-tax benefits. Research Associates and Graduate Students (External) working with certain foreign visas or under certain tax treatments may not be eligible for pre-tax payroll deductions.

Effect on Social Security

The amount of any Social Security benefit you become eligible to receive in the future for retirement or disability will be based on the amount of your annual pay that is subject to Social Security taxes. Your pre-tax Benefits price tags for benefit coverage may reduce the amount of your pay subject to Social Security taxes. As a result, your Social Security benefits may also be reduced. Based on the present Social Security Administration provisions, the reduction caused by your pre-tax payroll deductions for your Flexible Benefits, if any, will be very small. However, you should consult your tax advisor for advice regarding your specific situation.

How To Enroll In Benefits

Enrolling in Benefits is simple. Newly hired Research Associates and Graduate Students (External) will receive a Benefits Enrollment Form (BEF). If you do not complete and return the Benefits Enrollment Form within the first
30 days following your date of eligibility, you will automatically be enrolled in the Default Plan*. Therefore, it is important to return the completed Form on time. Once you return your Benefits Enrollment Form along with applicable proof of dependency, you will be enrolled as of your date of eligibility.

*Default Plan = the HMO Medical Plan (participant only).

Currently enrolled participants may make changes to their coverage during the annual Open Enrollment period or when you incur a qualified status change (see “Changing Your Elections on Account of a Qualified Status Change Event” below), subject to the terms of the applicable Plan. A confirmation of your selections will be sent to you after the Open Enrollment period ends.

With certain exceptions, participation in Benefits allows you to pay Premiums for the Plans you choose with Pre-tax Dollars. In exchange for this, the Internal Revenue Service (IRS) imposes the following restrictions: You must make your pre-tax benefit elections when you first enroll for benefits or during Open Enrollment; and you may not change these elections during the Plan year unless such change is on account of and consistent with a qualified status change and you submit a properly completed Benefits Coverage Change Form along with proof of status change and dependency (if applicable) to Human Resources within 31 days of the status change or such other period described under “Changing Your Elections on Account of a Qualified Status Change Event” below.

Please note that the Plan Administrator may unilaterally adjust allocations and elections to the extent necessary to comply with the requirements of the Internal Revenue Code, including but not limited to the antidiscrimination provisions of the Code.

Status Changes

An event that qualifies as a change in status enables a participant to change his or her selection of benefits during the Plan year, subject to the terms of the applicable benefit Plan (including the Dependent Care Spending Account Plan). Any change in your selections must, as discussed in more detail below, be on account of and consistent with the applicable change in status as determined by the Plan Administrator in its sole discretion. Voluntary termination of coverage is not considered a status change.

Examples of status changes that qualify for a change in benefit elections (please see each Plan's applicable section for more detailed information regarding status changes):

- **HIPAA “Special Enrollment” Period:** You may enroll yourself and/or your new dependent for Medical and Dental benefits in accordance with any of the “special enrollment” periods described in each Plan's section.

- **Marriage:** You may enroll yourself and your new dependents acquired by marriage into the Medical and Dental Plans (see definition of children under Medical Benefits, Dependent/Domestic Partner Eligibility). You may also change your elections under the Dependent Care Spending Account Plan provided your change in elections is on account of and consistent with this change in status.

- **Attainment of Domestic Partnership:** You may enroll a Domestic Partner in the Medical and Dental Insurance Plans. California participants must provide a certificate of Domestic Partner Registry with the State of California. The certificate must be submitted along with a Benefits Coverage Change Form. Participants outside of California must provide an Affidavit of Domestic Partnership. Please refer to the Domestic Partner information in the Medical and/or Dental Plan sections. Domestic Partner expenses are not eligible for Spending Account reimbursement unless the Domestic Partner also qualifies as your dependent for federal income tax purposes.

- **Divorce, Legal Separation or Annulment:** You must change your status (e.g., participant + spouse to participant only coverage) for your Medical and Dental benefits as a result of a final divorce decree or legal separation. Your former spouse may be eligible for continued coverage under the provisions of COBRA. You may also change your elections under the Dependent Care Spending Account Plans provided your change in elections is on account of and consistent with this change in status.
Termination of Domestic Partnership: You must change your status (e.g., participant + domestic partner to participant only coverage) for your Medical and Dental benefits as a result of a termination of your domestic partnership. Domestic partners are not eligible for continued coverage under COBRA in the event of this status change. You should review your beneficiary designations at this time and, if applicable.

Birth, Adoption or Placement for Adoption of a Dependent: You may enroll your new dependent(s) in the Medical and Dental Plans. You may also change your elections under the Dependent Care Spending Account Plan provided your change in elections is on account of and consistent with this change in status.

Death of a Dependent: You should discontinue your Medical and Dental coverage for a dependent that dies as well as review your beneficiary designations. You may also change your elections under the Dependent Care Spending Account Plans provided your change in elections is on account of and consistent with this change in status.

Commencement of or Return From an Unpaid Leave of Absence: This includes commencement or return from an unpaid leave of absence under the Family and Medical Leave Act (FMLA). Eligible participants who go on an unpaid FMLA leave may revoke existing Medical and Dental elections or continue such coverage at the same cost during the leave in accordance with procedures established by the Plan Administrator. Participants who go on any other type of unpaid leave may be eligible to continue their coverage during the leave and should contact Human Resources about the rules applicable to their leave and their return from leave.

Commencement of or return from a paid leave of absence is not a qualified status change. In most cases, benefit selections will continue during your leave unless you experience a status change that would otherwise permit you to change your benefit selections.

NOTE: Special rules apply to the Dependent Care Spending Account Plan and you should refer to those sections or contact Human Resources for more information.

Change in Worksite: You may change Medical and Dental coverage for you or your dependent who experiences a change in worksite provided the change in worksite affects eligibility for coverage and your change in elections is on account of and consistent with such change in eligibility.

Change in Residence: You may change Medical and Dental coverage for you or your dependent who experiences a change in residence (including a change to U.S. residence or foreign residence) provided the change in residence affects eligibility for coverage and your change in elections is on account of and consistent with such change in eligibility. You must submit such proof of change in residence (or other applicable change in status), including valid passport documentation, as the Plan Administrator may require.

Entitlement to or Loss of Medicare or Medicaid: You may change Medical and Dental coverage for you or your dependent who becomes entitled to or loses entitlement to Medicare or Medicaid provided your change in elections is on account of and consistent with entitlement or loss of entitlement to Medicare or Medicaid.

Administrative Agency or Court Orders Health Care Coverage for Your Child: You may be required to enroll your child for Medical and Dental coverage if we receive an administrative agency or court order (including a “qualified medical child support order”) that requires your child be enrolled for coverage. Similarly, you may discontinue your child’s Medical and Dental coverage if we receive an administrative agency or court order (including a “qualified medical child support order”) that requires your spouse, former spouse or other individual to provide coverage and that coverage is provided.

Termination, Commencement or Change in Employment Status of Your Dependent: You may enroll or discontinue Medical and Dental coverage for a dependent who either gains or loses benefits at his or her employment as the result of a termination, commencement or change in employment status (e.g., full-time to part-time) provided the change in employment status affects eligibility for coverage and your change in
elections is on account of and consistent with such change in eligibility. In the event of this status change, you may change your status (e.g., participant only to participant + spouse coverage). You may also change your elections under the Dependent Care Spending Account Plan provided your change in elections is on account of and consistent with this status change. In some cases, written proof of the change in your dependent’s coverage may be required from your dependent’s insurer (or plan administrator, as applicable) stating the date coverage was terminated. An election by your dependent to voluntarily drop coverage does not constitute a loss of coverage.

- **Eligibility for COBRA:** You may change Medical and Dental coverage if you, your spouse or other dependent becomes eligible for COBRA (as described in the "Continuation of Health Care Benefits under COBRA" section) in order to pay for such coverage provided such individual otherwise remains eligible for coverage.

- **Significant Change in Coverage:** You may make changes to your Medical or Dental coverage selections if there is a significant change in coverage as determined by the Plan Administrator in its sole discretion. In some cases, you may also be able to make changes in your coverage selections due to changes your dependent makes in the coverage offered by his or her employer (e.g., changes made during an Open Enrollment period that is different from this Plan’s Open Enrollment period). You will be required to provide documentation as to the reason why dependents are being added/dropped from your coverage. You are required to complete a Benefit Coverage Change form and provide proof within 31 days of the qualified status change.

- **Significant Change in Cost of Coverage:** You may make changes to your Medical or Dental coverage selections if there is a significant change in the cost of coverage as determined by the Plan Administrator in its sole discretion.

- **Termination or Change in Your Employment Status:** You may make changes to your Medical and Dental coverage elections if you experience a change in your employment status, provided the change in employment status affects your eligibility for coverage. Your change in status may also affect your eligibility for the Dependent Care Spending Account Plan.

If you terminate your employment with TSRI and are rehired as an eligible participant within 90 days of your termination, but still within the same calendar year, your previous elections will automatically be reinstated retroactively to your termination date. If you terminate your employment with TSRI and are rehired as an eligible participant after 90 days of your termination, but still within the same calendar year, you have the option of reinstating your previous elections for the remainder of the calendar year in which you return to TSRI or reenrolling as a new hire within 30 days of your reemployment/return from leave and making new elections. In either case, your elections will be effective as of the date of your return to TSRI.

- **Dependent reaching ineligible age/status:** Dependents must be removed from the Medical and Dental Plans when they reach an age that disqualifies them from continued coverage under the Plan (19 up to 25 if full time student).

**Changing Your Elections on Account of a Qualified Status Change**

**General Rules**

If you wish to change your elections on account of a qualified status change, your change in elections must be consistent with your qualified status change (see discussion below) and you must file a signed Benefits Coverage Change Form along with proof of status change and dependency (if applicable) with Human Resources. Except as provided below with respect to a Qualified Change in Status Due to a Special Enrollment Right and a Qualified Change in Status That May Also be a COBRA Qualifying Event, election changes will be effective on the first day of the next administratively practicable pay period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency, provided such documentation is received within 31 days of the qualified status change event.
Qualified Change in Status Due to a HIPAA Special Enrollment

In the event of a special enrollment period involving a loss of other coverage or marriage, election changes will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) following the date you file a signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency with Human Resources; provided, however that all documentation is received within 31 days of the date of loss of coverage or marriage.

In the event of a special enrollment period involving the birth, adoption or placement for adoption of a child, election changes will be effective retroactive to the date of the birth, adoption or placement, provided you file a signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency with Human Resources within 31 days of the birth, adoption or placement.

In the event of a special enrollment period involving (i) termination of coverage under Medicaid or a state Children’s Health Insurance Program (CHIP) or (ii) eligibility for a premium assistance subsidy under Medicaid or CHIP, election changes will be effective on the first day of the next administratively practicable payroll period-following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency; provided, however, that all such documentation is received within 60 days of the occurrence of one of the foregoing events.

Qualified Change in Status That May Also be a COBRA Qualifying Event

In the event of a qualified status change that results in your and/or your dependents’ loss of coverage under a TSRI group health care plan because (i) you cease Active Work (regardless of the reason you cease Active Work), (ii) your hours are reduced such that you are no longer eligible for coverage, (iii) you become entitled to Medicare, (iv) you divorce or legally separate, or (v) your dependent loses his or her dependent status, election changes will be effective on the first day of the next month following the date Human Resources receives the Benefits Coverage Change Form and related documentation; provided, however, that all documentation is received within 31 days of the date of one of the foregoing qualified change in status events.

If you and/or your covered dependents lose coverage due to one the above-described qualified change in status events, you and/or your covered dependents may also be eligible for COBRA continuation coverage (see “Continuation of Health Care Benefits under COBRA” below for detailed information regarding your rights under COBRA). For example, you and your covered dependents may be eligible for COBRA continuation coverage if you lose coverage because you cease Active Employment for reasons other than gross misconduct.

Consistency Rule

As noted above, if you experience one of the qualified status changes described above, any change in your elections must be on account of and consistent with the qualified status change as determined by the Plan Administrator in its sole discretion. A change in election generally satisfies this requirement if the qualifying status change results in you or your eligible dependents becoming eligible or ineligible for coverage under TSRI’s Plans or a similar plan offered by your dependant’s employer and the change in your elections corresponds with the change in eligibility for coverage. In some cases, a more specific consistency rule applies.

A change in status does not generally allow you to change from one Medical Plan to another Medical Plan (e.g. from the Comprehensive Medical Plan to the HMO Medical Plan). However, if your change in status permits a change to your coverage category (e.g., from participant only to participant + family, participant + family to participant only), you may also be able to change from one Medical Plan to another Medical Plan. For example, you are enrolled in the Comprehensive Medical Plan as “participant only” and you marry during the Plan year, acquiring a new spouse and dependent child. You may also be able to change from the Comprehensive Medical Plan to the HMO Medical Plan. You should contact Human Resources for more information if you experience a qualified change in status and wish to change from one Medical Plan to another.

Proof of Status Change and Dependency
You must provide such information and documentation necessary to verify your qualified status change and dependency of covered dependents as the Plan Administrator may require. This documentation may include:

- a birth, marriage or death certificate;
- Affidavit of Domestic Partnership;
- written certification regarding changes made under another employer’s plan;
- verification of an eligible dependent’s change in employment status; or
- court orders for adoption, legal guardianship, legal separation and divorce.

Please note that in the event you discontinue TSRI Medical and Dental coverage due to a gain in other coverage, proof of other coverage will be required with your Benefits Coverage Change Form.

**General Enrollment Provisions**

- **Medical Plans**
  You may enroll in this Plan during your Initial Enrollment Period, Open Enrollment or due to a qualified status change, provided you submit a Benefits Enrollment Form (or Benefits Coverage Change Form, as applicable) to Human Resources within 31 days of the applicable change in status event or such other period described under “Changing Your Elections on Account of a Qualified Status Change Event” above.

- **Dental Plan**
  You may enroll in this Plan during your Initial Enrollment Period, Open Enrollment or due to a qualified status change, provided you submit a Benefits Enrollment Form (or Benefits Coverage Change Form, as applicable) to Human Resources within 31 days of the applicable change in status event or such other period described under “Changing Your Elections on Account of a Qualified Status Change Event” above.

- **Employee Assistance Program**
  Enrollment in this Plan is automatic.

- **Dependent Care Spending Account**
  You may enroll in this Plan during your Initial Enrollment Period, Open Enrollment, or due to qualified status changes, provided you submit a Benefits Enrollment Form (or Benefits Coverage Change Form, as applicable) to Human Resources within 31 days of the applicable change in status event. You should refer to the Dependent Care Spending Account Plan section for more information regarding this benefit.

**Definitions**

- **Benefits Coverage Change Form** - An individual form that is used to notify the Plan Administrator of a change in your coverage selections.

- **Benefit Enrollment Form** - An individual enrollment form that includes benefit Premiums. This form is provided to you at orientation.

- **Benefit Options** - The selection of different benefits and coverage levels available to you under the Benefits program.

- **Default Plan** - The Default Plan limits coverage to the HMO Medical Plan for you only. Dental coverage is not part of this Plan.

- **Family Coverage Category** - You have a choice of six family coverage categories for your Medical and Dental benefits.
- Participant Only (EO)
- Participant plus Child(ren) (EC)
- Participant plus Spouse (ES)
- Participant plus Domestic Partner (ED)
- Participant plus Family (EF)
- Participant plus Child(ren) plus Domestic Partner (EP)

Initial Enrollment Period – The thirty (30) days after your initial eligibility date or the thirty-one (31) days after your change of status to a Benefit Eligible position.

Open Enrollment - Open enrollment is the time period during which you may make certain changes to your benefits package. Open enrollment is held once per year, as determined by Human Resources.

Plan Administrator - The Scripps Research Institute (TSRI) is the Plan Administrator for The Scripps Research Institute Group Health and Welfare Plan. The Plan Administrator for each of the component plans is identified in the section entitled “General Information” at the end of this Summary Plan Description.

Premium - Your cost for each Benefits option. This is the amount you are charged for one year's worth of coverage for a particular Benefit Option.

Pre-tax Deductions (Dollars) - Money taken from your pay before taxes are calculated. This may result in lower taxes because your taxable income is reduced.

Section 125 - Section 125 refers to a part of the Internal Revenue Code that makes certain Flexible Benefit programs available to participants. These plans can offer participants a choice between permissible taxable benefits such as cash and pre-tax benefits such as Medical, Dental and Life Insurance.

Total Premium - The sum or total cost of your Premiums for all the benefits you elect under Benefits Options.

Medical Benefits

Eligibility

Active full-time and part-time Research Associates and Graduate Students (External) who are regularly scheduled to work 20 or more hours a week are eligible for Benefits participation. Temporary and seasonal employees, independent contractors, leased employees and collectively bargained employees are not eligible.

- You must apply for coverage within 30 days of becoming an eligible participant. If you do not apply within 30 days see below for "Late Enrollee" and "Special Enrollee" information.

Effective Date of Your Coverage

Your coverage starts on the latest of the following dates:

- the date you become eligible under the Plan;
- the date you complete and return to the Plan Administrator a Benefits Election Form for Benefits under the TSRI Flexible Benefits Plan, electing coverage under this Plan. Such Election of Coverage must be made within 30 days of becoming eligible. NOTE: Coverage is generally retroactive to your start date if you make your Election of Coverage within the 30-day period after your start date. However, deductions are
not taken from your pay retroactively. If you do not apply within 30 days, see below for “Late Enrollee” and “Special Enrollee” information.

**Late Enrollee**

You are considered a late enrollee if all of these are true:

- You declined coverage at the first available opportunity to enroll.
- You did not have other health coverage when you declined.
- You completed and signed a declination of coverage form, which notified you of the consequences of declination.

Late enrollees may enroll only during the Plan’s annual Open Enrollment period. Coverage will be effective on the first day of the next Plan year (January 1st).

**Special Enrollee**

You are considered a special enrollee if:

- You declined coverage under the Plan at the first available opportunity to enroll because you had other health coverage (see “Special Enrollment for Loss of Other Coverage” below);
- You had a status change event such as a marriage, birth, adoption, or placement for adoption;
- You had a status change event involving a termination of coverage under a Medicaid or CHIP program or eligibility for premium assistance under one of these programs (see “Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009” below).

Coverage under Special Enrollment due to marriage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. In the case of a Special Enrollment period involving the birth, adoption or placement of a child, election changes will be effective retroactive to the date of the birth, adoption or placement, provided you file a signed Benefits Coverage Change Form with Human Resources within 31 days of the birth, adoption or placement. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

**Special Enrollment for Loss of Other Coverage**

A Special Enrollment period for loss of other coverage is available to you if you meet all of these requirements:

- You must otherwise be eligible for coverage under the Plan.
- You must have been covered under another group health plan or must have had other health coverage.
- You must have declared in writing at the time you initially declined coverage under the Plan that you already had other coverage.
- If the other coverage was COBRA continuation coverage, COBRA continuation was exhausted.
- If the other coverage was not COBRA continuation coverage, you have lost eligibility for the other coverage or your Employer has stopped contributions for the other coverage. Loss of eligibility must not be due to failure to pay Premiums or for cause (such as making a fraudulent claim).

You must request Special Enrollment within 31 days of the loss of other coverage. You do not have to elect COBRA continuation or other similar continuation to preserve the right to Special Enrollment. Coverage under Special Enrollment due to loss of other coverage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received
a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. If you do not elect to enroll in the Plan during the Special Enrollment period, you generally will not be able to enroll until the following annual enrollment period.

**Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009**

If you are eligible, but not enrolled, for medical coverage (or your dependent is eligible, but not enrolled, for such coverage), a Special Enrollment period is available, and you may enroll yourself and/or your eligible dependent for coverage, if either of the following conditions is met:

- You or your dependent are covered under a Medicaid plan or under a Children’s Health Insurance Program (CHIP) and your coverage, or your dependent’s coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or
- You or your dependent become eligible for premium assistance as to coverage under the TSRI group health plan under such Medicaid plan or CHIP plan.

You must provide Human Resources with a signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency within 60 days of the occurrence of one of these Special Enrollment events. Coverage under Special Enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the next administratively practicable pay period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form (along with applicable proof of status change and dependency), provided all such documentation is received within 60 days of the occurrence of the Special Enrollment event. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

**Termination of Coverage**

Your coverage stops on the earliest of the following dates:

- the last day of the month in which your employment terminates because you cease Active Work or you are no longer eligible for coverage under the Plan because you begin to work fewer hours than required under the definition of an eligible participant in the Plan;
- the first day of the next administratively practicable pay period after the date you are no longer eligible for coverage under the Plan for reasons other than your cessation of Active Work or reduction in hours;
- the first day of the next administratively practicable pay period after the date Human Resources receives, In Writing, your intent to stop medical coverage for yourself due to a qualified status change (other than your cessation of Active Work or reduction in hours) by completing a Benefits Coverage Change Form;
- the date when the Plan you are enrolled in terminates;
- the end of the period for which you paid contributions, if you do not make the next required contribution when due;
- the date that coverage for a particular service is no longer provided under the Plan;
- coverage for you or any of your covered dependents may be also be terminated for cause on the date specified in the Plan Administrator’s Written notice of its determination that:
  - you or your covered dependent made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form; or
  - you or your covered dependent, by allowing another individual to use the information regarding your (or your dependent’s) coverage, services or Benefits under the Plan, assisted such other individual in obtaining Plan coverage, services or Benefits that he or she was not entitled to receive under the terms of the Plan; or
  - you or your covered dependent altered any prescription or referral furnished by a service provider under the Plan; or
A specific set of circumstances results in termination of your coverage and entitlement to Benefits for cause, as determined by the Plan Administrator in its sole discretion.

In addition to termination of your or your dependent’s coverage and entitlement to Benefits, the Plan Administrator may take any other action it deems appropriate, including, but not limited to, seeking reimbursement of any amount paid under the Plan or refusing to pay any amount with respect to services rendered or expenses incurred before the date specified in the notice.

**Continuation of Coverage through COBRA**

If you are no longer eligible for coverage because you cease Active Work, cease to be in an eligible job classification, or you begin to work fewer hours than required under the definition of an eligible participant in the Plan, your coverage may be continued pursuant to a law known as COBRA.

COBRA allows participants to continue coverage under an employer’s group health plan for a limited period by paying the appropriate premium for continuation of coverage. If the premium is not paid on time, your coverage stops at the end of the period for which your contributions were paid. Your continuation of coverage is subject to all other provisions of the Plan. See the section entitled “Continuation of Healthcare Benefits under COBRA” for additional information.

**Reinstatement of Coverage**

Participants who have resigned or have been terminated from TSRI for a period of ninety (90) days or less and are reemployed shall have all coverage in effect prior to termination reinstated.

**Dependent/Domestic Partner Eligibility**

Participants are required to show proof of dependency for all eligible dependents he or she enrolls in the benefit plans. Eligible dependents are the participant's:

- Spouse - defined as a person to whom the Participant is married within the meaning of the laws of the jurisdiction of the Participant’s domicile, provided that marriage is recognized as valid under the laws of the United States including, but not limited to, the Code. A couple is “married” if their relationship is recognized as a marriage under the laws of the state or country in which the Participant is domiciled and of the United States;
- Domestic Partner as defined herein;
- unmarried dependent children from birth up to age 19 (through age 18);
- unmarried dependent children from age 19 up to age 25 (through age 24) if the dependent child is enrolled as a full-time student in an accredited school, college or university and is dependent upon you for support (except as provided under “Termination of Eligibility as a Student Dependent” below);
- certain dependent children who reach the maximum age for dependent coverage may be able to continue coverage under the Plan. See “Handicapped Dependent Children” below for details.

“Children” include natural children, adopted children, children placed for adoption with you or your spouse, children for whom you or your spouse are the permanent legal guardian, and step children and foster children, provided the foster or step children depend upon the participant for more than half their support and maintenance and live with the participant in a parent-child relationship. Eligible foster children must be placed by an authorized placement agency. Children also include those individuals covered by a "Qualified Medical Child Support Order (QMCISO)" or “National Medical Support Notice (NMSN)" as described below in this section of the Summary Plan Description.

The dependents of eligible participants become eligible dependents on the same date that the participant, of whom they are dependents, becomes eligible. Dependents acquired later become eligible dependents as soon as they acquire dependent status as defined by the Plan.
TSRI recognizes same gender Domestic Partners (or opposite gender Domestic Partners age 62 and older) in the Medical, Mental Health, Prescription, Vision and Dental Plans if they are registered with the State of California’s Domestic Partner Registry. Throughout this document, in relation to such Plans, the word “dependent” or "spouse" also applies to an eligible Domestic Partner.

If both parents of a dependent are enrolled as Plan participants, then each unmarried, eligible, dependent child can be the covered dependent of only one Plan participant. A Participant may enroll in the Plan either as a participant or as a covered dependent of his/her spouse who is enrolled in the Plan with family coverage, but not both.

The term “dependent” does NOT include:

- a spouse who is covered as a TSRI participant under the Plan;
- a child eligible as a TSRI participant under the Plan;
- a spouse, child, or other person on active military duty;
- a parent of the participant or of the participant’s spouse;
- a Domestic Partner who has not filed an Affidavit of Domestic Partnership with Human Resources.
- a child of a participant’s registered Domestic Partner is not eligible for Benefits, unless he or she is a legal dependent of the participant.

You are eligible for dependent coverage on the later of the following dates:

- the date you are eligible for coverage as a TSRI Participant;
- the date you first acquire a dependent or attain Domestic Partnership by filing an Affidavit of Domestic Partnership with the Human Resources Department;
- the date your dependent loses other coverage through no fault of his/her own;
- the date you otherwise experience a qualified status change listed in the "Introduction" section of this document.

You must meet all of the following conditions to become covered for dependent coverage:

- be covered by one of the TSRI Medical Plans; and
- you must apply for coverage within 31 days of the date you are eligible for dependent coverage (except for a HIPAA Special Enrollment right due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance (see “Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009” below)). If you are applying because your dependent lost other coverage, a letter must be submitted from the previous insurer stating the name of the insured and the date coverage was lost. Applicable proof of dependency must also be submitted.

If you and your spouse or Domestic Partner are covered as a participant under the Plan, neither you nor your spouse/Domestic Partner can also apply for dependent coverage. If the spouse/Domestic Partner loses eligibility for the TSRI Plan, the TSRI Participant may enroll that spouse/Domestic Partner by applying within 31 days of the qualified status change.

**Coverage Options**

Plan participants may elect from the following coverage categories:

- Participant only;
- Participant plus spouse;
- Participant plus Domestic Partner;
- Participant plus dependent children;
- Participant plus spouse and dependent children;
- Participant plus Domestic Partner and dependent children.
Domestic Partners

A Domestic Partner is defined as a person of the same gender who, with the participant, for the past 6 months has met, and continues to meet, the following requirements:

- share a common residence; and
- have a close, personal relationship; and
- agree to be jointly responsible for each other’s “basic living expenses” (as defined below) which are incurred during the domestic partnership; and
- neither person is married or a member of another domestic partnership; and
- are each eighteen (18) years of age or older; and
- are not related by blood in a way that would prevent them from being married to each other in the state they reside; and
- are capable of consenting to the Domestic Partnership; and
- have completed an Affidavit of Domestic Partnership form.

"Basic living expenses” is defined as the cost of basic food, shelter, and any other living expenses. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. **NOTE: Children of Domestic Partners are not eligible for Benefits, unless they are legal dependents of the participant as defined under “Dependent/Domestic Partner Eligibility”**.

If a participant decides to add an eligible Domestic Partner to his or her Medical Plan, an Affidavit of Domestic Partnership must be completed. This form may be obtained from the Human Resources Department.

Tax Implications

Domestic Partners may be considered to be tax-qualified dependents under Internal Revenue Section 152; please contact your Human Resources Department for more details. Unless proof is provided of eligibility as defined under 26 U.S.C. Section 152, the value of benefits provided to a Domestic Partner will be considered taxable income to a participant. This cost appears on a participant’s second paycheck of each month under the taxable income information.

**Example:** A TSRI participant currently has the Comprehensive Medical Plan, Participant Only coverage, and adds a qualified Domestic Partner to the medical and dental plans. The participant’s taxable income is calculated as follows:

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost for participant &amp; Domestic Partner per month</td>
<td>$1187.51</td>
<td>$72.66</td>
</tr>
<tr>
<td>subtract cost for participant coverage</td>
<td>-593.87</td>
<td>-36.34</td>
</tr>
<tr>
<td>subtotal</td>
<td>593.64</td>
<td>36.32</td>
</tr>
<tr>
<td>subtract participant cost of Domestic Partner Premium</td>
<td>207.00</td>
<td>18.00</td>
</tr>
<tr>
<td>Taxable income</td>
<td>$386.64</td>
<td>$18.32</td>
</tr>
</tbody>
</table>

Total taxable income would be $404.96 ($386.64 + $18.32) per month.

Federal taxes (Federal Income Tax, FICA and FUTA) and any applicable State taxes are deducted from the participant's taxable income for the cost of providing coverage for Domestic Partners. If we assume the participant is in the 27th percentile income tax bracket, the increase in Federal tax withheld would be $109.33 per month. Therefore, the total monthly cost to the participant for Domestic Partner Medical and Dental coverage would be $334.33 ($207.00 + $18.00 for insurance Premiums, plus $109.33 in Federal tax). The participant may also owe additional applicable state taxes on the Domestic Partner coverage.

Termination of Domestic Partner Coverage
If a participant provides Medical and/or Dental coverage for a Domestic Partner and that Partnership subsequently ends, the participant must notify Benefits Administration to terminate the Domestic Partner’s coverage. **Domestic Partners are NOT eligible for COBRA continuation coverage.**

**Effective Date of Dependent Coverage**

Your dependent coverage starts on the latest of the following dates:

- the date you become eligible for dependent coverage; or
- the date you apply for dependent coverage, if you have to pay any part of the cost;
- except as otherwise provided in this subsection, in the event of a qualified status change event, coverage will be effective the first day of the next administratively practicable pay period after the Benefits Coverage Change Form and applicable proof of status change and dependency is properly completed, signed and received by Human Resources; provided, however, that all such documentation is received within 31 days of the status change event. For more information regarding qualified status change events, please see the section entitled “Introduction” above.
- in the event of a special enrollment period due to marriage or loss of other coverage, coverage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources receives a properly signed and completed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents; provided, however, that all such documentation is received within 31 days of the marriage or loss of other coverage, as applicable. For more information regarding qualified status change events, please see the section entitled “Introduction” above.
- in the event of a special enrollment period due to new child acquired by birth, adoption, or placement for adoption, coverage will be effective on the date of the child’s birth, adoption, or placement for adoption provided you submit a properly signed and completed Benefits Coverage Change Form and applicable proof of status change and dependency to Human Resources within 31 days of the child’s birth, adoption or placement for adoption. If you do not request coverage for your child within the 31 day period following the child’s date of birth, adoption or placement, Benefits will be payable only for Covered Expenses incurred by the child during the 31-day period in which coverage was in force. If a new child is acquired, your spouse may also be enrolled. For more information regarding qualified status change events, please see the section entitled “Introduction” above.
- in the event of a special enrollment period due to (i) termination of coverage under Medicaid or a state Children’s Health Insurance Program (CHIP) or (ii) eligibility for a premium assistance subsidy under Medicaid or CHIP, election changes will be effective on the first day of the next administratively practicable payroll period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency; provided, however, that all such documentation is received within 60 days of the occurrence of one of the foregoing events. For more information regarding qualified status change events, please see the section entitled “Introduction” above.

If you apply for dependent coverage later than the applicable time period discussed above, you must wait until Open Enrollment for coverage to begin. See below for “Late Enrollee” or “Special Enrollee” information.

**Late Enrollee**

Your eligible dependent is considered a late enrollee if all of these are true:

- Coverage was declined for your eligible dependent at the first available opportunity to enroll.
- Your eligible dependent did not have other health coverage when coverage was declined.
- Notification was given of the consequences of declination of coverage.

Late enrollees may enroll only during the Plan’s annual enrollment period. Coverage will be effective on the first day of the next Plan year (January 1st).
Special Enrollee

Your eligible dependent is considered a special enrollee if:

- Coverage for your eligible dependent was declined under the Plan at the first available opportunity to enroll because you or your eligible dependent had other health coverage (see “Special Enrollment for Loss of Other Coverage” below);
- You had a status change event such as marriage, birth, adoption or placement for adoption; or
- You had a status change event involving a termination of coverage under a Medicaid or CHIP program or eligibility for premium assistance under one of these programs (see “Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009” below).

Coverage under Special Enrollment due to marriage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. In the case of a Special Enrollment period involving the birth, adoption or placement of a child, election changes will be effective retroactive to the date of the birth, adoption or placement, provided you file a signed Benefits Coverage Change Form with Human Resources within 31 days of the birth, adoption or placement. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

Special Enrollment for Loss of Other Coverage

A Special Enrollment period for loss of other coverage is available to your eligible dependent if your eligible dependent meets all of these requirements:

- Your eligible dependent is otherwise eligible for coverage under the Plan.
- Your eligible dependent was covered under another group health plan or had other health coverage at the time coverage was declined.
- You declared in writing that your eligible dependent already had other coverage.
- If the other coverage was COBRA continuation coverage, COBRA continuation was exhausted.
- If the other coverage was not COBRA continuation coverage, your eligible dependent lost eligibility for the other coverage or the Employer has stopped contributions for the other coverage.

You or your eligible dependent must request a Special Enrollment within 31 days of a loss of other coverage. Your eligible dependent does not have to elect COBRA continuation or other similar continuation to preserve the right to Special Enrollment. Coverage under Special Enrollment due to loss of other coverage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009

If you or your dependent are eligible, but not enrolled, for coverage under a group health plan maintained by TSRI (or your dependent is eligible, but not enrolled, for such coverage), a Special Enrollment period is available, and you may enroll yourself and/or your eligible dependent for coverage under the TSRI group health plan, if either of the following conditions is met:

- You or your dependent are covered under a Medicaid plan or under a Children’s Health Insurance Program (CHIP) and your coverage, or your dependent’s coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or
• You or your dependent become eligible for premium assistance as to coverage under the TSRI group health plan under such Medicaid plan or CHIP plan.

You must provide Human Resources with a signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency within 60 days of the occurrence of one of these Special Enrollment events. Coverage under Special Enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the next administratively practicable pay period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form (along with applicable proof of status change and dependency), provided all such documentation is received within 60 days of the occurrence of the Special Enrollment event. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

**Responsibility for Determining Ineligible Dependents**

If you have covered dependents between the ages of 19 up to 25, it is your responsibility to notify, In Writing, using a Benefits Coverage Change Form, the Plan Administrator (Human Resources Department) when your dependents no longer meet the Plan definition of dependent or Student Dependent (see the section entitled "Medical and Dental Plan Definitions"). The effective date of change for an ineligible dependent will be the first day of the next month after Human Resources receives a properly signed and completed Benefits Coverage Change Form and applicable proof of status change and dependency. Changes will not be made retroactively.

**Qualified Medical Child Support Orders (QMCSO)/National Medical Support Notice (NMSN)**

In accordance with federal law, the Plan provides medical coverage to certain dependent children (called alternate recipients) if the Plan is directed to do so by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). This is an order or judgment from a court, or produced as a result of a state-authorized administrative process directing the Plan Administrator to include a child in the participant's coverage.

In addition to requiring the participant to provide coverage for the child, the law authorizes TSRI to make applicable payroll deductions, if any.

When the Plan Administrator receives a medical child support order, it will promptly notify both the participant and the alternate recipient that the order has been received and what procedures the Plan will use to determine if the order is qualified. Then the Plan Administrator will decide, on the basis of the Plan's Written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the Plan Administrator will notify the participant and alternate recipient(s) by mail.

You can get more information on QMCSO or NMSN procedures by contacting the Plan Administrator. A copy of the Plan’s QMCSO/NMSN procedures is available without charge from Human Resources.

**Termination of Dependent Coverage**

Your dependent coverage stops on the earliest of the following dates:

- the date the dependent coverage provisions of the Plan terminate;
- the date the Plan terminates;
- the end of the period for which you made your last contribution for dependent coverage if you do not make the next required contribution when due. However, in the case of a child covered due to a QMCSO/NMSN, you must provide proof that the child support order is no longer in effect, and that the dependent has replacement coverage which will take effect immediately upon termination or the child otherwise loses eligibility for coverage;
• the date your coverage under the Plan ends (see “Termination of Coverage” above). This does not apply if your medical coverage stops because you have received the maximum Benefits under the Plan. In this case your dependent coverage continues until otherwise stopped under the Plan;
• the last day of the month in which your covered dependent is no longer a dependent, a Student Dependent (see below), or a handicapped dependent child as defined under the Plan;
• the last day of the month in which you notify Human Resources, In Writing, of your intent to stop medical coverage for your dependent due to a qualified status change attributable to divorce or legal separation;
• the first day of the next administratively practicable pay period after the date you notify Human Resources, In Writing, of your intent to stop medical coverage for your dependent or dependents due to a qualified status change attributable to a major life event other than divorce, legal separation or your child’s loss of dependency status;
• the date that coverage for a particular service is no longer provided under the Plan;
• coverage of your covered dependents may be also be terminated for cause on the date specified in the Plan Administrator’s Written notice of its determination that:
  • you or your covered dependent made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form; or
  • you or your covered dependent, by allowing another individual to use the information regarding your (or your dependent’s) coverage, services or Benefits under the Plan, assisted such other individual in obtaining Plan coverage, services or Benefits that he or she was not entitled to receive under the terms of the Plan; or
  • you or your covered dependent altered any prescription or referral furnished by a service provider under the Plan; or
  • a specific set of circumstances results in termination of your coverage and entitlement to Benefits for cause, as determined by the Plan Administrator in its sole discretion.

In addition to termination of your dependent’s coverage and entitlement to Benefits, the Plan Administrator may take any other action it deems appropriate, including, but not limited to, seeking reimbursement of any amount paid under the Plan or refusing to pay any amount with respect to services rendered or expenses incurred before the date specified in the notice.

**Termination of Eligibility as a Student Dependent**

A covered Student Dependent will no longer be eligible for dependent coverage on the earliest of the following dates:

• the last day of the month in which the dependent graduates;
• the last day of the month in which the dependent voluntarily stops attending school full-time as defined by attending school’s registrar, except as described below;
• the last day of the month after 31 days elapses following the date the dependent involuntarily stops attending school full-time and does not return to school full-time within that 31 days, except as described below;
• the first day of the next month after the end of any 12-month period during which the Student Dependent did not complete at least eight months of full-time attendance, unless he or she is attending school full-time on that date, except as described below.

Coverage does not stop solely due to school vacations or for certain medically necessary leaves of absence as described in the paragraph below.

If your covered Student Dependent takes a medically necessary leave of absence from school, the Plan will continue his or her coverage for a period of one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the Plan), provided the Plan receives written certification from the covered Student Dependent’s treating physician stating that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. A “medically necessary leave of absence” is a leave of absence from a post-secondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965), or any other change in enrollment at such an institution, that
begins while a covered Student Dependent is suffering from a serious sickness or injury, is medically necessary, and causes the covered Student Dependent to lose student status for purposes of coverage under the terms of the Plan.

If your covered Student Dependent is otherwise unable to attend school full-time because of Sickness or Accidental Injury, the Plan will continue the coverage until the first day of the next regular semester or quarter, whichever is applicable to the school.

Continuation of Coverage for Dependents

If coverage for your dependents ends because of your termination of employment, ceasing to be in an eligible job classification, or reduction in hours, your death, your divorce or legal separation, your Medicare entitlement or your dependent child’s loss of dependent status, your dependents’ coverage may be continued pursuant to a law known as COBRA. COBRA allows dependents to continue coverage under an employer’s group health plan for a limited period by paying the appropriate premium for continued coverage. If the premium is not paid on time, the coverage stops at the end of the period for which any contributions were paid. Your covered dependents’ continuation is subject to all other terms of the Plan. See the section entitled "Continuation of Health Care Benefits under COBRA" for additional information.

NOTE: Domestic Partners are not eligible for COBRA continuation coverage. However, as described in the section entitled “Continuation of Health Care Benefits under COBRA”, if the covered Participant becomes entitled to and elects to continue coverage under COBRA, he or she may elect to continue coverage for his or her covered Domestic Partner. Also, Domestic Partners may, under certain circumstances, be eligible for continuation coverage (similar to COBRA continuation coverage) available under state law. Please contact the Human Resources Department for more information regarding the availability of continuation coverage for Domestic Partners.

Handicapped Dependent Child

If your covered dependent child is physically or mentally handicapped and reaches the maximum age for dependent coverage, his or her coverage may continue. To continue coverage you must give the Plan proof that:

- your child is handicapped and not self-supporting;
- your child became handicapped before reaching the maximum age for dependent coverage;
- your child is dependent on you for support.

Proof must be given within 31 days after the date your child reaches the maximum age for coverage. The Plan may require that a Doctor examine your child before granting a continuation of your dependent child’s coverage. The Plan chooses the Doctor and pays the fees for all required exams.

If your physically or mentally handicapped dependent child is covered by another medical plan, but that coverage is ending (regardless of the reason), you may enroll the dependent under TSRI’s medical plan. To qualify under TSRI’s group plan, you must enroll the dependent within 31 days of the loss of other coverage and the dependent must meet the definition of a handicapped child as specified above.

The Plan may ask for proof of your child's continued handicap generally once each year. However, the Plan may ask for such proof more or less frequently at the Plan's sole discretion. A Doctor's exam may be required as part of the proof. The Plan chooses the Doctor and pays the fees for all required exams. Contributions must be paid by you to continue your dependent child's coverage in the same amounts as required for coverage of non-handicapped dependent children under the Plan.

It is your responsibility to notify, In Writing, the Plan when your dependent child no longer meets the Plan’s definition of handicapped dependent.
The continuation of coverage for your handicapped dependent child stops on the earliest of the following dates:

- the last day of the month in which your child is no longer handicapped according to the Plan;
- the last day of the month in which you do not give the Plan proof of your child's handicap when requested in accordance with the terms discussed above;
- the date on which your dependent coverage would otherwise stop under the Plan (see “Termination of Dependent Coverage” above).

If this handicapped coverage terminates because your dependent coverage would otherwise cease under the Plan (e.g., due to a COBRA Qualifying Event), coverage for your handicapped child may be continued pursuant to COBRA. See the section entitled "Continuation of Healthcare Benefits under COBRA" for additional information.

Medical Plans

There are three Medical Plans from which you may choose. For more information regarding the HMO Medical Plan, please refer to the Aetna HMO Evidence of Coverage booklet.

The coverage for the Comprehensive and Catastrophic Plans is outlined on the Schedule of Benefits. Both Plans provide primary and specialty care Benefits, as well as Hospital and surgical coverage. The Plans vary by specific services covered and contribution levels. A pre-existing condition provision applies to the Comprehensive and Catastrophic Medical Plans. Please see the "Pre-existing Condition" in this section below for further detail.

The Plan’s Benefits are based on a percentage of the Reasonable and Customary charges for a particular service or supply for out of network charges.

The Plans cover only those procedures, services, and supplies, which are Medically Necessary unless otherwise specified. For a service to be covered it must be considered necessary for the diagnosis or treatment of an illness or injury and the care must be given at the appropriate level. In determining questions of reasonableness and necessity, consideration is given to the customary practices of Health Care Providers in the community where the service is provided. See the section entitled "Medical and Dental Plan Definitions" for details regarding Medical Necessity.

Comprehensive Medical Plan

In the Comprehensive Medical Plan, you are allowed to see the Network Provider of your choice, or any Physician outside of the Network. Your cost for services is greater when you select Non-Network Providers (with some exceptions). Your Physician choice can vary with each service received. Your reimbursement in each case will follow the schedule (Network or Non-Network) that applies to your choice of provider. The United Healthcare Options PPO is the Network Provider. To locate a participating UHC provider, visit UMR's website at www.umr.com or contact your provider.

For Network services, there is a $200 per person annual Deductible and the Plan pays 90% of eligible expenses after the Deductible is met. Preventive care Benefits are covered at 90% after the annual Deductible.

For Non-network services, there is a $400 per person annual Deductible, a separate $200 Hospital Co-payment (per admission), and the Plan pays 70% of eligible expenses after the Deductibles are met.

Catastrophic Plan

This Plan has been designed for those who rarely have medical claims and do not anticipate significant medical expenses. After a $2,000 Deductible, the Plan pays 80% of eligible expenses including Inpatient Hospital expenses. With this Plan, you may choose any provider. Limited preventive care is covered.

You are not required to designate a Primary Care Physician with either Medical Plan, and you are not required to obtain a referral in order to see a specialist. However, you are required to acquire a prescription for ancillary providers such as speech therapists.
## Medical Plan Schedule of Benefits – Summary**

<table>
<thead>
<tr>
<th>Percentages given represent what the Plan pays</th>
<th>Comprehensive Medical Plan PPO (annual deductibles apply)</th>
<th>Catastrophic Plan (annual deductibles apply)</th>
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</thead>
<tbody>
<tr>
<td><strong>Plan Deductible</strong></td>
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<tr>
<td>Per Person</td>
<td>UHC $200</td>
<td>Non-UHC $400</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>UHC $600</td>
<td>Non-UHC $1,200</td>
</tr>
<tr>
<td>Deductible Carryover</td>
<td>UHC Last 3 months of calendar year</td>
<td>Non-UHC Last 3 months of calendar year</td>
</tr>
</tbody>
</table>

| **Office Visits**                               | 90%                                                       | 70%                                        |
| **Inpatient Hospital**                          | 90%                                                       | 70%                                        |
|                                                | $200 per admit co-pay $200 add’l co-payment or penalty without pre-certification. | 80% $200 add’l co-payment without pre-certification. |
| **Outpatient Surgery**                          | 90%                                                       | 70%                                        |
| **Skilled Nursing Facility**                    | 90%                                                       | 70%                                        |
|                                                | $200 add’l co-payment without pre-certification. 90 days per Confinement max |
| **Emergency Room**                              | 90%                                                       | 70%                                        |
| **Home Health Care**                            | 90% 100 Visits per year max                               | 70% 100 Visits per year max                |
| **Acupuncture**                                 | 90% 20 Visits Per year max                                | 90% 20 Visits Per year max                 |
| **Ambulance**                                   | 90%                                                       | 90%                                        |
| **Cancer Screening**                            | 90%                                                       | 70%                                        |
| **Chiropractic**                                | 90% 20 Visits Per year max                                | 90% 20 Visits Per year max                 |
| **Durable Medical Equipment**                   | 90%                                                       | 70%                                        |
| **Lab & X-Ray**                                 | 90%                                                       | 70%                                        |
| **Well Baby Care**                              |                                                           |                                            |
| Inpatient Nursery                               | 90%                                                       | 70%                                        |
| Dr. Office Visit                                | 90%                                                       | None                                       |
| **Physical Therapy**                            | 90% 39 Visits Per year max                                | 70% 39 Visits Per year max                 |
| **Speech and Occupational Therapy**             | 90%                                                       | 70%                                        |
|                                                | 39 visits per year max (combined)                          | 39 visits per year (combined)               |
| **Routine Exams (age 2 and over)**              | 90%                                                       | None                                       |
| **Maximum Annual Out of Pocket**                |                                                           |                                            |
| Per Person                                      | $1,500                                                    | $3,000                                     |
| Family                                          | $3,000                                                    | $6,000                                     |
| Lifetime Maximum*                               | $2,000,000                                                | $2,000,000                                 |

**For HMO Medical Plan information, please reference the Aetna HMO Evidence of Coverage booklet.
IMPORTANT NOTICES:

*The $2,000,000 lifetime maximum is combined for all coverage under the Plan. For example, if you are covered under the Catastrophic Plan coverage in 2010 and incur $30,000 in covered medical expenses, and then switch to the Comprehensive Medical Plan coverage in 2011 and incur $15,000 in covered medical expenses, you would have accumulated $45,000 toward the lifetime maximum.

You can obtain additional information about Plan coverage for treatment, procedure, preventive service, etc., from the following office. No charge will be made for providing the information.

UMR
PO Box 30541
Salt Lake City, UT 84130-0530
(800) 834-3482

A complete listing of Preferred Providers is available to Plan participants on the web as described below. To locate a participating UHC provider, visit UMR’s website at www.umr.com or contact your provider. For these purposes, a "Plan participant" is each participant, each former participant on COBRA and each alternative recipient under a Qualified Medical Child Support Order (QMCSO).

Covered Expenses

Certain Covered Expenses are limited as stated in this section. Covered Expenses include only the expenses incurred by you or your covered dependent to the extent they are Reasonable and Customary. An expense is incurred on the date of treatment, service or purchase.

Covered Expenses will also include utilization management services provided pursuant to this plan, to utilize a more cost effective Generally Accepted form of Medically Necessary Care, when compared to use of Covered Expenses contained in this Plan.

Acupuncture Expenses

The Plan pays covered treatment and services for up to 20 visits per calendar year provided by a certified or licensed acupuncturist or a Doctor. All acupuncture providers are treated as in-network for this benefit. As such, acupuncture expenses are subject to all applicable in-network annual deductibles and out of pocket maximums. Massage therapy performed in conjunction with acupuncture is not a covered benefit.

Allergy Services

The Plan pays covered services for the diagnosis and treatment of allergies.

Cancer Screening

The Plan pays covered services for cancer screening that includes:

- Mammograms:
  - A mammogram for women ages 35 and above.
- Routine pap smears or other cancer screenings
- PSA screening
- Colon/rectal screening

NOTE: Women who have been determined by their Health Care Provider to be at high risk for breast cancer, and have a letter from the provider regarding their high-risk status, may receive mammograms on a different schedule at the Plan Administrator’s sole discretion.
**Chiropractic**

Covered Expenses for diagnosis and treatment of dislocation, strain, sprain or misplaced vertebrae are a Covered Expense provided by a chiropractor for up to 20 visits per calendar year. Massage therapy performed by a chiropractor is not covered. However, massage therapy is covered when provided by a MD, Doctor of Osteopathy (DO) or a Physical Therapist when the services are performed in conjunction with physical therapy.

**Cornea Transplants**

The Plan pays covered services for corneal transplants at the percentage listed under the Schedule of Benefits.

**Dental Expenses Covered Under the Medical Plan**

The Plan pays Covered Expenses for the following:

- Hospital expenses (including anesthesia) if medically necessary for dental treatment;
- Doctor, surgeon or Dentist's fees for Surgery or dental services related to:
  - surgical treatment of temporomandibular joint dysfunction or syndrome (TMJ) up to $5,000 maximum lifetime amount;
  - repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the dental services are completed within six months after the accident. Covered Expenses are limited to the least expensive procedure that would provide professionally acceptable results;
  - other surgical treatment of the mouth or jaw, but not of the teeth;
  - other conditions of the mouth or jaw, with the following exceptions:
    - a condition, which is secondary to treatment of dental cavities;
    - extraction of diseased or decayed teeth; or
    - any condition normally treated with routine dental care (for example, periodontal treatment).

Note: Dental expenses covered under the Medical Plan will not include non-surgical treatment.

**Durable Medical Equipment**

Rental of durable medical supplies and equipment, for treatment purposes, will be covered up to the purchase price of the equipment rented. This does not include any changes made to your home, auto, or personal property such as air conditioning and remodeling. However, the Plan covers (1) Medically Necessary repair, adjustment, and servicing of durable medical equipment unless the damage is as a result of your or your dependent's negligence or abuse; (2) purchase of standard models at the option of the Plan; (3) Medically Necessary replacement of the durable medical equipment due to a change in the covered person’s physical condition or if the equipment cannot be satisfactorily repaired.

If you or a dependent resides 30 miles or more from a Network Provider who supplies durable medical equipment, Covered Expenses will be payable at the Network level of benefits, regardless of the provider used.

**Emergency Treatment**

An Emergency is any treatment or service that the Claims Administrator determines to be due to the sudden onset of severe medical symptoms that:

- could not have been reasonably anticipated; and
- require immediate medical care.
Under the Comprehensive Medical Plan and the Catastrophic Medical Plan you are required to contact the Claims Administrator by calling the phone number listed on your Benefits Card, within 24 hours when admitted to a Hospital to receive the full Emergency benefit.

If you or one of your dependents requires treatment for a medical Emergency and cannot reasonably reach a Network Provider, Benefits for such treatment received will be paid at the same level as the in network benefit percentage.

Medically Necessary treatment in an emergency room is a covered service, regardless of whether the visit is an Emergency, whether you are covered under the Comprehensive Medical Plan or the Catastrophic Medical Plan.

Emergency treatment under the Catastrophic Medical Plan is covered as any other Hospital expense if the treatment is Medically Necessary.

**Emergency Ambulance Transportation Expenses**

The Plan pays transportation by ambulance (ground or air) provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care.

**Extended Care Facility Expenses**

The Plan pays Extended Care Facility expenses if confinement in an Extended Care Facility begins with prior approval from the Claims Administrator, whether the Comprehensive Medical Plan or the Catastrophic Plan covers you.

The Plan pays Covered Expenses for:

- daily room and board, up to the amount payable for Hospital daily room and board expenses up to 100% of the semi-private room rate;
- a maximum of 90 days of Extended Care Facility coverage per Period of Hospital Confinement;
- services, other than room and board, provided during any day for which extended care room and board Benefits are payable.

**Eye Examinations (Medically Necessary)**

If examinations for conditions involving the pathology of the eye are necessary, and not part of a routine eye exam, they will be covered under the Medical Plan. Routine eye examinations are not covered under the Medical Plan.

**NOTE:** Routine eye exams, eyeglasses and contacts are covered through the Vision Plan. See the section entitled "Vision Benefit" for further information.

**Home Health Care Expenses**

Covered Expenses will include charges by a Home Health Care Agency for:

- part-time or intermittent home nursing care by or under the supervision of a licensed registered nurse (R.N.); and
- part-time or intermittent home care by a Home Health Aide; and
- physical, occupational, speech, or respiratory therapy; and
- intermittent services of a registered dietician or social worker; and
- drugs and medicines which require a Doctor's prescription, as well as other supplies prescribed by the attending Doctor; and
- laboratory services.
The Home Health Care services must be rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:

- established prior to the initiation of the Home Health Care services; and
- prescribed by the attending Physician.

The general medical exclusions and maximums listed in this section will apply to Home Health Care. In addition, Covered Expenses will not include charges for:

- services or supplies not included in the Home Health Care Plan; or
- more than 100 visits in a calendar year. For a Home Health Aide, up to four hours of continuous service will be counted as one visit. A visit by any other covered provider equals one visit regardless of the length of the visit; or
- the services of any Close Relative, or any person who normally lives in your or your Dependent's home; or
- Custodial Care; or
- transportation services.

**Hospice Care Expenses**

Covered Expenses will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility for:

- any terminally ill individual (you or one of your Dependents) who chooses to participate in a Hospice Care Program rather than receive aggressive medical treatment to promote cure, and who, in the opinion of the attending Doctor, is not expected to live longer than six months; and
- the family (you and your Dependents) of any such individual;

but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program and are billed through the Hospice that manages that program.

Hospice Care Services consist of:

- Inpatient and Outpatient care, home care, nursing care, homemaking services, dietary services, social counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and
- drugs and medicines (requiring a Physician's prescription and not covered under the Prescription Drug Plan) and other supplies prescribed for the dying individual by any Physician who is a part of the Hospice Care Team; and
- homemaker services if prescribed by a Doctor as part of the Hospice benefit; and
- instructions for care of the patient, social counseling, and other supportive services for the family of the dying individual.

The general medical exclusions listed in this section will apply to Hospice Care. In addition, Covered Expenses will not include Hospice Care charges that:

- are for Hospice Care Services not approved by the attending Physician and the Plan Administrator; or
- are for transportation services; or
- are for Custodial Care.

**Hospital Expenses**

The Plan pays Covered Expenses for:

- Hospital daily room and board, up to the Hospital Room Maximum for each day of confinement; 24 hour private duty nursing is not a Covered Expense;
- intensive care unit (including the cardiac care unit if it is determined to be Medically Necessary);
• Outpatient treatment received in a Hospital if necessary:
  • because of Surgery or non-surgical treatment;
  • for Emergency care within 48 hours of an accident causing Accidental Injury;
  • for Emergency care within 48 hours of an illness.
• miscellaneous Hospital services, not including room and board, received on an Outpatient basis due to Surgery, or for any day that Hospital room and board Benefits are payable. These include services of a radiologist and pathologist that are under contract with the Hospital.

Immunizations

The Plan pays covered Medically Necessary expenses for FDA approved immunizations that include, but are not limited to:
• Chicken Pox - series of 2 if no history of disease;
• Hepatitis;
• Influenza vaccine;
• Measles/Mumps/Rubella (MMR);
• Pneumonia;
• Polio - series of 3 if not immunized as a child;
• TB skin test;
• Tetanus - every 10 years;
• Immunizations required or recommended for personal or business foreign travel.

This list does not reflect a complete list of covered immunizations. Participants may contact the Plan Administrator for specific questions in regards to immunizations.

Infertility Treatment Expenses

The Plan will pay for infertility procedures in an attempt to correct an underlying medical condition. This would include diagnostic testing and surgical correction of reproductive organs. The Plan will also cover artificial insemination. Any other treatment or service for the restoration of fertility or the promotion of conception will not be covered including but not limited to in vitro fertilization, embryo transplant, and reversal of voluntary sterilization.

See the "Prescription Benefit" section regarding infertility drugs.

Nutritional Counseling

The Plan will pay for medically-based nutritional counseling, education and programmatic support for the management of diabetes and obesity in the case of such diagnosis of diabetes or obesity.

Occupational/Speech Therapy

The Plan pays Covered Expenses for Occupational/Speech Therapy for up to 39 visits per calendar year in a clinic or Outpatient type setting.

Orthotics

The Plan will pay for custom-molded foot orthotics and braces up to a maximum of $1,000 per calendar year.

Pre-admission Testing Expenses

The Plan pays Covered Expenses for routine diagnostic X-rays, lab tests, and any other Medically Necessary tests if the tests are:
• administered on an Outpatient basis prior to a Non-Emergency Admission in a Hospital;
• in connection with a scheduled Hospital Confinement;
• made within two weeks of the scheduled Hospital Confinement.

Pregnancy/Obstetrics

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a Federal law called the Newborns’ and Mothers’ Health Protection Act (NMHPA), restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The length of stay begins at the time of delivery if the delivery takes place in a Hospital. If the delivery does not take place in a Hospital, the length of stay begins once the mother and newborn are admitted to the Hospital as Inpatients.

The attending Physician, in consultation with the mother, may authorize an earlier discharge. Plans may not provide incentives or impose penalties to encourage early discharge.

The Plan may apply its regular Deductibles and co-payments, provided they do not increase during the mandated minimum Hospital stay (for example, by requiring a higher co-payment after the first 24 hours of Hospitalization).

Covered Expenses include medically necessary treatment of normal pregnancy and complications of pregnancy including maternity care and delivery services.

Covered Routine Prenatal Exams

• Monthly visits up to 28 weeks gestation.
• Biweekly visits from 28 weeks to 36 weeks gestation.
• Weekly visits from 36 weeks until delivery.

Covered Routine Prenatal Diagnostic Testing

• Alpha-fetoprotein (benefits are paid at the PPO in-network level for lab charges only, regardless of provider choice);
• antibody screen, initial and repeat testing;
• blood group and Rh type determination;
• cervical cytology;
• Gestational Diabetes screening;
• hemoglobin or Hematocrit measurement;
• Hepatitis B virus screen;
• Human Immunodeficiency Virus (HIV) screen;
• initial ultrasound (prenatal screening);
• Rubella antibody titre measurement;
• Syphilis screen;
• urinalysis, with microscopy;
• Amniocentesis when ordered by a Health Care Provider practicing in the OB/GYN specialty or who is a family practitioner and only when Medically Necessary.

Hospital & Delivery Coverage

The following services are covered under the Plan:

• Hospital admission;
• management of uncomplicated labor;
● Medically Necessary tests;
● physical exams;
● semi-private Hospital room;
● vaginal & cesarean delivery;
● midwife services, if services are rendered during a delivery in a Hospital;
● birthing center admission if part of a Hospital.

Newborn Care

Newborn care is covered under the Plan for the following services:

● circumcision,
● nursery care during initial confinement (except as limited below under “Nursery Charges”),
● routine tests during initial confinement.

Nursery Charges

Nursery charges for newborn care are covered by the Plan. You have 31 days following the birth of the baby to enroll the baby as a dependent under the Plan. Should you choose not to enroll the baby, only Covered Expenses incurred by the child for the first 31 days will be covered.

Routine Post-Natal Exams

Routine post-natal exams for the mother of a newborn child are covered as long as Medically Necessary.

Routine Well Baby Care

See the section below entitled "Well Baby Care."

Preventive Physical Examinations

The Comprehensive Medical Plan pays Covered Expenses for one routine check-up every 12 consecutive months for you and your covered dependent age 2 and over provided that you utilize a Network Provider.

A routine checkup is a physical or well woman exam, which may include developmental assessment, history, sensory screening, appropriate immunizations, laboratory tests, and x-rays.

The Catastrophic Plan does not cover preventive physical examinations except as noted under "Cancer Screenings."

Note: Non-Network routine newborn charges are covered during the initial Hospital confinement. After the newborn is discharged, the patient must see a Network Provider in order for preventive care Benefits to be paid.

Physical Therapy

The Plan pays Covered Expenses for physical therapy up to a maximum of 39 visits per calendar year in a clinic or Outpatient type setting, as long as a Health Care Provider prescribes the therapy. Massage and aquatic therapy performed in conjunction with physical therapy is covered, as long as the services are provided by a MD, Doctor of Osteopathy (DO), or a Physical Therapist. Massage therapy performed in conjunction with acupuncture or chiropractic care is not covered.
Reconstructive Surgery

Following Mastectomy

Individuals receiving Benefits in connection with a mastectomy may elect breast reconstruction in connection with such mastectomy. Such reconstruction includes the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy including lymph edemas.

Other Reconstructive Surgery

Medically Necessary reconstructive Surgery following an accident or illness, or because of a birth defect for a child born to you or your spouse is a Covered Expense. Cosmetic correction is not a covered service.

These Benefits are subject to the regular terms, conditions and limitations of your health coverage, including determinations of Medical Necessity, and Reasonable and Customary charges, and any applicable coinsurance and Deductibles.

Surgery Expenses

The Plan pays Covered Expenses for:

- Doctor's fees for Surgery;
- assistant surgeon's fees at 20 percent of Reasonable and Customary charge for the Surgery (Assistant surgeon's fees will not be considered as a Covered Expense for certain surgical procedures deemed not to require an assistant surgeon);
- Assistant surgeon's services will be paid a Network Benefit when the Primary surgeon is a Network Provider (under the Comprehensive Medical Plan only);
- administration of general or regional anesthetics by a Doctor or R.N. anesthetist;
- reconstructive Surgery following an accident or illness, or because of a birth defect for a child born to you or your spouse.

Multiple Surgical Procedures

If you or your covered dependent has two or more procedures performed during the same anesthesia period, the amount the Plan pays will be based on the following:

- if the procedures are performed through the same or different incisions, the Plan pays Benefits for the procedure with the highest Reasonable and Customary charge plus 50% of the Reasonable and Customary charge for the additional procedures;
- no additional Benefit is paid for incidental procedures done at the same time and under the same anesthetic as another procedure.
Transplant Services – Applicable to the Comprehensive Medical Plan Only

- **Transplant Covered Expenses**

   Once it has been determined that you or one of your Dependents may require an organ transplant from the list in this summary, you, or your Physician should call the Claims Administrator to discuss coordination of transplant care. UMR will coordinate all transplant services. In addition, you must follow the Utilization Management Requirements described in the Utilization Review section of your Summary Plan Description. Organ means solid organ; stem cell; bone marrow; and tissue.

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<th>URN Facility</th>
<th>Other PPO Facility</th>
<th>Out of Network</th>
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<tr>
<td><strong>Deductible</strong></td>
<td>Not Applicable</td>
<td>Applies</td>
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<td><strong>Out of Pocket</strong></td>
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<tr>
<td><strong>Benefit %</strong></td>
<td>100%</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>NONE</td>
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- **United Resource Network (URN)**

   This is a facility that is contracted with UHC to furnish particular Treatment or Service to you or your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the URN Provider for such Treatment or Service will be the amount agreed to between UHC and the URN.

   Transplant Covered Expenses include the following:
   - Charges for activating the donor search process with national registries.
   - Compatibility testing of prospective organ donors who are immediate family. For the purpose of this Transplant Services section, “immediate family” is defined as a first-degree biological relative. This means your or your Dependant’s biological parent, sibling or child.
   - Inpatient and outpatient Covered Expenses directly related to a transplant.
   - Charges made by a Physician or transplant team.
   - Charges made by a Hospital, outpatient facility, or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
   - Related Treatment or Service provided by the URN facility during the transplant process. The Treatment or Service may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; Home Health Care, and home infusion services.

   Transplant Covered Expenses are typically incurred during the four phases of transplant care described on the next page. Covered Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

   “Transplant Occurrence” a period of time beginning at the point of evaluation for a transplant and ends either: (1) 180 days from the date of the transplant; or (2) upon the date the transplant recipient is discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

   The four phases of one Transplant Occurrence and a summary of Transplant Covered Expenses during each phase are:
   - **Pre-transplant Evaluation/Screening:** Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program.
- **Pre-transplant/Candidacy Screening**: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family.

- **Transplant Event**: Includes inpatient and outpatient services for all Transplant-related Covered Expenses provided to the transplant recipient and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during the Hospital Inpatient Confinement or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during the transplant recipient’s Hospital Inpatient Confinement or outpatient visit(s); cadaveric and live donor organ procurement.

- **Follow-up Care**: Includes all transplant Covered Expenses; Home Health Care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell transplant;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant; or
- Any other single organ transplant, unless otherwise excluded under this plan.

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant);
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process; or
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

- **Travel and Lodging Expenses**

If Treatment or Service of a covered transplant is performed in a facility that is more than 100 miles from the transplant recipient’s residence, expenses related to travel and lodging for the transplant recipient and one companion will be considered Covered Expenses, not to exceed $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the transplant recipient, companion, and donor.

Travel is reimbursed between the transplant recipient’s home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage Reimbursement is the current standard government rate.

Reimbursement of expenses incurred by the transplant recipient and companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person (or $100 per night total).
- **Exclusions**

The general Medical exclusions as described in your Summary Plan Description will apply to Transplant Services. In addition, Transplant Services do not include charges for:

- outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence;
- Treatment or Service furnished to a donor when the recipient is not you or your Dependent;
- home infusion therapy after the Transplant Occurrence;
- harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;

Benefits paid for Transplant Services will be applied to the Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

**Transplant Services – Applicable to the Catastrophic Plan Only**

"Transplant Services" means Covered Expenses incurred in connection with the Covered Transplants listed below that are for Medically Necessary Care and not considered to be an Experimental or Investigational measure. The following benefits will be payable for treatment or service for Transplant Services. These benefits will be payable instead of any other benefits described in this booklet, unless otherwise indicated below.

- **Covered Transplants**
  The following human-to-human organ or bone marrow transplant procedures will be considered Covered Expenses, subject to all exclusions and maximums described in this section, for a patient that is covered under this plan.

  - Heart;
  - Heart/lung (simultaneous);
  - Lung;
  - Liver;
  - Kidney;
  - Pancreas;
  - Kidney-Pancreas;
  - Skin;
  - Small bowel;
  - Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12-month period, unless a tandem transplant or infusion meets the plan's definition of Medically Necessary Care and is not an Experimental or Investigational measure.

- **Covered Expenses**
  Transplant Services Covered Expenses will include all services listed in the general Medical Covered Expenses section, including, but not limited to, services by a Home Health Care Agency, Extended Care Facility, or Hospice.
Covered Expenses will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Claims Administrator to be Medically Necessary Care, not to exceed $10,000 per approved transplant.

Covered Expenses will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage. Covered Expenses will include the necessary diagnostic testing of a donor to confirm compatibility with the transplant recipient and the usual procurement services for the removal of the organ. If the donor is not covered under this Plan, then charges incurred by the organ donor after discharge from the Hospital or after an outpatient procurement of donor stem cells, including any follow-up care or related complications resulting from the organ donation will not be covered by the Plan.

**Benefits Payable**

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<tr>
<td><strong>Benefit %</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>NONE</td>
<td>NONE</td>
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Travel and lodging expenses for the transplant recipient and a travel companion will be covered if the treating facility is greater than 50 miles one way from the transplant recipient's home (excluding travel or lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Medical ambulance benefit, if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any deductible or copayment amount under the ambulance benefit in the normal provisions of the Medical section.

Travel and lodging benefits will be payable at 100% without application of any deductible amount, up to a maximum benefit of $10,000 for each approved transplant.

**Exclusions Within and Outside the Transplant Network**

The general Medical exclusions as described in your Summary Plan Description will apply to Transplant Services. In addition, Transplant Services do not include charges for:

- outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence;
- Treatment or Service furnished to a donor when the recipient is not you or your Dependent;
- home infusion therapy after the Transplant Occurrence;
- harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;

Benefits paid for Transplant Services will be applied to the Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

**Uncontrollable Providers**

For emergency room and resulting hospital stay Physician charges, assistant surgeon charges, charges by a Doctor assigned to Hospital rounds (attending physician), anesthesiology, radiology, and pathology services provided by a
Non-PPO Provider, benefits will be payable at the PPO level when such services are provided at a PPO Hospital (Inpatient, Outpatient, and Hospital emergency room) or licensed freestanding surgical center.

**Well Baby Care Expenses**

Well baby care must be provided by an individual licensed to provide such care and must be provided by a Network Provider under the Comprehensive Medical Plan. Well Baby care expenses are not covered under the Catastrophic Medical Plan.

The Plan pays Covered Expenses for:

- routine check-ups in the first 24 months following birth. Routine check-ups do not include diagnosis and treatment of Sickness or Accidental Injury;
- routine immunizations, injections, and inoculations, including but not limited to the following:
  - a complete polio series;
  - a complete DPT (diphtheria, pertussis, tetanus) series;
  - a complete MMR (mumps, measles, rubella) series;
  - one test for TB (tuberculosis);
  - one hemoglobin blood test;
  - Chicken Pox vaccine;
  - complete Hepatitis series;
  - HIB (Haemophilus influenza type b vaccine).

**Other Medical Services**

**Physician and Professional Services**

The Plan pays Covered Expenses for:

- medical care and treatment furnished by a Doctor;
- the services of a Health Care Extender;
- R.N. and L.P.N. services;
- therapeutic treatment by licensed physical or occupational therapist and speech therapy, up to 39 visits, if prescribed by a Physician. Such treatment will not be covered if the Plan Administrator determines that the treatment would not result in medical improvement of the condition;
- Inpatient rehabilitation services at a Hospital, rehabilitation unit or facility, Extended Care Facility for short-term active, progressive rehabilitation that cannot be provided in an Outpatient or home setting;
- sterilization, including vasectomy and tubal ligation;
- voluntary termination of pregnancy;
- Birth control, the dispensing and fitting of diaphragms and IUD devices, the implant and/or removal of Norplant devices, the purchase and administration of Depo-Provera, and any other prescription contraceptives administered in a Doctor’s office.

**NOTE:** Hormonal contraceptives which do not require a physician to administer (i.e., contraceptive ring, patches or oral pill) are covered under the Prescription Plan.

**Medical Supplies**

The Plan pays Covered Expenses for:

- diagnostic X-ray and lab services;
- radiation and chemotherapy treatment;
- anesthetics, oxygen, nebulizers and related charges;
false limbs and false eyes;
hearing aids if the hearing loss is caused by accident, disease, or as a result of medical treatment, and not by natural occurrence. The maximum benefit is $1,000 per lifetime;
prosthetic devices following a mastectomy;
surgical bandages;
blood and plasma, unless replaced by you or on behalf of you or your covered dependent;
casts, splints, braces and crutches;
drugs and medicines requiring a Doctor’s prescription and approved by the Food and Drug Administration for general marketing (excluding those charges covered under the Prescription Drug plan);

Deductibles

Plan Deductible

The Plan Deductible is the amount of Covered Expenses you or your covered dependent must incur during the calendar year before the Plan will pay Benefits. The Plan Deductible and the expenses subject to the Plan Deductible are shown on the Schedule of Benefits Summary.

Family Deductible

The Plan will consider the Family Deductible met for you and all covered dependents for the remainder of the calendar year if three members of your family each meet the individual Deductible in that calendar year. The Family Deductible is set forth in the Schedule of Benefits Summary.

Carry-Over Deductible

Covered Expenses used toward meeting the individual and Family Deductibles in the last three months of a calendar year are used to meet the individual and Family Deductibles for the next calendar year.

Common Accident Deductible

The Plan requires only one individual Deductible be met if you and one or more of your covered dependents, or two or more of your covered dependents incur Covered Expenses from the same accident for the Benefit Period in which the accident occurs and also the next Benefit Period. This Deductible applies only to those Covered Expenses incurred because of the accident.

Hospital Admission Co-payment (Comprehensive Medical Plan only)

You pay a Hospital Admission Co-payment each time you or your covered dependent is admitted to and confined in a Non-network Hospital.

This Co-payment will not be applied towards meeting the following:

- maximum out-of-pocket expense;
- Plan Deductible;
- Carry-over Deductible;
- Common Accident Deductible;
- any other Deductible.
Pre-Authorization Co-payment (All Medical Plans)

You pay this Co-Payment each time you or your covered dependent is admitted to the Hospital, and pre-authorization is not obtained from the Utilization Management Provider. There is no Pre-authorization Co-payment in the Comprehensive Medical Plan when a Network Provider is used.

Pre-authorization is intended to determine the Medical Necessity of the Hospital stay.

This Co-payment will not be applied towards meeting the following:

- Maximum out-of-pocket expense;
- Plan Deductible;
- Carry-over Deductible;
- Common Accident Deductible;
- Any other Deductible.

Exclusions

The following is a list of medical services and supplies or expenses not covered under the Plan. The Plan Administrator and the Claims Administrator (at the direction of the Plan Administrator) will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

Expenses incurred, as the result of or exceeding:

- before the participants became covered under the Plan;
- after coverage under the Plan ends (except where COBRA continuation coverage exists);
- Plan Benefits or other Plan limitations;
- Reasonable and Customary charges (as determined by the Claims Administrator) or the contracted charges under the Plan;
- for which a third party is responsible;
- for Educational services, supplies or equipment, including, but not limited to non-implantable communicator-assist devices, computers, communication boards, software, printers, books, tutoring, visual aides, auditory aides, speech aids, etc, even if they are required because of an injury, illness or disability of a person covered under this Plan (except as described under Covered Expenses for nutritional counseling for a diagnosis of diabetes or obesity);
- diabetic supplies. Diabetic supplies will be covered under the Prescription Drug Plan;
- for preparing medical reports, bills or claims forms, mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees;
- autopsy and any related expenses except as required by the Plan Administrator or its delegate;
- for blood pressure monitor for home use;
- for diagnosis and treatment of refractive errors, including eye examination and providing, replacing, or fitting of glasses or contact lenses except after cataract Surgery, the initial charge for the eye exam, refraction, glasses and/or contacts are covered under the Medical Plan;
- for purchase of hearing aids and fees for the fitting or providing of hearing aids, unless the loss of hearing is caused by an accident, disease or medical treatment and not the result of naturally occurring hearing loss;

Exceptions:

- The Plan pays services received by you or your covered dependent up to $1,000 per lifetime if:
  - the loss of hearing is caused by an accident, disease or medical treatment and not the result of naturally occurring hearing loss;
- wigs and hair prostheses;
- for services when Benefits for them are provided to the covered individual (1) under any plan or program (including, without limitation, TRICARE and VA programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political
subdivision of the United States, or of any other country or any political subdivision of any other country or (2) under any plan or program in which any government participates other than as an Employer; unless otherwise required by law.

Exceptions:

- The Plan pays services received by you or your covered dependent due to a non-service-connected disability, if:
  - you or your covered dependent is a veteran and does not have a service-connected disability;
  - Inpatient Hospital care received by you or your covered dependent as a retiree or dependent described in SS 1074(b), 1076(a) or (b) of Title 10, United States Code.

- for medical or surgical diagnosis and/or treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions (except as described under Covered Expenses for nutritional counseling), and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition. The Plan will, however, cover mental health counseling and medications for morbid obesity. Please see the sections entitled "Prescription Drug Plan" and "Mental Health Benefit" for more information (obesity means having an initial Body Mass Index (BMI) of >30kg/m², or per the current standard as may be updated from time to time by the FDA. Body Mass Index is calculated by taking individual weight (in kilograms) and dividing that weight by the individual's height (in meters squared).

- for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs;

- for medical and/or surgical treatment of sexual dysfunction or inadequacy, and any complications thereof;

- by any covered individual for injuries resulting from or sustained as a result of commission, or attempted commission by the covered individual, of an act that the Plan Administrator or Claims Administrator (at the direction of the Plan Administrator) determines in his or her sole discretion, on the advice of legal counsel (1) involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual, and (2) a reasonably prudent person should know may be the subject of criminal charges. The Plan Administrator’s or Claims Administrator’s (at the direction of the Plan Administrator) discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved;

- construction or modification to a home, residence, or vehicle required as a result of an injury, illness or disability of a covered individual, including, without limitation, construction or modification of ramps, grab bars, railings, elevators, chair lifts, swimming pools, spas, air conditioning, standing frames, etc.;

- for the patient’s convenience, including, but not limited to, care of family members while the covered individual is confined to a Hospital or other facility or to bed at home, guest meals, television, VCR, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.;

- use of a private room in a Hospital or other facility unless the facility only has private rooms or unless the use of a private room is certified as Medically Necessary by the Claims Administrator or its delegate;

- for a Health Care Provider who did not directly provide or supervise medical services to the patient, even if the provider was available to do so on a stand-by basis;

- any and all telephone calls between a Health Care Provider and the patient, other Health Care Provider, or any representative of the Plan for any purpose whatsoever;

- for genetic testing;

- for cochlear implants;

- for vitamins, minerals, nutritional supplements (even if only sources of nutrition) or special diets (whether they require a Doctor’s prescription or not);

- for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic Surgery when the services, procedures, prescription drugs, or prophylactic Surgery is prescribed or performed for the purposes of: (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except when the services or procedures are
specifically designated covered medical expenses by the Plan, and/or when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS), or alpha-fetoprotein (AFP) analysis;

- for all human organ and/or tissue transplants except as described in the Plan.

Services or supplies determined or for:

- by the Plan Administrator, Claims Administrator or its delegate not to be Medically Necessary as defined by the Plan;
- Experimental or Investigational services, supplies, drugs, or medicines as determined by the Plan Administrator, Claims Administrator, or a delegate;
- any services for care and treatment of teeth or gum tissue including dental implants except as stated under Dental expenses;
- any services related to the process of in vitro fertilization, embryo transplant or other means of conception that do not attempt to correct an underlying medical condition;
- cosmetic Surgery or Medically Necessary treatment resulting from cosmetic Surgery;
- Custodial Care;
- orthoptics, visual therapy or Surgery, for the correction of vision (including but not limited to radial keratotomy (RK) and automated keratoplasty (ALK), laser in situ keratomileusis (LASIK);
- private duty nursing;
- reversal of sterilization;
- routine hearing screening;
- Sickness or Accidental Injury for which you or your covered dependent has or had a right to payment under a Workers' Compensation or similar law;
- Sickness or Accidental Injury arising out of or in the course of work for pay, profit, or gain unless the person is not covered by Worker’s compensation and lawfully chose not to be;
- Sickness or injury which occurs in any armed conflict, whether declared as war or not, involving any country or government;
- Sickness or injury that occurs while in military service for any country or government while you are covered by this Plan;
- treatment or services provided by a Close Relative;
- treatment (medical, surgical, or prescription drug) for the purpose of a gender change, or the preparation for such treatment or any complications resulting from such treatment;
- treatment of corns, calluses, or toenails, unless part of the nail root is removed;
- weak, unstable, or flat feet or bunions, unless Surgery is required;
- smoking cessation, nicotine addiction, gambling addiction, or stress management;
- which a covered individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan;
- to not be recommended or prescribed by a Doctor, except for covered services and supplies provided by a midwife (if services are rendered in a Hospital), nurse practitioner, physician assistant, chiropractor, acupuncturist or podiatrist.
- physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party;
- acupressure, chelation therapy, prayer, and naturopathic treatment.
- massage therapy if performed by a chiropractor or any other provider (including a massage therapist or acupuncturist).

**Exceptions:**

- The Plan pays services received by you or your covered dependent if:
  - the services are provided by a MD, Doctor of Osteopathy (DO), or Physical Therapist; and
  - the services are provided in conjunction with physical therapy.

- treatment or services for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained;
charges for e-mail communication or e-mail consultation;
charges for Doctor overhead, including but not limited to equipment used to perform the particular treatment or service (i.e. laser equipment);
additional charges incurred because care was provided after hours, on a Sunday, holidays, or weekend;
treatment or services for non-synostotic plagiocephaly (positional head deformity);
charges for heating pads, heating and cooling units, ice bags or cold therapy units;
treatment or service for unattended home sleep studies;
Treatment or Services for standby services;
charges for motorized carts, scooters, or strollers.

Out-of-Pocket Expense

Out-of-pocket expense includes the percentage of Covered Expenses and the Plan Deductible that you or your covered dependent pays. Any other Deductibles, including the Hospital Admission Deductible and the Pre-Authorization Deductible are not applied toward the out-of-pocket expense. In addition, health care services and supplies incurred by you, which are not covered by the Plan, charges in excess of the Reasonable and Customary charges and charges in excess of the maximum allowable covered amount, are not applied toward the out-of-pocket maximum. If an individual’s out-of-pocket maximum is reached during a calendar year, the Benefit Percentage is 100% for Covered Expenses incurred by that person for the rest of the calendar year. If the family out-of-pocket maximum is reached during a calendar year, the Benefit Percentage is 100% for you and all your covered dependents for the rest of that calendar year. The individual and family maximum out-of-pocket expense is set forth in the Schedule of Benefits Summary. A patient’s failure to follow the Plan’s Utilization Review procedures may affect the application of this out-of-pocket maximum provision. See Utilization Review below.

Pre-Existing Condition

A pre-existing condition is a Sickness or Accidental Injury for which you or your covered dependent received any medical treatment or advice or any medication was prescribed within three (3) months of becoming covered under the Plan. The pre-existing condition provision below does not apply to adopted children or children placed for adoption. It also does not apply to pregnancy or newborn children. Genetic information will also not be considered a pre-existing condition in the absence of a diagnosis of the condition related to such information.

After you or your covered dependent becomes covered under the Plan, the Plan will pay Covered Expenses related to a pre-existing condition when:

6 Months: You or your covered dependents are covered for major medical coverage under the Plan for at least 6 consecutive months, regardless of whether you have received any medical treatment or advice, or any medication was prescribed for the Sickness or Accidental Injury during that 6-month period.

Reducing the Pre-Existing Condition Limitation

Under the Heath Insurance Portability and Accountability Act of 1997, TSRI may reduce the pre-existing condition limitation month-for-month, provided you supply the Plan with proof of previous coverage and there was no lapse in coverage for longer than a 63-day period. A waiting period or an HMO affiliation period will not be considered a break in coverage. A Certificate of Group Health Coverage can be obtained from the prior health plan and must specifically list all members who wish to obtain credit for prior coverage.

Certificate of Creditable Coverage

The Plan Administrator will provide you with a certificate of creditable coverage in the event that you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) under another employer’s group health plan.
Preferred Provider Leaves the PPO

If you or your covered dependent incur any Covered Expenses with a Network Provider after the provider is no longer a member of the Network, those expenses will be paid based on the Non-network level of Benefits. You or your covered dependent may also continue medical treatment or service by choosing a different Network Provider.

Weekend Admission

If you or your covered dependent are admitted to a Hospital on Friday, Saturday, or Sunday, the Hospital daily room and board charges for Friday, Saturday, and/or Sunday will not be covered if both of the following are true:

- you or your covered dependent does not receive any treatment, therapy, or Surgery requiring Hospitalization on the Friday, Saturday, or Sunday;
- the admission is a Non-Emergency admission that is scheduled before you or your covered dependent enters the Hospital.

However, if you or your covered dependent was scheduled for treatment, therapy, or Surgery and for reasons beyond your control it was not performed, the Plan will pay Covered Expenses for the Hospital daily room and board for Friday, Saturday and Sunday.

Utilization Review

Utilization Review is used to monitor quality control and cost containment through a variety of mechanisms including review of treatments, programs, procedures, pre-authorization for Hospitalization and concurrent Hospitalization.

When you receive services through a Network Provider, the utilization process will most likely be initiated for you. However, in all instances, you, your covered dependent, or your Doctor should obtain Pre-Admission Certification through the Utilization Management Provider by calling the phone number listed on your Benefits Card to ensure that the admission and stay will be considered Medically Necessary. Pre-Admission Certification must be obtained:

- no later than the day of admission for a Non-Emergency Admission;
- within 2 business days or as soon as reasonably possible after an Emergency Admission.

The Utilization Management Provider must approve all Hospitalizations and surgeries for you to receive optimal Benefit coverage, whether you are covered under the Comprehensive Medical Plan or the Catastrophic Plan. Before any Hospitalization or Surgery, call the phone number listed on your Benefits Card. It is your responsibility to make certain that specific treatment or services are covered under the Medical Plan. Services, which are not Medically Necessary are not covered by the Plan.

NOTE: In no instance will Pre-Admission Certification be required for a Hospital admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended period is subject to Pre-Admission Certification.

If you go to a Non-Network Hospital, whether you are enrolled in the Comprehensive Medical Plan or the Catastrophic Plan and Pre-Admission Certification is not obtained, an additional out of pocket Deductible of $200 will apply. The Benefit Percentage is greater for Network services. The Benefit Percentages are shown on the Schedule of Benefits. Generally, the additional Benefit Percentage for Non-network services is not applied towards meeting the out-of-pocket limit when you fail to obtain a Pre-Admission Certification.

If the Hospital Confinement extends beyond the number of certified days, no Benefit will be paid unless:
the extension of days is Medically Necessary;
certification for the extension is obtained prior to exceeding the number of certified days.

The Outpatient Pre-Procedure Review focuses on those procedures that are most frequently over utilized. The Utilization Management Provider’s Utilization Management department applies the same process utilized for Hospital pre-admission review to evaluate these Outpatient procedures, generating a prior authorization form to document that the Medical Necessity of the procedure has been pre-certified.

The following standard surgical procedures are currently included in the Outpatient Pre-Procedure Review program:

- Blepharoplasty (eye lid Surgery);
- Cardiac Catherization;
- Carpal Tunnel Release;
- Laparoscopic Cholecystectomy;
- Laparoscopic Vaginal Hysterectomy;
- Percutaneous Coronary Angioplasty;
- Percutaneous Diskectomy;
- Prostate;
- Reduction Mammoplasty;
- Septoplasty/Submucous, Resection/Rhinoplasty;
- Stem Cell Transplant;
- Thyroid;
- Tonsillectomy;
- Uvulopalatopharyngoplasty (soft palate Surgery for sleep apnea);
- Varicose Vein.

The Utilization Management Provider must approve all of the above listed Outpatient procedures for you to receive optimal Benefit coverage. In all of the above instances, you, your covered dependent, or your Doctor should obtain pre-approval from the Utilization Management Provider, by calling the phone number listed on your Benefits Card, before services are rendered to ensure that the procedure will be considered Medically Necessary. Outpatient procedures that are not Medically Necessary are not covered by the Plan.

Notice of Utilization Review

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when the Utilization Management Provider receives Notification of Utilization Review Services. The Utilization Management Provider may request additional information to substantiate the loss or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with the Utilization Management Provider's request could result in declination of Utilization Review services.

If you, your Dependent, or designated patient representative fails to follow the Utilization Management Provider's procedures for filing a claim for a Pre-Admission Certification, a Pre-Service Review or an Urgent Review, the Utilization Management Provider will notify you, your Dependent, or designated patient representative of the failure and the proper procedures to be followed.

Utilization Review Program

Pre-Service Review

For an initial Pre-Service Review, a decision and notification of the decision will be made within 15 calendar days of the date the Utilization Management Provider receives Notification of Utilization Review services. If a decision cannot be made due to insufficient information, the Utilization Management Provider will either issue a Noncertification or send an explanation of the information needed to complete the review prior to expiration of the 15 calendar days. If the Utilization Management Provider does not issue a Noncertification and requests additional
information to complete the review, you, the patient, the attending Doctor or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Utilization Management Provider will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, the Utilization Management Provider will provide notification to the attending Doctor or other Ordering Provider, the facility rendering service and you or the patient. Upon request, the Utilization Management Provider will provide written notification of the certification. For Noncertifications, notification will be made In Writing to the attending Doctor or other Ordering Provider, the facility rendering service, and you or the patient.

Urgent Pre-Service Review

For Urgent Review of a Pre-Service Review, a decision and notification of the decision will be made within 72 hours of the date the Utilization Management Provider receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Utilization Management Provider will either issue a Noncertification or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If the Utilization Management Provider does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Doctor or other Ordering Provider or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Utilization Management Provider will render a decision within 48 hours of either receiving the necessary information or if no additional information is received, at the expiration of the 48 hours given to provide the specified additional information. For certifications, the Utilization Management Provider will provide notification to the attending Doctor or other Ordering Provider, the facility rendering service and you or the patient. Upon request, the Utilization Management Provider will provide written notification of the certification. For Noncertifications, notification will be made In Writing to the attending Doctor or other Ordering Provider, the facility rendering service and you or the patient.

Concurrent Review

For a Concurrent Review that does not involve an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Utilization Management Provider will be decided within the timeframes and according to the requirements for Pre-Service Review.

For an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Utilization Management Provider will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. If a request is made less than 24 hours prior to the expiration of the previously approved period or number of treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services.

Post-Service Review

For a Post-Service Review, a decision and notification of the decision will be made within 30 calendar days after the date the Utilization Management Provider receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Utilization Management Provider will either issue a Noncertification or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If the Utilization Management Provider does not issue a Noncertification and requests additional information, you, the patient, the attending Doctor or other Ordering Provider or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Utilization Management Provider will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, the Utilization Management Provider will provide notification to the attending Doctor or other Ordering Provider, the facility rendering service and you or the patient. Upon request, the Utilization Management Provider will provide written notification of the certification. For Noncertifications, notification will be made In Writing to the attending Doctor or other Ordering Provider, the facility rendering service, and you or the patient.
Notification of Noncertification

The Utilization Management Provider will provide you with written or electronic notification of any Noncertification as described above. If the notice of Noncertification is provided electronically, such notice will comply with the standards imposed by the Department of Labor Regulations. Any notice of Noncertification will set forth, in a manner calculated to be understood by you:

- The specific reason or reasons for the Noncertification;
- References to the specific Plan provisions on which the Noncertification is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of your rights to bring a civil action under Section 502(c) of ERISA following a determination of Noncertification on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination of Noncertification, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Noncertification and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Noncertification is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge; and
- If the Noncertification relates to an Urgent Review, a description of the expedited review process applicable to Urgent Reviews.

Request for Reconsideration

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one business day to discuss the Noncertification decision with the attending Doctor or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Doctor or other Ordering Provider will be informed of their right to initiate an appeal and the procedure to do so. For certifications, the Utilization Management Provider will provide notification to the attending Doctor or other Ordering Provider, the facility rendering service and you or the patient. Upon request, the Utilization Management Provider will provide written notification of the certification. For Noncertifications, notification will be made In Writing to the attending Doctor or other Ordering Provider, the facility rendering service, and you or the patient.

Appeal of Noncertifications

You, your Dependent, a designated patient representative, Doctor, or other Health Care Provider has the right to request two appeal reviews of any utilization management determination In Writing. The Claims Administrator will make a full and fair review of the Noncertification. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Expeditited Appeal Review and Voluntary Appeal Review

An expedited appeal review is a request, that must be In Writing and is for an additional review of a decision not to certify an Urgent Review. An expedited appeal review must be requested within 180 calendar days of the receipt of
a Noncertification. A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review. Written or electronic notification of the appeal review outcome will be made to the attending Doctor or other Ordering Provider and you or the patient.

A Peer Clinical Reviewer who did not make the original determination, is not a subordinate of the Peer Clinical Reviewer who made the original determination and who is in the same or similar specialty as the attending Doctor or other Ordering Provider will conduct the review. No deference will be given to the prior adverse determination.

If the Noncertification is affirmed on the appeal review, you, the patient, attending Doctor or other Ordering Provider can request a voluntary appeal. The appeal must be requested In Writing and can be either mailed or faxed to the Claims Administrator. You, the patient, attending Doctor or other Ordering Provider may submit Written comments, documents, records, and other information relating to the request for appeal. The Claims Administrator will make a decision within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a Written explanation of the additional information that is required or an authorization for you or the patient’s signature so information can be obtained from the attending Doctor or other Ordering Provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the Written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate your right or the patient’s right to bring civil action following notification of the decision rendered during the expedited appeal, nor does it have any effect on your rights or the patient’s rights to any other benefit under the group Plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies. Any statute of limitations defense is tolled during the period of the voluntary appeal. You and your Plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor and your State insurance regulatory agency.

Note: The expedited appeal process does not apply to Post-Service Reviews.

**Standard Appeal Review and Voluntary Appeal Review**

A standard appeal must be requested In Writing and may either be mailed or faxed to the Claims Administrator. It must be requested within 180 calendar days of the receipt of a Noncertification. To complete the standard appeal process, it may be necessary for the Claims Administrator to request a statement from the attending Doctor or other Ordering Provider and request all or part of the medical records. A Peer Clinical Reviewer who did not make the original determination, is not a subordinate of the Peer Clinical Reviewer who made the original determination and who is in the same or similar specialty as the attending Doctor or other Ordering Provider will conduct the review. No deference will be given to the prior adverse determination. A decision and notification of the decision will be made In Writing to you or the patient, the attending Doctor or other Ordering Provider within two business days (but not later than 30 calendar days from receiving the request for an appeal review).

If the Noncertification is affirmed on the appeal review, you, the patient, attending Doctor or other Ordering Provider can request a voluntary appeal. The appeal must be requested In Writing. You, the patient, attending Physician or other Ordering Provider may submit Written comments, documents, records, and other information relating to the request for appeal. The Claims Administrator will make a determination within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a Written explanation of the additional information that is required or an authorization for your or the patient’s signature so information can be obtained from the attending Doctor or other Ordering Provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the Written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.
Election of a second appeal is voluntary and does not negate your right or the patient’s right to bring civil action following notification of the decision rendered during the standard appeal, nor does it have any effect on your rights or the patient’s rights to any other benefit under the group Plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies. Any statute of limitations defense is tolled during the period of the voluntary appeal. You and your Plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Claims Procedures

Claim Forms

Regardless of provider choice, application for benefits, claim forms and other information needed to prove loss must be filed with the Claims Administrator in order to obtain payment of Plan Benefits. It is the patient’s responsibility in all cases to ensure proof of loss is filed within the 15-month limit. TSRI will provide Health Insurance Claim Forms (HCFA forms) and other filing assistance upon request. If forms are not provided within 15 calendar days after TSRI receives such request, you will be considered to have complied with the requirements of the group Plan regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

When you become covered, you will be issued a Benefits Card. This Card should be presented to each provider at the time you or a Dependent receive needed medical care. The Utilization Management Provider will assist you with the Pre-Admission Certification and Outpatient Pre-Procedure Review requirements in accordance with the terms of your Plan.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss must be sent to the Claims Administrator within 15 months after the date of loss except in the case of legal incapacity. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Claims Administrator receives proof of loss. Proof of loss includes the patient's name, your name (if different from patient's name), provider of services, dates of service, diagnosis, description of treatment or service provided and extent of the loss. The Claims Administrator may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Payment, Denial, and Review of Claims

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim, which was not processed under the Utilization Review Program, cannot be processed due to incomplete information, the Claims Administrator will either deny the claim or send a Written explanation prior to the expiration of the 30 calendar days. If the Claims Administrator does not deny the claim and requests additional information to complete the review, the Claimant is then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, Benefits under the group Plan may be processed and paid within a few days after the Claims Administrator receives completed proof of loss. If a claim cannot be paid, the Claims Administrator will promptly explain why.

A Claimant may request an appeal of a claim denial by Written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the
claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant In Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a Claimant may request a voluntary appeal. The appeal must be requested In Writing. The Claimant may submit Written comments, documents, records, and other information relating to the claim for Benefits. The Claims Administrator will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a Written explanation of the additional information that is required or an authorization for the Claimant's signature so information can be obtained from the provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the Written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request. All final determinations are made at the discretion of the Plan Sponsor.

Election of a second appeal is voluntary and does not negate the Claimant's right to bring civil action following the first appeal, nor does it have any effect on the Claimant's right to any other benefit under the group Plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the Claimant may file a civil action or pursue any other legal remedies. Any statute of limitations defense is tolled during the period of the voluntary appeal. You or your Plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

For purposes of this section, "Claimant" means you or your covered Dependent.

**Benefit Payments**

Benefits under the Plan are paid when a claim is submitted. Claims are paid in the order received.

All Benefits for services or treatment rendered by a Network Provider will be paid by the Plan directly to the Preferred Provider. All Benefits for services or treatment rendered by a Non-Network Provider will be paid by the Plan to you if you are living; otherwise, to your estate. You may authorize the Plan to pay Benefits directly to the Non-network Provider by having them submit the claim on a standard NAIC claim form, which they can provide. The Non-Network Provider will need to complete the section of the NAIC form, which allows for the assignment of Benefits.

**Overpayment**

If the Plan pays a Benefit and it is later shown that a lesser amount should have been paid, the Plan will be entitled to a refund of the excess. This applies to payments made to you, your covered dependent, or to the provider of medical services, supplies, and treatment.

**Open Enrollment**

Open Enrollment will be scheduled annually. The time for Open Enrollment is designated and communicated by TSRI Human Resources. During Open Enrollment, you may change Medical Plans under which you and your dependents, if any, are covered. Open Enrollment is also a time when you and your dependents can be enrolled if not enrolled when first eligible. You may also drop coverage for you and/or your dependents during Open Enrollment. Changes made during Open Enrollment are effective the following January 1.

If you do not file a request for changes, you and your covered dependents will remain in the same Plan as enrolled for the preceding calendar year.
How You Can Help Keep Costs Down

There are a number of ways you can ensure that you receive quality and cost-efficient health care:

- choose a Physician while you are healthy. Find a Doctor who participates in the Network or who is concerned about cost and tries to stay within eligible charge limits;
- ask your Doctor to prescribe drugs by their generic names, and then do some comparison-shopping;
- review all of your bills for accuracy and keep good medical records;
- follow emergency room procedures when out of the Network area.

Benefit Advice

Benefit Advice is the Claims Administrator’s toll-free service that can answer questions about your benefit program or specific coverages. The staff provides information on topics such as outpatient surgery, generic drugs, health care alternatives, health care providers and treatment costs in your area.

The staff does not prescribe medical treatment. That is up to your Physician. However, they can help you understand your benefits and how to use them in the most cost-effective manner.

Call the toll-free UMR Health Info Line number (see your Benefits Card or contact TSRI Benefits Administration for the Health Info Line number) if you wish to discuss medical Benefits with the benefit advice staff.

Medical Examinations

The Plan Administrator may have the person whose loss is the basis for claim examined by a Physician. The Plan Administrator will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action for a claim may not be started before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Coordination of Benefits

Coordination of Benefits is the way Benefits are payable under more than one medical plan. Under Coordination of Benefits, you or your covered dependent will not receive more than the allowed expenses. Under no circumstances will this Medical Plan consider coordinating Benefits between two individuals enrolled under different options within the Plan.

Allowed Expense

The allowed expense for Coordination of Benefits is the Reasonable and Customary expense for medical treatment. Part of the expenses must be covered under at least one of the plans covering you or your covered dependent.

Effect on Medical Benefits

The Coordination of Benefits provision applies when the participant or the participant's covered dependent has medical coverage under more than one plan. If this provision applies, the benefit determination rules state whether this Plan pays before or after another plan.

The Benefits of this Plan:

- will not be reduced when this Plan is primary;
may be reduced when another plan is primary and this Plan is secondary. The Benefits of this Plan are reduced so that they and the benefits payable under the other plan do not exceed 100% of the allowed expenses; will not exceed the Benefits payable in the absence of other coverage.

Plans Subject to Coordination of Benefits

Plans subject to Coordination of Benefits are:

- this Plan;
- any group, blanket, or franchise health coverage;
- a group contractual pre-payment or indemnity plan;
- a health maintenance organization (HMO), whether group practice or individual practice association;
- a labor-management trustee plan or a union welfare plan;
- an employer or multi-employer plan or participant benefit plan;
- a government program;
- coverage required or provided by statute.

Plans not subject to Coordination of Benefits are any individual or family policies or contracts or public medical assistance programs.

Primary Plan/Secondary Plan

When this Plan is primary, its Benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan is secondary, its Benefits are determined after those of the other plan. This Plan’s Benefits may be reduced because of the payment of the other plan's benefits. Under Coordination of Benefits, you or your covered dependent will not receive more than the allowed expenses for a loss. When there are more than two plans, this Plan may be primary to one and may be secondary to another.

Order of Benefit Determination Rules

General - A plan that does not coordinate with other plans is always the primary plan.

Non-dependent/Dependent - The plan that covers the person as a participant, member, or subscriber (other than a dependent), is the primary plan; the plan that covers the person as a dependent is the secondary plan.

Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- Secondary to the plan covering the person as a dependent; and
- Primary to the plan covering the person as other than a dependent (e.g. a retired Participant), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

Dependent Child/Parents Not Separated or Divorced - When this Plan and another plan provide coverage for the same dependent, the primary coverage is determined as follows:

- The primary plan is the plan of the parent whose birthday (month and date) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, the benefits of the plan, which covered the parent the longer is the primary plan; the plan that covered the parent the shorter time is the secondary plan.
- If the other plan does not have the birthday rule but has the male/female rule and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Dependent Child/Separated or Divorced Parents - If two or more plans cover a person as a dependent child of divorced or separated parents, Benefits for the child are determined in this order:
• first, the plan of the parent with custody of the child;
• then, the plan of the spouse of the parent with custody;
• finally, the plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, that plan is the primary plan. This paragraph does not apply with respect to any Benefit Period or plan year during which any Benefits are actually paid or provided before the entity has actual knowledge.

Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

Active/Inactive Participant - The primary plan is the plan that covers the person as a participant who is neither laid off nor retired (or as that participant's dependent). The secondary plan is the plan that covers that person as a laid off or retired participant (or as that participant's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

Continuation of Coverage - If coverage is provided for a person under a right of continuation according to Federal or state law and the person is also covered under another plan, the following will be the order of benefit determination:

• First, the benefits of a plan covering the person as a Participant, member or subscriber (or as that person's dependent);
• Second, the benefits under the continuation coverage.

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

Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the primary plan is the plan that covered a participant, member, or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

Effect of Medicare on Your Medical Insurance

Age 65 and Over

If you are an active participant, age 65 and over, you must elect:

• your Medical Plan as your primary medical coverage and Medicare as your secondary medical coverage; or
• Medicare for your medical coverage.

The covered dependent spouse, age 65 and over, of any active participant must also make an election. If you elect Medicare as your medical coverage, your covered dependent spouse will also have Medicare as his or her medical coverage. If you elect your Medical Plan as your primary medical coverage, your covered dependent spouse may elect Medicare as his or her medical coverage, or he or she may continue coverage under your Medical Plan. NOTE: Medicare rules do not recognize Domestic Partners as spouses. As such, Domestic Partners on Medicare must elect Medicare as his or her primary medical coverage and your Medical Plan as secondary medical coverage.

If Medicare is elected, coverage under your Medical Plan will terminate. Until an election is made, coverage will automatically continue under your Medical Plan.
If a person is eligible for Medicare but doesn’t apply for coverage, the amount that would have been payable by Medicare for end stage renal disease will be estimated by this Plan. This Plan will then pay Benefits as if you or your covered dependent were covered under Medicare.

**Permanent Kidney Failure**

The Plan is primary and Medicare will be secondary for you or your insured dependent spouse or child during the first 30 months in which you or your insured dependent spouse or child is eligible for Medicare because of permanent kidney failure.

Otherwise Medicare is primary and the Plan will be secondary. Medicare will be considered a plan for purposes of Coordination of Benefits. The Plan will coordinate its Benefits with Medicare whether or not you or your insured dependent spouse or child is actually receiving Medicare benefits.

**Effect of Medicaid**

If you are covered by the Plan, then coverage you or your covered dependent has under Medicaid will be secondary.

The Plan will make Benefit payments in accordance with any assignments made by you or your insured dependents behalf.

Your qualification for Medicaid does not affect your eligibility for coverage under the Plan.

**Miscellaneous Provisions**

**Exchange of Information**

Any person who claims Benefits under this Plan must, upon request, provide all information that is needed to coordinate Benefits.

In addition, all information that is needed to coordinate Benefits may be exchanged with other companies, organizations, or persons.

**Facility of Payment**

The payment made under another plan may have included an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not pay that amount again. The term "payment made" includes providing Benefits in the form of services. In this case, “payment made” means the reasonable cash value of the Benefits provided in the form of services.

**Right of Recovery**

If the amount of the payments made by the Plan is more than it should have been, the Plan may recover the excess from one or more of the:

- persons the Plan has paid or for whom it has paid;
- insurance companies;
- other organizations.

The "amount of payments made" includes the reasonable cash value of any Benefits provided in the form of services.

If you or your insured dependent is a Medicaid recipient, the state may have collection of debt rights. The Plan will honor these rights.
Effect of No-Fault Auto Insurance

The Plan reduces the Benefits payable based on the benefits no-fault auto insurance would pay for injuries from an accident for the same Covered Expenses. In no event will the amount paid by this Plan exceed the Benefits payable in the absence of no-fault auto insurance.

Health Coverage Assignment

You or your covered dependent may not transfer to anyone else:

- ownership of any Summary Plan Description issued under the Plan;
- health coverage under the Plan.

Exam and Autopsy

When reasonably necessary, the Plan may have you or your covered dependent examined while a claim is pending under the Plan. The Plan pays for the initial exam. If not forbidden by state law, the Plan may have an autopsy performed if you or your covered dependent dies.

Subrogation and Reimbursement for Acts of Third Parties

Under some circumstances, you or one of your covered Dependent (each, a “covered person”) may need services provided under this Plan for which a third party may be liable or legally responsible (for example, by reason of negligence, an intentional act, or breach of any legal obligation). As a covered person, and by accepting such benefits, you and your covered Dependent(s) agree to the following conditions under which the services will be provided:

1. As used below:
   a. “responsible person” means a third party or its insurer or guarantor, or anyone else legally responsible for an illness, disease, injury or condition.
   b. “recovery” means any actual or potential payment on account of any illness, disease, injury or condition, for which a responsible person may be liable to you, regardless of whether the payment results from a settlement, judgment or otherwise.
   c. “you” means you, your covered Dependent, or anyone acting in your stead or on your behalf, including your estate, parent or legal guardian.

2. The Plan shall automatically have a first lien upon any recovery that you receive, or may be entitled to receive, from a responsible person. The lien shall be in the amount of benefits paid under this Plan for the treatment of any illness, disease, injury or condition for which the responsible person may be liable to you. You hereby consent to this lien and agree to cooperate with the Plan or its agents or assignees to enforce any rights that the Plan may have with respect to any recovery.

3. You shall segregate any recovery received by you (up to the amount of the Plan’s first lien) in a separate account, and shall preserve such recovery so that the Plan may enforce its lien and any disputes as to entitlement may be resolved.

4. Within 60 days of the date when you first act to assert a claim against the responsible person (for example, by sending notice of the claim or by submitting or filing a claim), you must advise the Claims Administrator in writing of that fact.

5. You must furnish such information and assistance, execute such papers, and take such other actions as the Plan or its agents or assignees may require to facilitate the enforcement of the Plan’s rights or interest. Without the prior written consent of the Plan or its agents or assignees, as may be applicable, you must not take any action that may prejudice the Plan’s rights or interests, including without limitation disbursing or dissipating any
recovery, or releasing or compromising any claim against a responsible person as to which the Plan may have an interest. Failing to advise the Plan of a claim against a third party, failing to cooperate with the Plan or its agents or assignees, disbursing, transferring or dissipating any recovery to which the Plan has a claim or upon which the Plan has a lien, or taking actions that prejudice the Plan’s rights or interests would be a material breach of this Plan, shall entitle the Plan to the imposition of a constructive trust, and may result in your being equitably responsible for reimbursing the Plan.

6. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan’s lien and/or to obtain (or to preclude or reverse the transfer, dissipation or disbursement of) any recovery. The Plan shall be entitled to enforce its lien even if the recovery is less than the actual loss you suffered.

7. The Plan may, at its option, become subrogated to, and thereby assume and prosecute, your claim against any responsible person for amounts paid under this Plan on account of an injury to you. The Plan may exercise that option by written notice to you or your legal representative. Upon such written notice, you or your legal representative shall transfer to the Plan any rights that you may have to a recovery from a responsible person of any amounts paid by the Plan to you or on your behalf. If the Plan chooses to proceed by subrogation, the Plan shall be entitled to obtain, out of any recovery, the actual expenses of litigation, including without limitation attorneys’ fees, in addition to any other amounts recoverable hereunder.

8. The Plan shall have specific and first rights of restitution and reimbursement, up to the amount of the Plan’s lien, out of the proceeds of any recovery that you may receive.

9. You acknowledge and agree that this section of the Plan (entitled SUBROGATION AND REIMBURSEMENT FOR ACTS OF THIRD PARTIES) and any actions taken pursuant to its provisions are intended to restore and preserve the status quo ante and to avoid duplicative or undeserved recovery by you.

10. You shall not assign any right, claim or cause of action against a responsible person to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan.

11. The Plan’s rights under this section shall not be affected, reduced or eliminated by the make-whole doctrine, comparative or contributory fault, or the common fund doctrine.

12. The Plan is governed by ERISA and, to the extent that such law is not preempted by ERISA, is subject to California law. To the extent that any portion of the Plan is inconsistent with applicable law in whole or in part, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect. Thus, for example, if an applicable law were to limit the amount of the lien provided for in paragraph 2 above, then the lien shall be enforceable in the greatest amount allowable consistent with that statute.

13. The Plan is not required to exercise all or any of its rights under this section, but is empowered to do so in its fiduciaries’ sole and absolute discretion. In exercising such discretion, the Plan’s fiduciaries may (but are not required to) consider factors such as the size of any potential recovery, the likelihood of obtaining a recovery, and the cost to the Plan of doing so.

14. A covered person might receive payments through this Plan that exceed the payments to which the covered person is legally entitled under the Plan. Such payments, to the extent that they exceed the amount to which the covered person is legally entitled under the Plan, are hereinafter referred to as “overpayments”. In the event that a covered person receives an overpayment, (i) the overpayment shall belong to the Plan; (ii) the covered person shall not have any right to retain the overpayment; (iii) the covered person shall segregate and not disburse or dissipate the overpayment so that the overpayment may be returned to the Plan and any dispute over entitlement to the overpayment may be resolved; (iv) the covered person shall be required to return the overpayment to the Plan; (v) the covered person shall cooperate with efforts to recover the overpayment; (vi) the Plan shall automatically have a lien upon any monies paid to the covered person by the Plan in the amount of the overpayment; (vii) the Plan shall have a right of equitable restitution with respect to the overpayment; (viii) the Plan shall have a right to the imposition of a constructive trust on the overpayment; and (ix) the Plan shall be entitled, at its option and in its sole discretion, to recoupment by withholding and retaining any monies payable to the covered person, up to the amount of the overpayment.

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Dental Benefit

Eligibility

Regular full-time and part-time (minimum of 20 hours per week) eligible Research Associates and Graduate Students (External) who satisfy the conditions described below are eligible for coverage on their date of hire.

You must meet the following conditions to become covered:

- Be eligible for the coverage (see definition of eligible participant above).
- Be Actively Employed at time of application.

Effective Date of Your Coverage

Your coverage starts on the latest of the following dates:

- the date you become eligible;
- the date you return to Active Work if you are not actively at work on the date coverage would otherwise start; **EXCEPTION:** Your coverage starts on a non-working day if you were actively at work on your last scheduled working day before the non-working day;
- in the event of a qualified status change event, coverage will be effective the first day of the next administratively practicable pay period after the Benefits Coverage Change Form is signed and received by Human Resources within 31 days of the applicable status change event or such other period described under “Changing Your Elections on Account of a Qualified Status Change Event” above.

If you apply for coverage later than the time required after the status change date or your first date of eligibility, you must wait until Open Enrollment to apply for coverage.

Late Enrollee

You are considered a late enrollee if all of these are true:

- You declined coverage at the first available opportunity to enroll.
- You did not have other dental coverage when you declined.
- You completed and signed a declination of coverage form, which notified you of the consequences of declination.

Late enrollees may enroll only during the Plan's annual Open Enrollment period. Coverage will be effective on the first day of the next Plan year (January 1st).

Special Enrollee

You are considered a special enrollee if:

- You declined coverage under the Plan at the first available opportunity to enroll because you had other dental coverage (see “Special Enrollment for Loss of Other Coverage” below);
- You had a status change event such as a marriage, birth, adoption, or placement for adoption; or
- You had a status change event involving a termination of coverage under a Medicaid or CHIP program or eligibility for premium assistance under one these programs (see “Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009” below).
Coverage under Special Enrollment due to marriage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. In the case of a Special Enrollment period involving the birth, adoption or placement for adoption of a child, election changes will be effective retroactive to the date of the birth, adoption or placement, provided you file a signed Benefits Coverage Change Form with Human Resources within 31 days of the birth, adoption or placement. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

**Special Enrollment for Loss of Other Coverage**

A Special Enrollment period for loss of other coverage is available to you if you meet all of these requirements:

- You must otherwise be eligible for coverage under the Plan.
- You must have been covered under another group dental plan or must have had other dental coverage.
- You must have declared in writing at the time you initially declined coverage under the Plan that you already had other coverage.
- If the other coverage was COBRA continuation coverage, COBRA continuation was exhausted.
- If the other coverage was not COBRA continuation coverage, you have lost eligibility for the other coverage or your Employer has stopped contributions for the other coverage. Loss of eligibility must not be due to failure to pay premiums or for cause (such as making a fraudulent claim).

You must request Special Enrollment within 31 days of the loss of other coverage. You do not have to elect COBRA continuation or other similar continuation to preserve the right to Special Enrollment. Coverage under Special Enrollment due to loss of other coverage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. If you do not elect to enroll in the Plan during the Special Enrollment period, you generally will not be able to enroll until the following annual enrollment period.

**Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009**

If you are eligible, but not enrolled, for dental coverage (or your dependent is eligible, but not enrolled, for such coverage), a Special Enrollment period is available, and you may enroll yourself and/or your eligible dependent for coverage, if either of the following conditions is met:

- You or your dependent are covered under a Medicaid plan or under a Children’s Health Insurance Program (CHIP) and your coverage, or your dependent’s coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or
- You or your dependent become eligible for premium assistance as to coverage under the TSRI group health plan under such Medicaid plan or CHIP plan.

You must provide Human Resources with a signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency within 60 days of the occurrence of one of these Special Enrollment events. Coverage under Special Enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the next administratively practicable pay period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form (along with applicable proof of status change and dependency), provided all such documentation is received within 60 days of the occurrence of the Special Enrollment event. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.
Termination of Coverage

Your coverage stops on the earliest of the following dates:

- the last day of the month in which you terminate because you cease Active Work or you are no longer eligible for coverage under the Plan because you begin to work fewer hours than required under the definition of eligible participant in the Plan;
- the first day of the next administratively practicable pay period after the date you are no longer eligible for coverage under the Plan for reasons other than your cessation of Active Employment or reduction in hours;
- the first day of the next administratively practicable pay period after the date Human Resources receives, In Writing, your intent to stop dental coverage for your dependent due to a qualified change in status (other than your cessation of Active Employment or reduction in hours) by completing the Benefits Coverage Change Form. For more information regarding qualified status change events and the applicable deadlines, please see the subsections entitled “Status Changes” and “Changing Your Elections On Account of a Status Change Event” under the section entitled “Introduction”;
- the date when the Plan you are enrolled in stops;
- the end of the period for which you paid contributions, if you do not make the next required contribution when due;
- the date that benefit is no longer provided under the Plan.

• coverage for you or any of your covered dependents may be also be terminated for cause on the date specified in the Plan Administrator’s Written notice of its determination that:
  - you or your covered dependent made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form; or
  - you or your covered dependent, by allowing another individual to use the information regarding your (or your dependent’s) coverage, services or Benefits under the Plan, assisted such other individual in obtaining Plan coverage, services or Benefits that he or she was not entitled to receive under the terms of the Plan; or
  - you or your covered dependent altered any prescription or referral furnished by a service provider under the Plan; or
  - a specific set of circumstances results in termination of your coverage and entitlement to Benefits for cause, as determined by the Plan Administrator in its sole discretion.

In addition to termination of your or your dependent’s coverage and entitlement to Benefits, the Plan Administrator may take any other action it deems appropriate, including, but not limited to, seeking reimbursement of any amount paid under the Plan or refusing to pay any amount with respect to services rendered or expenses incurred before the date specified in the notice.

Continuation of Coverage through COBRA

If you are no longer eligible for coverage because you cease Active Work, cease to be in an eligible job classification or you begin to work fewer hours than required under the definition of eligible participant in the Plan, your coverage may be continued pursuant to a law known as COBRA.

COBRA legislation allows participants to continue coverage under an employer’s group plan by paying the appropriate premium for continuation of coverage. If the premium is not paid on time, your coverage stops at the end of the period for which your contributions were paid. Your continuation of coverage is subject to all other provisions of the Plan. See the section entitled “Continuation of Healthcare Benefits under COBRA” for additional information.

Reinstatement of Coverage

Participants who have resigned or have been terminated from TSRI for a period of ninety (90) days or less and are reemployed shall have all coverage prior to termination reinstated.
Dependent/Domestic Partner Eligibility

Participants are required to show proof of dependency for all eligible dependents he or she enrolls in the benefit plans. Eligible dependents are the participant’s:

- Spouse - defined as a person to whom the Participant is married within the meaning of the laws of the jurisdiction of the Participant’s domicile, provided that marriage is recognized as valid under the laws of the United States including, but not limited to, the Code. A couple is “married” if their relationship is recognized as a marriage under the laws of the state or country in which the Participant is domiciled and of the United States;
- Domestic Partner as defined herein;
- unmarried dependent children from birth up to age 19 (through age 18);
- unmarried dependent children from age 19 up to age 25 (through age 24) if the dependent child is enrolled as a full-time student in an accredited school, college or university and is dependent upon you for support (except as provided under “Termination of Eligibility as a Student Dependent” below);
- certain dependent children who reach the maximum age for dependent coverage may be able to continue coverage under the Plan. See “Handicapped Dependent Children” below for details.

“Children” include natural children, adopted children, children placed for adoption with you or your spouse, children for whom you or your spouse are the permanent legal guardian, and step children and foster children, provided the foster or step children depend upon the participant for more than half their support and maintenance and live with the participant in a parent-child relationship. Eligible foster children must be placed by an authorized placement agency. Children also include those individuals covered by a "Qualified Medical Child Support Order (QMCSO)" or “National Medical Support Notice (NMSN)” as described below in this section of the Summary Plan Description.

The dependents of eligible participants become eligible dependents on the same date that the participant, of whom they are dependents, becomes eligible. Dependents acquired later become eligible dependents as soon as they acquire dependent status as defined by the Plan.

TSRI recognizes same gender Domestic Partners in the Medical, Mental Health, Prescription, Vision and Dental Plans if an Affidavit of Domestic Partnership is completed and returned to Human Resources. Throughout this document, in relation to such Plans, the word “dependent” or "spouse" also applies to an eligible Domestic Partner.

If both parents of a dependent are enrolled as Plan participants, then each unmarried, eligible, dependent child can be the covered dependent of only one Plan participant. An Participant may enroll in the Plan either as a participant or as a covered dependent of his/her spouse who is enrolled in the Plan with family coverage, but not both.

The term “dependent” does NOT include:

- a spouse who is covered as a TSRI participant under the Plan;
- a child eligible as a TSRI participant under the Plan;
- a spouse or child on active military duty;
- a parent of the participant or of the participant’s spouse;
- a Domestic Partner who has not filed an Affidavit of Domestic Partnership with Human Resources.
- a child of a participant’s registered Domestic Partner is not eligible for Benefits, unless he or she is a legal dependent of the participant.

You are eligible for dependent coverage on the later of the following dates:

- the date you are eligible for coverage as a TSRI participant;
- the date you first acquire a dependent or attain Domestic Partnership;
- the date your dependent loses other coverage through no fault of his/her own;
- the date you otherwise experience a qualified status change listed in the "Introduction" section of this document.

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You must meet all of the following conditions to become covered for dependent coverage:

- be covered by the TSRI Dental Plan; and
- you must apply for coverage within 31 days of the date you are eligible for dependent coverage (except for a HIPAA Special Enrollment right due to loss coverage under a Medicaid or CHIP plan or eligibility for premium assistance (see “Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009” below)). If you are applying because your dependent lost other coverage, a letter must be submitted from the previous insurer stating the name of the insured and the date coverage was lost. Applicable proof of dependency must also be submitted.

If you and your spouse or Domestic Partner are covered as a participant under the Plan, neither you nor your spouse/Domestic Partner can also apply for dependent coverage. If the spouse/Domestic Partner loses eligibility for the TSRI Plan, the TSRI participant may enroll that spouse/Domestic Partner by applying within 31 days of the qualified status change.

**Coverage Options**

Plan participants may elect from the following coverage categories:

- Participant only;
- Participant plus spouse;
- Participant plus Domestic Partner;
- Participant plus dependent children;
- Participant plus spouse and dependent children;
- Participant plus Domestic Partner and dependent children.

**Domestic Partners**

A Domestic Partner is defined as a person of the same gender who, with the participant, for the past 6 months has met, and continues to meet, the following requirements:

- share a common residence; and
- have a close, personal relationship; and
- (agree to be jointly responsible for each other’s “basic living expenses” (as defined below) which are incurred during the domestic partnership; and
- neither person is married or a member of another domestic partnership; and
- are each eighteen (18) years of age or older; and
- are not related by blood in a way that would prevent them from being married to each other in the state they reside; and
- are capable of consenting to the Domestic Partnership; and
- neither person has previously filed for Domestic Partnership that has not been terminated; and
- have completed an Affidavit of Domestic Partnership form.

"Basic living expenses” is defined as the cost of basic food, shelter, and any other living expenses. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. **NOTE:** Children of Domestic Partners are not eligible for Benefits, unless they are legal dependents of the participant as defined under “Dependent/Domestic Partner Eligibility”.

If a participant decides to add an eligible Domestic Partner to his or her Dental Plan, an Affidavit of Domestic Partnership must be submitted.
Tax Implications

Domestic Partners may be considered to be tax-qualified dependents under Internal Revenue Section 152; please contact your Human Resources Department for more details. Unless proof is provided of eligibility under 26 U.S.C. Section 152, the value of benefits provided to a Domestic Partner will be considered taxable income to a participant. This cost appears on a participant’s second paycheck of each month under the taxable income information.

Example: A TSRI participant currently has the Comprehensive Medical Plan, Participant Only coverage, and adds a qualified Domestic Partner to the medical and dental plans. The participant’s taxable income is calculated as follows:

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost for participant &amp; Domestic Partner per month</td>
<td>$1187.51</td>
<td>$72.66</td>
</tr>
<tr>
<td>subtract cost for participant coverage</td>
<td>-593.87</td>
<td>-36.34</td>
</tr>
<tr>
<td>subtotal</td>
<td>593.64</td>
<td>36.32</td>
</tr>
<tr>
<td>subtract participant cost of Domestic Partner Premium</td>
<td>-207.00</td>
<td>18.00</td>
</tr>
<tr>
<td>Taxable income</td>
<td>$386.64</td>
<td>$18.32</td>
</tr>
</tbody>
</table>

Total taxable income would be $404.96 ($386.64 + $18.32) per month.

Federal taxes (Federal Income Tax, FICA and FUTA) and any applicable State taxes are deducted from the participant's taxable income for the cost of providing coverage for Domestic Partners. If we assume the participant is in the 27th percentile income tax bracket, the increase in Federal tax withheld would be $109.33 per month. Therefore, the total monthly cost to the participant for Domestic Partner Medical and Dental coverage would be $334.33 ($207.00 + $18.00 for insurance Premiums, plus $109.33 in Federal tax). The participant may also owe additional applicable state taxes on the Domestic Partner coverage.

Termination of Domestic Partner Coverage

If a participant provides medical and/or dental coverage for a Domestic Partner and that Partnership subsequently ends, the participant must notify Benefits Administration to terminate the Domestic Partner’s coverage. Domestic Partners are NOT eligible for COBRA continuation coverage.

Effective Date of Dependent Coverage

Your dependent coverage starts on the latest of the following dates:

- the date you become eligible for dependent coverage; or
- the date you apply for dependent coverage, if you have to pay any part of the cost;
- except as otherwise provided in this subsection, in the event of a qualified status change event, coverage will be effective the first day of the next administratively practicable pay period after the Benefits Coverage Change Form and applicable proof of status change and dependency is properly completed, signed and received by Human Resources; provided, however, that all such documentation is received within 31 days of the status change event. For more information regarding qualified status change events, please see the section entitled "Introduction" above.
- in the event of a special enrollment period due to marriage or loss of other coverage, coverage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly signed and completed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents; provided, however, that all such documentation is received within 31 days of the marriage or loss of other coverage, as applicable. For more information regarding qualified status change events, please see the section entitled "Introduction" above.
- in the event of a special enrollment period due to new child acquired by birth, adoption, or placement for adoption, coverage will be effective on the date of the child's birth, adoption, or placement for adoption.
providing you submit a properly signed and completed Benefits Coverage Change Form and applicable proof of status change and dependency to Human Resources within 31 days of the child's birth, adoption or placement for adoption. If you do not request coverage for your child within the 31 day period following the child’s date of birth, adoption or placement, Benefits will be payable only for Covered Expenses incurred by the child during the 31-day period in which coverage was in force. If a new child is acquired, your spouse may also be enrolled. For more information regarding qualified status change events, please see the section entitled "Introduction" above.

- in the event of a special enrollment period due to (i) termination of coverage under Medicaid or a state Children’s Health Insurance Program (CHIP) or (ii) eligibility for a premium assistance subsidy under Medicaid or CHIP, election changes will be effective on the first day of the next administratively practicable payroll period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency; provided, however, that all such documentation is received within 60 days of the occurrence of one of the foregoing events. For more information regarding qualified status change events, please see the section entitled "Introduction" above.

If you apply for dependent coverage later than the applicable time period discussed above, you must wait until Open Enrollment for coverage to begin. See below for “Late Enrollee” and “Special Enrollee” information.

**Late Enrollee**

Your eligible dependent is considered a late enrollee if all of these are true:

- Coverage was declined for your eligible dependent at the first available opportunity to enroll.
- Your eligible dependent did not have other dental coverage when coverage was declined.
- Notification was given of the consequences of declination of coverage.

Late enrollees may enroll only during the Plan’s annual enrollment period. Coverage will be effective on the first day of the next Plan year (January 1st).

**Special Enrollee**

Your eligible dependent is considered a special enrollee if:

- Coverage for your eligible dependent was declined under the Plan at the first available opportunity to enroll because you or your eligible dependent had other dental coverage (see “Special Enrollment for Loss of Other Coverage” below);
- You had a status change event such as marriage, birth, adoption or placement for adoption; or
- You had a status change event involving a termination of coverage under a Medicaid or CHIPs program or eligibility for premium assistance under one these programs (see “Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009” below).

Coverage under Special Enrollment due to marriage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. In the case of a Special Enrollment period involving the birth, adoption or placement for adoption of a child, election changes will be effective retroactive to the date of the birth, adoption or placement, provided you file a signed Benefits Coverage Change Form with Human Resources within 31 days of the birth, adoption or placement. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

**Special Enrollee for Loss of Other Coverage**

A Special Enrollment period for loss of other coverage is available to your eligible dependent if your eligible dependent meets all of these requirements:
Your eligible dependent is otherwise eligible for coverage under the Plan.
Your eligible dependent was covered under another group dental plan or had other dental coverage at the time coverage was declined.
You declared In Writing that your eligible dependent already had other coverage.
If the other coverage was COBRA continuation coverage, COBRA continuation was exhausted.
If the other coverage was not COBRA continuation coverage, your eligible dependent lost eligibility for the other coverage or the Employer has stopped contributions for the other coverage.

You or your eligible dependent must request a Special Enrollment within 31 days of the loss of other coverage. Your eligible dependent does not have to elect COBRA continuation or other similar continuation to preserve the right to Special Enrollment. Coverage under Special Enrollment due to loss of other coverage will be effective on the first day of the next administratively practicable pay period (but in no event later than the first day of the first month) after Human Resources has received a properly completed and signed Benefits Coverage Change Form (along with applicable proof of status change and dependency) requesting enrollment for yourself or on behalf of your eligible dependents. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009

If you or your dependent are eligible, but not enrolled, for dental coverage (or your dependent is eligible, but not enrolled, for such coverage), a Special Enrollment period is available, and you may enroll yourself and/or your eligible dependent for coverage, if either of the following conditions is met:

- You or your dependent are covered under a Medicaid plan or under a Children’s Health Insurance Program (CHIP) and your coverage, or your dependent’s coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or
- You or your dependent become eligible for premium assistance as to coverage under the TSRI group dental plan under such Medicaid plan or CHIP plan.

You must provide Human Resources with a signed and properly completed Benefits Coverage Change Form and applicable proof of status change and dependency within 60 days of the occurrence of one of these Special Enrollment events. Coverage under Special Enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the next administratively practicable pay period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form (along with applicable proof of status change and dependency), provided all such documentation is received within 60 days of the occurrence of the Special Enrollment event. If you do not elect coverage during this Special Enrollment period, you generally will not be able to enroll in the Plan until the following annual enrollment period.

Responsibility for Determining Ineligible Dependents

If you have covered dependents between the ages of 19 up to 25, it is your responsibility to notify, In Writing, using a Benefits Coverage Change Form, the Plan Administrator (Human Resources Department) when your dependents no longer meet the Plan definition of dependent or Student Dependent (see the section entitled "Medical and Dental Plan Definitions"). The effective date of change for an ineligible dependent will be the first day of the next month after Human Resources receives a properly signed and completed Benefits Coverage Change Form and applicable proof of status change and dependency. Changes will not be made retroactively.

Qualified Medical Child Support Orders (QMSCO) or National Medical Support Notices (NMSN)
In accordance with federal law, the Plan provides medical coverage to certain dependent children (called alternate recipients) if the Plan is directed to do so by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). This is an order or judgment from a court, or produced as a result of a state-authorized administrative process directing the Plan Administrator to include a child in the participant’s coverage.

In addition to requiring the participant to provide coverage for the child, the law authorizes TSRI to make applicable payroll deductions, if any.

When the Plan Administrator receives a medical child support order, it will promptly notify both the participant and the alternate recipient that the order has been received and what procedures the Plan will use to determine if the order is qualified. Then the Plan Administrator will decide, on the basis of the Plan’s Written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the Plan Administrator will notify the participant and alternate recipient(s) by mail.

You can get more information on QMCSO or NMSN procedures by contacting the Plan Administrator. A copy of the Plan’s QMCSO/NMSN procedures is available without charge from Human Resources.

### Termination of Dependent Coverage

Your dependent coverage terminates on the earliest of the following dates:

- the date the dependent coverage provisions of the Plan terminate;
- the date the Plan terminates;
- the end of the period for which you made your last contribution for dependent coverage if you do not make the next required contribution when due. However, in the case of a child covered due to a QMCSO, you must provide proof that the child support order is no longer in effect, that the dependent has replacement coverage which will take effect immediately upon termination or the child otherwise loses eligibility for coverage;
- the date your coverage stops under the Plan (see “Termination of Coverage” above). This does not apply if your Dental coverage stops because you have received the maximum Benefits under the Plan. In this case your dependent coverage continues until otherwise stopped under the Plan;
- the last day of the month in which your covered dependent is no longer a dependent, Student Dependent (see below) or a handicapped dependent child as defined by the Plan;
- the last day of the month in which you notify Human Resources, In Writing, of your intent to stop Dental coverage for your dependent due to a qualified status change attributable to divorce or legal separation;
- the first day of the next administratively practicable pay period after the date you notify Human Resources, In Writing, of your intent to stop Dental coverage for your dependent or dependents due to a qualified status change attributable to a major life event other than divorce, legal separation, or your child’s loss of dependency status;
- the date that coverage for a particular service is no longer provided under the Plan;
- coverage of your covered dependents may be also be terminated for cause on the date specified in the Plan Administrator’s Written notice of its determination that:
  - you or your covered dependent made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form; or
  - you or your covered dependent, by allowing another individual to use the information regarding your (or your dependent’s) coverage, services or Benefits under the Plan, assisted such other individual in obtaining Plan coverage, services or Benefits that he or she was not entitled to receive under the terms of the Plan; or
  - you or your covered dependent altered any prescription or referral furnished by a service provider under the Plan; or
  - a specific set of circumstances results in termination of your coverage and entitlement to Benefits for cause, as determined by the Plan Administrator in its sole discretion.

In addition to termination of your dependent’s coverage and entitlement to Benefits, the Plan Administrator may take any other action it deems appropriate, including, but not limited to, seeking reimbursement of any
amount paid under the Plan or refusing to pay any amount with respect to services rendered or expenses incurred before the date specified in the notice.

**Termination of Eligibility as a Student Dependent**

A covered Student Dependent will no longer be eligible for dependent coverage on the earliest of the following dates:

- the last day of the month in which the dependent graduates;
- the last day of the month in which the dependent voluntarily stops attending school full-time as defined by attending school’s registrar, except as described below;
- the last day of the month after 31 days elapses following the date the dependent involuntarily stops attending school full-time and does not return to school full-time within that 31 days, except as described below;
- the first day of the next month after the end of any 12-month period during which the Student Dependent did not complete at least eight months of full-time attendance, unless he or she is attending school full-time on that date, except as described below.

Coverage does not stop solely due to school vacations or for certain medically necessary leaves of absence as described in the paragraph below.

If your covered Student Dependent takes a medically necessary leave of absence from school, the Plan will continue his or her coverage for a period of one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the Plan), provided the Plan receives written certification from the covered Student Dependent’s treating physician stating that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. A “medically necessary leave of absence” is a leave of absence from a post-secondary educational institution (including an institute of higher education as defined in Section 102 of the Higher Education Act of 1965), or any other change in enrollment at such an institution, that begins while a covered Student Dependent is suffering from a serious sickness or injury, is medically necessary, and causes the covered Student Dependent to lose student status for purposes of coverage under the terms of the Plan.

If your covered Student Dependent is otherwise unable to attend school full-time because of Sickness or Accidental Injury, the Plan will continue the coverage until the first day of the next regular semester or quarter whichever is applicable to the school.

**Continuation of Coverage for Dependents**

If coverage for your dependents ends because of your termination of employment, ceasing to be in an eligible job classification, or reduction in hours, your death, your divorce or legal separation, your Medicare entitlement or your dependent child’s loss of dependent status, your dependents’ coverage may be continued pursuant to a law known as COBRA. COBRA allows dependents to continue coverage under an employer’s group health plan for a limited period by paying the appropriate premium for continued coverage. If the premium is not paid on time, the coverage stops at the end of the period for which any contributions were paid. Your covered dependents’ continuation is subject to all other terms of the Plan. See the section entitled "Continuation of Health Care Benefits under COBRA" for additional information.

**NOTE:** Domestic Partners are not eligible for COBRA continuation coverage. However, as described in the section entitled “Continuation of Health Care Benefits under COBRA”, if the covered Participant becomes entitled to and elects to continue coverage under COBRA, he or she may elect to continue coverage for his or her covered Domestic Partner. Also, Domestic Partners may, under certain circumstances, be eligible for continuation coverage (similar to COBRA continuation coverage) available under state law. Please contact the Human Resources Department for more information regarding the availability of continuation coverage for Domestic Partners.

**Handicapped Dependent Child**
If your covered dependent child is mentally or physically handicapped and reaches the maximum age for dependent coverage, his or her coverage will continue. To continue coverage you must give the Plan proof that:

- your child is handicapped and not self-supporting;
- your child became handicapped before reaching the maximum age for dependent coverage;
- your child is dependent on you for support.

Proof must be given within 31 days after the date your child reaches the maximum age for coverage. The Plan may require that a Doctor examine your child before granting a continuation of your dependent child's coverage. The Plan chooses the Doctor and pays the fees for all required exams.

If your physically or mentally handicapped dependent child is covered by another dental plan, but that coverage is ending (regardless of the reason), you may enroll the dependent under TSRI’s dental plan. To qualify under TSRI’s group plan, you must enroll the dependent within 31 days of the loss of other coverage and the dependent must meet the definition of a handicapped child as specified above.

The Plan may ask for proof of your child's continued handicap generally once each year. However, the Plan may ask for such proof more or less frequently at the Plan's sole discretion. A Doctor's exam may be required as part of the proof. The Plan chooses the Doctor and pays the fees for all required exams. Contributions must be paid by you to continue your dependent child's coverage in the same amounts as required for coverage of non-handicapped dependent children under the Plan.

It is your responsibility to notify, In Writing, the Plan when your dependent child no longer meets the Plan’s definition of handicapped dependent.

The continuation of coverage for your handicapped dependent child stops on the earliest of the following dates:

- the last day of the month in which your child is no longer handicapped according to the Plan;
- the last day of the month in which you do not give the Plan proof of your child's handicap when requested in accordance with the terms discussed above;
- the date on which your dependent coverage would otherwise stop under the Plan (see “Termination of Dependent Coverage” above).

If this handicapped coverage terminates because your dependent coverage would otherwise cease under the Plan (e.g., due to a COBRA Qualifying Event), coverage for your handicapped child may be continued pursuant to COBRA. See the section entitled “Continuation of Healthcare Benefits under COBRA” for additional information.

**Delta Dental Plan**

Delta Dental is the Claims Administrator for the Dental Plan (see the table at the end of the Summary Plan Description entitled “General Information” for contact information).

With Delta Dental, the amount the Plan pays is contingent upon the Dentist you select for your Dental services. There are three categories of Dentists including:

1. PPO Delta Dentist;
2. Delta Premier Dentist;
3. Dentists that have not contracted with Delta.

To receive the highest level of coverage, select a Delta Preferred Option (DPO) Dentist. To receive a DPO listing or to determine if your current Dentist is a Delta Dentist or a Delta Preferred Option (DPO) Dentist, call a Claims Administrator representative directly at (800) 427-3237, or visit the website at www.deltadentalins.com. If a Delta Dentist or a Delta Preferred Option Dentist provides your services, all dental claim forms will be submitted directly
to Delta on your behalf. If you choose any other Dentist, you may be required to submit the claim form to the Claims Administrator.

The following chart provides an overview of both Plans.

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentages given represent what the Plan pays.</td>
<td>DPO Dentists</td>
</tr>
<tr>
<td>Annual Deductible per Individual</td>
<td>$50.00 Waived for Diagnostic, Preventive and Orthodontic Services</td>
</tr>
<tr>
<td>Diagnostic and Preventive Benefits</td>
<td>Oral exams, cleaning, and bite wing X-rays; two exams/cleanings per calendar year; sealants (for dependents under age 15)</td>
</tr>
<tr>
<td>Basic Benefits</td>
<td>Oral Surgery – extractions</td>
</tr>
<tr>
<td></td>
<td>Restorative – fillings</td>
</tr>
<tr>
<td></td>
<td>Endodontic/Periodontal</td>
</tr>
<tr>
<td></td>
<td>Repair of Crowns, fixed bridges, partial dentures, or complete dentures</td>
</tr>
<tr>
<td>Major Benefits</td>
<td>Crowns, jackets, inlays, onlays and Cast Restorations</td>
</tr>
<tr>
<td>Prosthodontic Benefits</td>
<td>Construction of fixed bridges, partial and complete dentures, and dental implants</td>
</tr>
<tr>
<td>Orthodontic Benefits (for dependents up to age 19)</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum Benefit per Calendar Year</td>
<td>Per year per individual (excluding Orthodontics)</td>
</tr>
<tr>
<td>Maximum Lifetime Orthodontic Benefit</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>Key Differences</td>
<td>• Claim forms handled by dental office.</td>
</tr>
<tr>
<td></td>
<td>• Fees are generally less than other Dentists.</td>
</tr>
<tr>
<td></td>
<td>• Reasonable &amp; customary rates charged.</td>
</tr>
<tr>
<td></td>
<td>• Deductible waived and 100% coverage for Diagnostic &amp; Preventive services.</td>
</tr>
<tr>
<td></td>
<td>• Claims are subject to a managed care review process.</td>
</tr>
</tbody>
</table>

**Covered Expenses**

Your Dental program covers several Categories of Benefits when a licensed Dentist provides the services, and when they are necessary and customary under the Generally Accepted standards of dental practice. After you have satisfied any Deductible requirements, the Plan will provide payment for those services deemed eligible at the percentage indicated up to a maximum benefit of $1,500 (except Orthodontics) for each calendar year for each enrolled person.

You must pay the first $50.00 of covered services for each enrolled person in your family in each calendar year. However, the Deductible is waived for Diagnostic and Preventive Benefits if a Delta Preferred Option (DPO) Dentist provides services. The Deductible is waived for Orthodontic Benefits provided by any dentist. Any covered Benefits used toward meeting the Deductible during the last three months of a calendar year will be applied toward the Deductible for the following year.

Payments for orthodontic Benefits are limited to a lifetime maximum of $1,500 for dependent children up to age 19.
All Covered Expenses are subject to exclusions. Certain Covered Expenses are also limited as stated in this section. Covered Expenses include only the expenses incurred by you or your covered dependents to the extent they are Reasonable and Customary. An expense is incurred on the date of treatment, service or purchase. Covered Expenses do not include expenses that are:

- payable under Medical coverage provided under the Plan;
- in excess of the dental maximum benefit.

**Diagnostic and Preventive Treatment Coverage - 80% (100% if using a DPO Dentist)**

The general types of dental treatments covered are as follows:

**Diagnostic**
- Routine examinations
- Diagnostic casts
- Consultation by a specialist
- Biopsy/tissue examination
- Emergency oral exam
- Routine bitewing and Diagnostic x-rays

**Preventive**
- Prophylaxis (cleaning)
- Fluoride treatment
- Space maintainers for missing primary teeth

**Sealants**
- Topically applied acrylic, plastic, or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay. Pit and fissure sealants are limited to eligible dependent children under age 15.

**Limitations on Covered Expenses**
- An oral examination is payable as a Benefit only if the Dentist has an accepted fee on file with the Claims Administrator for this procedure.
- Oral examinations are payable Benefits only twice in a calendar year.
- Prophylaxes (cleanings), fluoride treatments, or procedures that include cleanings are payable Benefits only twice in a calendar year.
- Unless special need is shown, full-mouth X-rays are payable Benefits only once in a three-year period.
- Supplementary bitewing X-rays are payable Benefits twice in a calendar year.
- Pit and fissure sealants are limited to eligible dependent children under age 15. Sealant Benefits include the application of sealants only to permanent posterior molars with no caries (decay), with no restorations and with the occlusal surface intact. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

**Basic Treatment Coverage - 80%**

The general types of dental treatments covered are as follows:

- Oral Surgery for extractions and certain other surgical procedures, including pre-and post-operative care as a Basic Benefit.
- Amalgam, synthetic, plastic, or resin restorations (fillings) for treatment of cavities (decay).
- Root canal therapy; endodontics - treatment of the tooth pulp.
- Periodontics - treatment of gums and bones that support the teeth to stop any severe and recurring symptoms.
- Relining or rebasing after six months from the date of placement of a denture. The Plan covers only one relining or rebasing in a period of 36 consecutive months.
- Repair of Crowns, fixed bridges, partial dentures, or complete dentures.
- Surgical removal of impacted wisdom teeth.

Limitation on Covered Expenses
- Periodontal procedures that include cleanings are subject to the same limitations as other cleanings; i.e., cleanings of any kind are payable Benefits no more than twice in any calendar year.

Major Treatment Coverage - 50%

You or your covered dependents are encouraged to send a Pre-Treatment Estimate form for any major treatment.
- Crowns, jackets, and Cast Restorations are Benefits only if they are provided to treat cavities that cannot be restored with amalgam, synthetic, plastic, or resin fillings.

Limitations on Covered Expenses
- Crowns, jackets, inlays, onlays and Cast Restorations are payable Benefits on the same tooth only once every five years, while you are eligible under any Dental program, unless they determine that replacement is required because the restoration is unsatisfactory as a result of poor quality or care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.
- Any Benefits paid for temporary Crowns, bridges, or dentures are subtracted from Benefits paid for permanent Crowns, bridges, or dentures. The total Benefits paid for temporary dentures will not be more than the maximum benefit for permanent dentures.

Prosthodontic Treatment Coverage - 50%

The Prosthodontic treatments covered are as follows:
- Construction of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth.
- Dental Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture).

Limitations on Covered Expenses
- Prosthodontic appliances are payable Benefits only once every five years unless the Plan determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissues, that the existing appliance cannot be made satisfactory.
- The Claims Administrator will pay the above percentage of the Dentist's fee for a standard partial or complete denture up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of the Claims Administrator's Participating Dentists. A standard partial or complete denture is one made from accepted materials and by conventional methods. The maximum fee allowance is revised periodically, as dental fees change. If your Dentist's accepted fee on file with the Claims Administrator for a partial or complete denture is higher than this maximum allowance, you must pay that portion of his or her fee that exceeds the Claims Administrator's allowance in addition to your portion of the allowance.
- Implants are payable only once every five years up to the maximum fee allowance.

Orthodontic Coverage - 50%

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly are covered Benefits. This coverage applies to only eligible dependent children up to age 19.

Limitations on Covered Expenses
- If Orthodontic Treatment is begun before you become eligible for coverage, the Plan payments will begin with the first payment due to the Dentist following your eligibility date.
- The Dental Plan payments will stop when the first payment is due to the Dentist following either a loss of eligibility or if treatment is ended for any reason before it is completed.
• X-rays and extractions that might be necessary for Orthodontic Treatment are not covered by orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

Exclusions

Your Dental Plan does not cover expenses resulting from:

• services for injuries covered by Worker's Compensation or employer's liability laws, or services that are paid by any federal, state, or local government agency, except Medi-Cal benefits;
• services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel;
• treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth (examples of such treatment are equilibration and periodontal splinting);
• any Single Procedure or bridge, denture, or other Prosthodontic service that was started before you were covered by this program;
• prescribed drugs;
• Experimental Procedures;
• charges by any Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility;
• anesthesia, except for general anesthesia given by a Dentist for covered Oral Surgery procedures;
• grafting tissues from outside the mouth to tissue inside the mouth ("extraoral grafts"), or the removal of implants;
• services for any disturbances of the jaw joints (temporomandibular joints, or "TMJ") or associated muscles, nerves or tissues (See the "Medical Benefit" section);
• orthodontic services, except those provided to eligible dependent children;
• charges for replacement of a lost or stolen prosthetic device or any other device or appliance;
• dietary planning, plaque control or oral hygiene instructions;
• missed appointments or completion of claim forms;
• any dentures, inlays, onlays, bridgework or other appliance or services used mainly for increasing vertical dimension;
• overdentures are not a covered benefit;
• Sickness or Accidental Injury:
  • resulting from any armed conflict, whether declared as war or not, involving any country or government;
  • while in military service for any country or government.

Choosing a Dentist

Delta Participating Dentists: You are free to choose any Dentist for treatment, but it is to your advantage to choose a Delta Participating Dentist. This is because his or her fees are approved in advance by the Claims Administrator. Participating Dentists have treatment forms on hand and will complete and submit the forms to the Claims Administrator.

If you go to a Non-Participating Dentist, the Claims Administrator cannot assure you what percentage of the charged fee may be covered.

A list of Dentists who participate in Delta is available by calling 1-800-427-3237. You can call that phone number to verify that your Dentist is a Delta Participating Dentist.

Delta Preferred Option Dentist (DPO): You are free to choose any Dentist for treatment but choosing a DPO Dentist will provide you with 100% coverage and no Deductible for Preventive and Diagnostic treatment. All fees are approved in advance by the Claims Administrator. DPO Dentists have treatment forms on hand and will complete and submit the forms to the Claims Administrator free of charge.
A list of Delta Preferred Option (DPO) Dentists is available by calling the Claims Administrator at (800) 427-3237 or visit their website at www.deltadentalins.com.

**Claims Procedures**

**Pre-Determinations**

After an examination, your Dentist will talk to you about treatment that you may need. If extensive services are to be provided, such as Crowns or bridges, or if the cost of treatment will be greater than $300, you should have your Dentist obtain Pre-Determination for your treatment.

Pre-determining treatment is recommended to prevent any misunderstandings about your treatment cost and your financial responsibility to your Dentist. If you are not satisfied with the way your Pre-Determination was considered, please contact the Claims Administrator for a review before treatment is done.

In order to receive Pre-Determination, your Dentist should submit an Attending Dentist’s Statement requesting a Pre-Determination from the Claims Administrator for the services you need. The Claims Administrator will send your Dentist a Notice of Pre-Determination, which estimates how much you will have to pay. You should review this information carefully with your Dentist before you schedule the treatment. After the treatment has been completed, your Dentist will return the statement to you or the Claims Administrator for payment.

A Pre-Determination does not guarantee payment. It is an estimate of the amount the Plan will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed. Computations are estimates only and are based on what would be payable on the date the Notice of Pre-Determination is issued if the patient is eligible. Payment will depend on the patient’s eligibility and the remaining annual maximum when completed services are submitted to the Claims Administrator.

**Benefit Payments**

The Claims Administrator will pay Participating Dentists directly. The Claims Administrator's agreement with the Participating Dentists makes sure that you will not be responsible to the Dentist for any money the Claims Administrator owes. However, if for any reason the Claims Administrator fails to pay a Dentist who is not a Participating Dentist, you may be liable for that portion of the cost. If you have selected a Non-Participating Dentist, the Claims Administrator may directly pay you.

If there is a difference between what your Dentist is charging you and what the Claims Administrator says your portion should be, or if you are not satisfied with the dental work you have received, contact the Claims Administrator's Customer and Member Service department (see the section entitled "General Information" for contact information). They may be able to help you resolve the situation.

Your Authorized Representative may act on your behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination.

**Urgent Care Claims**

In the case of an Urgent Care Claim, the Claims Administrator will notify you of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan’s receipt of the Urgent Care Claim, unless you fail to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan.

In the case of such failure by you to provide sufficient information or a failure by you to follow the Plan’s procedures for filing an Urgent Care Claim, the Claims Administrator will notify you as soon as possible, but not later than twenty-four (24) hours after the Plan’s receipt of the Urgent Care Claim, of the specific information
necessary to complete the Urgent Care Claim. You will be afforded a reasonable time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

The Claims Administrator will notify you of the Plan’s benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the Plan’s receipt of the specified information, or the end of the forty-eight (48) hour period afforded you to provide the specified information.

Non-Urgent Care Claims

In the case of a Non-Urgent Care Claim, benefit determination shall be made in accordance with this section.

Pre-Service Claims – A Pre-Service claim is a request for authorization of medical care or treatment that you have not yet received, which is conditioned in whole or in part on the Claims Administrator’s approval of coverage in advance of obtaining the medical care. The Claims Administrator does not require Pre-Service Claims. However, the Claims Administrator does provide for Pre-Determination of claims (see section above entitled “Pre-Determinations”).

Post-Service Claims – In the case of a Non-Urgent Care Claim that is a Post-Service Claim, the Claims Administrator will notify you of the Plan’s adverse benefit determination within a reasonable time period, but not later than thirty (30) days after the Plan receives the claim. The Plan may extend this period one time for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the Plan’s control and notifies you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

Special Rules Regarding Concurrent Care – If the Plan has approved previously an ongoing course of treatment to be provided over a period of time or number of treatments:

- Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period or number of treatments will constitute an adverse benefit determination. The Claims Administrator will notify you of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- If your request is an Urgent Care Claim to extend the course of treatment beyond the period or number of treatments, it will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify you of the benefit determination, whether adverse or not, within twenty-four (24) hours after the Plan’s receipt of the claim, provided that any such claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period or number of treatments.

Calculating Time Periods for Benefit Determinations

The time within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that the time within which a benefit determination is required to be made is extended as permitted, for claims other than Urgent Care Claims or Concurrent Care claims, due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the Claims Administrator sends the notification of extension to you until the date on which you respond to the request for additional information.

Notice of Benefit Determination
The Claims Administrator will provide you with written or electronic notification of any adverse benefit determination. If the notice of an adverse benefit determination is provided electronically, such notice will comply with the standards imposed by the Department of Labor regulations.

Any notice of adverse benefit determination will set forth, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provision on which the adverse benefit determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan’s appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request;
- If the adverse benefit determination is based on Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- If the adverse benefit determination relates to an Urgent Care Claim, a description of the expedited review process applicable to Urgent Care Claims.

In the case of adverse benefit determination concerning an Urgent Care Claim, the information described above may be provided to you orally within the time frame prescribed above; provided however, that a written or electronic notice is provided to you in the manner set forth in this section not later than three (3) days after the oral notification.

**Appeals Procedures**

**General Appeals Procedure**

If you receive an adverse benefit determination, you may appeal the adverse benefit determination within one hundred eighty (180) days after your receipt of the notice of adverse benefit determination. You must make any appeal in writing. You should include a copy of the treatment form and the notice of payment you received from the Claims Administrator. Clearly explain why you think the denial is wrong. The appeal should be sent to the Claims Administrator at their home office address as listed in the "General Information" section.

During the one hundred eighty (180) day period, you may:

- Submit written comments, documents, records, and other information relating to the claim for benefits; and
- Request and receive, free of charge, reasonable access to, and copies of, all relevant records.

The review will be made by one or more dental consultant(s) who are neither the individuals who made the initial adverse benefit determination, nor the subordinate of any such individuals. The review of your appeal will not give deference to the initial adverse benefit determination. The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In deciding the appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the dental consultant may speak with other healthcare professionals who have appropriate training and experience in the field of medicine involved in the medical
judgment, or to a peer review committee of the local dental society. Such health care professional must be an individual who is neither the individual who was consulted in connection with the initial adverse benefit determination, nor the subordinate of such individual.

The Claims Administrator will provide you with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

**Expedited Appeals Involving Urgent Care Claims**

If the adverse benefit determination involves an Urgent Care Claim you may submit a request, either orally or In Writing, for an expedited appeal. If you request an expedited appeal of Urgent Care Claim, all necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

**Timing of Notice of Benefit Determination on Appeal**

**Urgent Care Claims** – In the case of an Urgent Care Claim, the Claims Administrator will notify you of the Plan’s benefit determination on appeal as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan’s receipt of your request for review of an adverse benefit determination.

**Post-Service Claims** – In the case of a Non-Urgent Claims that is a Post-Service Claim, the Claims Administrator will notify you of the Plan’s benefit determination on appeal within a reasonable period, but not later than sixty (60) days after receipt by the Plan of the Claimant’s request for review of an adverse benefit determination.

**Calculating Time Periods for Appeals Procedure**

The period of time within which a benefit determination on appeal is required to be made shall begin at the time an appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

**Notice of Benefit Determination on Appeal**

The Claims Administrator will provide you with written or electronic notification of the Plan’s benefit determination on appeal. Any electronic notification shall comply with the Department of Labor Regulations.

In the case of an adverse benefit determination, the notification will set forth, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant records;
- A statement of your right to bring an action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- If the adverse benefit determination is based on medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and State insurance regulatory agency.

**Untimely Submission of Claims by Participating Dentists**

The Claims Administrator may deny payment of an Attending Dentist’s Statement for services submitted more than six months after the date the services were provided. If a claim is denied due to a Delta Participating Dentist’s failure to make a timely submission, you shall not be liable to that Dentist for the amount which would have been payable by the Claims Administrator (unless you failed to advise the Dentist of your eligibility at the time of treatment).

**Complaint Procedure**

If you have questions or complaints regarding the policies, procedures or operations of the Claims Administrator, or the quality of dental services performed by a Delta Dentist, you may contact the Claims Administrator by calling toll-free (800) 765-6003 or contact the Claims Administrator on the Internet through E-mail: cms@delta.org or through the web site: www.deltadentalins.com, or write to the Claims Administrator at P.O. Box 997330, Sacramento, CA 95899, Attention: Customer Service Department. (Any questions of ineligibility should be handled with TSRI Human Resources at (858) 784-8487). If you write to the Claims Administrator, you must include the name of the patient, the group name and number, the eligible participant’s name and social security number, and a telephone number on all correspondence.

The Claims Administrator will review the complaint and will resolve the matter within 30 days of receipt or inform you of the pending status of the complaint if more information or time is needed to resolve the matter.

**Second Opinions**

The Claims Administrator reserves the right to obtain second opinions through regional consultant members of its quality review committee. This committee conducts clinical examinations, prepares objective reports of dental conditions, and evaluates treatment that is proposed or has been proposed.

The Claims Administrator will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a predetermination of treatment cost by a Dentist. The Claims Administrator will also authorize a second opinion after treatment if a participant has a complaint regarding the quality of care provided. The Claims Administrator will notify the participant and the treating Dentist when a second opinion is necessary and appropriate, and direct the participant to the regional consultant selected by the Claims Administrator to perform the clinical examination. When the Claims Administrator authorizes a second opinion through a regional consultant it will pay for all charges.

The participant may otherwise obtain second opinions about treatment from any Dentist they choose, and claims for the examination or consultation may be submitted to the Claims Administrator for payment. The Claims Administrator will process such claims in accordance with the Benefits of the program.

A copy of Delta’s formal policy on second opinions is available from Delta’s Customer and Member Service Department, upon request.

**Coordination of Benefits**

Coordination of Benefits determines the way Benefits are payable if you or your family member is covered by more than one dental plan. Under Coordination of Benefits, you or your covered dependent will not receive more than the allowed expenses for a loss. Under no circumstances will this Plan consider coordinating Benefits between two individuals enrolled under different options within the Plan.

**Allowed Expenses**
The allowed expense for Coordination of Benefits is the Reasonable and Customary expense for dental care or treatment. Part of the expenses must be covered under at least one of the plans covering you or your covered dependent.

**Effect on Dental Benefits**

The Coordination of Benefits provision applies when the participant or the participant's covered dependent has dental coverage under more than one plan. If this provision applies, the benefit determination rules state whether this Plan pays before or after another plan.

The Benefits of this Plan:

- will not be reduced when this Plan is primary;
- may be reduced when another plan is primary and this Plan is secondary. The Benefits of this Plan are reduced so that they and the Benefits payable under the other plan do not exceed 100% of the allowed expenses;
- will not exceed the Benefits payable in the absence of other coverage.

**Plans Subject to Coordination of Benefits**

Plans subject to Coordination of Benefits are:

- this Plan;
- any group, blanket, or franchise health coverage;
- a group contractual pre-payment or indemnity plan;
- a health maintenance organization (HMO), whether group practice or individual practice association;
- a labor-management trustee plan or a union welfare plan;
- an employer or multi-employer plan or participant benefit plan;
- a government program;
- coverage required or provided by statute.

Plans not subject to Coordination of Benefits are any individual or family policies or contracts or public medical assistance programs.

**Primary Plan/Secondary Plan**

When this Plan is primary, its Benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan is secondary, its Benefits are determined after those of the other plan. Its Benefits may be reduced because of the other plan's benefits. Under Coordination of Benefits, you or your covered dependent will not receive more than the allowed expenses for a loss. When there are more than two plans, this Plan may be primary to one and may be secondary to another.

**Order of Benefit Determination Rules**

The Plan determines its order of Benefits by using the first of the following that applies:

**General** - A plan that does not coordinate with other plans is always the primary plan.

**Non-dependent/Dependent** - The benefit of the plan, which covers the person as a participant, member, or subscriber (other than a dependent), is the primary plan; the plan that covers the person as a dependent is the secondary plan.

**Dependent Child/Parents Not Separated or Divorced** - When this Plan and another plan provide coverage for the same dependent, the primary coverage is determined as follows:

- The primary plan is the plan of the parent whose birthday (month and date) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year.
If both parents have the same birthday, the benefits of the plan, which covered the parent the longer is the primary plan; the plan that covered the parent the shorter time is the secondary plan.

If the other plan does not have the birthday rule but has the male/female rule and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

**Dependent Child/Separate or Divorced Parents** - If two or more plans cover a person as a dependent child of divorced or separated parents, Benefits for the child are determined in this order:

- first, the plan of the parent with custody of the child;
- then, the plan of the spouse of the parent with custody;
- finally, the plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, that plan is the primary plan. This paragraph does not apply with respect to any Benefit Period or plan year during which any Benefits are actually paid or provided before the entity has actual knowledge.

**Joint Custody** - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

**Active/Inactive Participant** - The primary plan is the plan that covers the person as a participant who is neither laid off nor retired (or as that participant's dependent). The secondary plan is the plan that covers that person as a laid off or retired participant (or as that participant's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule does not apply.

**Continuation of Coverage** - If coverage is provided for a person under a right of continuation according to Federal or state law and the person is also covered under another plan, the following will be the order of benefit determination:

- First, the benefits of a plan covering the person as a Participant, member or subscriber (or as that person's dependent);
- Second, the benefits under the continuation coverage.

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

**Longer/Shorter Length of Coverage** - If none of the above rules determine the order of Benefits, the primary plan is the plan that covered a participant, member, or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

**Miscellaneous Provisions**

**Right to Receive and Release Information**

Certain facts are needed to Coordinate Benefits. The Claims Administrator in its capacity has the right to decide which facts it needs. The Claims Administrator may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

**Facility of Payment**

The payment made under another plan may have included an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it was a Benefit paid under this Plan. The Plan will not pay that amount again. The term "payment made"
includes providing Benefits in the form of services. In this case, "payment made" means the reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have been, the Plan may recover the excess from one or more of the:

- persons the Plan has paid or for whom it has paid;
- insurance companies;
- other organizations.

The "amount of payments made" includes the reasonable cash value of any Benefits provided in the form of services.

If you or your insured dependent is a Medicaid recipient, the state may have collection of debt rights. The Plan will honor these rights.

Health Coverage Assignment

You or your covered dependent may not transfer to anyone else:

- ownership of any book or Summary Plan Description issued under the Plan;
- health coverage under the Plan.

Exam

When reasonably necessary, the Plan may have you or your covered dependent examined while a claim is pending under the Plan. The Plan pays for the initial exam.

Medical and Dental Plan Definitions

Accidental Injury
An accidental injury is a bodily injury resulting from a sudden, violent, unexpected, and external event. All injuries received in one accident are considered as one accidental injury. Infection resulting from a cut or wound caused by an accident is also an accidental injury.

Accidental injury does not include disease or any other type of infection except as stated above.

Active Work, Actively at Work
Active at work means that the participant is physically present at his or her customary place of employment with the intent and ability to work the scheduled hours and do the normal duties of his or her job on that day.

A participant will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. A participant will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his/her own health status. An exception applies only to a participant's first scheduled day of work. If a participant does not report for employment on his/her first scheduled workday, he will not be considered as having commenced active employment.

Attending Dentist's Statement
An attending dentist's statement is a form used by your Dentist to request payment for dental treatment or pre-authorization for proposed dental treatment.
**Average Wholesale Price**
The published cost of a drug product to the wholesaler.

**Benefit Percentage**
The benefit percentage is the percentage of Covered Expenses the Plan pays.

**Benefit Period**
The benefit period is a calendar year, unless the Schedule of Benefits states a different time period for a specific benefit.

**Benefits**
Benefits are those medical and dental services available as described in this Summary Plan Description.

**Carry-Over Deductible**
Carry-over deductible means that any Covered Expenses used toward meeting the Plan Deductible during the last three months of a Benefit Period, as defined previously will be applied toward the Deductible for the next Benefit Period. A Benefit Period is the same as the calendar year.

**Categories of Dental Benefits**
The categories are:

- **Diagnostic:** Procedures to help the Dentist evaluate your dental health to determine necessary treatment.
- **Preventive:** Procedures to prevent dental disease (cleanings, for example).
- **Basic:** Procedures necessary to restore the teeth (other than crowns or cast restorations), oral Surgery, endodontic (root canals) and periodontic (gum) procedures.
- **Crowns and cast restoration:** Caps, veneers, inlays, and onlays.
- **Prosthodontic:** Procedures involving bridges and dentures to replace missing teeth.
- **Orthodontic:** Procedures involving appliances (such as braces) or Surgery to realign teeth and/or jaws which otherwise do not function properly.

**Claims Administrator**
For the Medical Plan, the claims administrator is UMR or any entity authorized by the Plan Administrator to process claims for benefits under this plan. For the Dental Plan, the claims administrator is Delta Dental.

**Close Relative**
A close relative is your spouse, or a person related to you or your spouse in any one of the following ways: brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), or parent (includes stepparent).

**COBRA**
COBRA means Consolidated Omnibus Budget Reconciliation Act of 1985. This Federal law requires that TSRI offer continuation coverage for those participants covered by the Medical Plan, Dental Plan and/or Healthcare Spending Account under certain limited circumstances. The conditions of this coverage are described in the section entitled "Continuation of Healthcare Benefits under COBRA."

**Common Accident Deductible**
The Plan requires only one individual Deductible be met if you and one or more of your covered dependents, or two or more of your covered dependents incur Covered Expenses from the same accident for the Benefit Period in which
the accident occurs and also the next Benefit Period. This Deductible applies only to those Covered Expenses incurred because of the accident.

**Complication of Pregnancy**
Complication of pregnancy is a condition that requires Hospital Confinement and that is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples are acute inflammation or disease of the kidney or bladder, cardiac decompensation, missed abortion, an ectopic pregnancy, non-elective cesarean section and eclampsia.

Complication of pregnancy does not include normal delivery, elective cesarean section, miscarriage, elective abortion, false labor, occasional spotting, morning sickness, excessive vomiting, pre-eclampsia, and other conditions associated with a difficult pregnancy.

**Concurrent Review**
A Utilization Review conducted during a patient's Hospital stay or course of treatment.

**Continued Stay Review**
A review by the Utilization Management Provider of a Doctor's report of the need for continued Hospital Inpatient confinement to determine if the continued stay is for Medically Necessary Care.

**Utilization Management Provider**
The organizations designated by the Plan Administrator to perform certain procedures described in the utilization review section.

**Covered Expense**
Covered expenses are only the expenses incurred by you or your covered dependent to the extent that they are Reasonable and Customary and Medically Necessary. An expense is incurred on the date of treatment, service, or purchase.

**Custodial Care**
Custodial care is services and supplies, including daily room and board, to help a person with personal hygiene and in the activities of daily living. Continuous attention by trained medical or paramedical personnel is not necessary. Custodial care may include:

- preparation of special diets;
- assisting the person to get in and out of bed, dress, eat, bathe or walk;
- supervision of medicine that can be self-administered.

**Deductible**
The deductible is the amount of Covered Expenses you or your covered dependent must incur during the Benefit Period before the Plan pays Benefits.

**Delta Dental**
Delta Dental is the claims-paying agent for TSRI's self-funded Dental Plan. Whenever Delta Dental is referred to in this Summary Plan Description it is in its capacity as a claims-paying agent. Please see the section entitled "General Information" for contact information.

**Delta Preferred Option (DPO) Dentist**
A DPO Dentist is a Participating Dentist who has signed an agreement with Delta Dental, agreeing to provide services under the terms and conditions established by Delta.

**Dentist**
A dentist is a person, other than a Close Relative, licensed to practice dentistry in the state in which the treatment is received.
Doctor or Physician
A doctor or physician is a person, other than a Close Relative, licensed to practice medicine in the state in which treatment is received. State law may require that Benefits be paid for professional services of a practitioner other than a medical doctor. If so, the term "doctor" also includes persons recognized as qualified to treat the Sickness or Accidental Injury for which claim is made by the state in which treatment is received. See also the definition for Health Care Practitioner and Health Care Provider.

Election of Coverage
The election of coverage is your election of a Plan for coverage. If no election for coverage is made, your right to elect coverage will be forfeited and TSRI will designate the Plan through which you will receive coverage.

Emergency
Any treatment or service that the Claims Administrator determines to be due to the sudden onset of severe medical symptoms that:

- could not have been reasonably anticipated; and
- require immediate medical care.

Emergency Admission
An emergency admission is a Hospital admission for a condition that is an Emergency as described above and unless promptly treated could cause serious damage to the bodily functions.

Employer
The employer is The Scripps Research Institute (TSRI).

Educational, Experimental, Investigational, or Research Services or Procedures
Any medical or surgical treatment or procedures, or any facility, drug, drug usage, equipment or supply that is determined by the Plan or its delegate to be educational, experimental, investigational or done for research will not be covered under the Plan. This provision applies unless otherwise specifically stated elsewhere in this Summary Plan Description.

The Plan or its delegate has final discretionary authority to determine whether a treatment, procedure, facility, drug, drug usage, equipment or supply is educational, experimental, investigational or done for research. The Plan or its delegate may use consultant services, peer review or other sources to assist in making that determination. The Plan or its delegate will not make medical or treatment decisions for you or your covered dependents. The right to make these decisions remains at all times with you and your covered dependents. The Plan’s or its delegate’s determination as to the educational, experimental, investigational, or research nature of a service or procedures will not constitute a medical or treatment decision.

In making these determinations, the Plan or its delegate will consider whether a treatment, procedure, facility, drug, drug usage, equipment or supply meets the following:

- it has been approved by the Food and Drug Administration (“FDA”) specifically for the particular indication or application in question.
- its use or application has not been largely confined to laboratory and/or animal research.
- it has been accepted by the majority of recognized medical professionals or appropriate government agencies as being proven and effective in clinical medicine.
- there is sufficient information in the peer-reviewed medical and scientific literature that is based upon credible, well-defined, randomized and controlled data to enable the Plan or its delegate to make conclusions about its safety and effectiveness.
- it is as safe and effective as existing diagnostic or therapeutic alternatives.
- it can be reasonably expected to provide:
  - safety and effectiveness.
a net beneficial effect on health outcomes for the particular indication or application in question.

**Extended Care Facility**

An extended care facility is any one of the following:

- a facility owned and operated by a Hospital or under Written contract with a Hospital;
- a distinct part of a Hospital;
- a facility or distinct part of a facility that meets the requirements for approved operation under Medicare.

The facility must:

- be operated, including any necessary licensing, according to the laws of the state or locality in which it is located;
- be primarily engaged in providing care for persons recovering from Sickness or injury;
- be under the supervision of a Doctor or staff of Doctors on call at all times;
- provide all of the following:
  - room and board;
  - skilled 24-hour Inpatient nursing services by a full-time R.N. or other nursing staff under the supervision of a Doctor or R.N. on duty at least eight hours per day;
  - adequate medical records for each patient;
  - necessary and customary special services.

An extended care facility is not an institution that is primarily a clinic, rest home, home for the aged, or place for Custodial Care.

**Family Deductible**

The family deductible is the maximum amount your family must pay for Plan Deductibles for the calendar year. To satisfy the family deductible, three persons must satisfy their individual deductible.

**Generally Accepted**

Treatment or service for the particular Sickness or injury which is the subject of claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical or dental community; and
- is not under scientific testing or research

**Health Care Extender**

An allied health practitioner who is delivering medical services under the direction and supervision of a Physician.

Direction and supervision means the Physician co-signs any progress notes Written by the health care extender; or there is a legal agreement that places overall responsibility for the health care extender’s services on the Physician.

**Health Care Practitioner**

A health care practitioner is a Doctor of Medicine (MD); Doctor of Osteopathy (DO); Acupuncturist; Audiologist; Certified Registered Nurse Anesthetist (CRNA); Certified Respiratory Care Practitioner; Chiropractor; Dentist; Mental Health Nurse/Professional (when services are provided in conjunction with Hospice); Certified Midwife; Nurse Practitioner; Occupational Therapist; Optometrist; Physical Therapist; Physician’s Assistant; Podiatrist (DPM); Psychologist; Social Worker; and Speech Pathologist who:

- is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and
- acts within the scope of his or her license and/or scope of practice; and
- is not a Close Relative of the patient.
Health Care Provider
A health care provider is a Health Care Practitioner as defined above, or a Hospital, ambulatory surgical facility, birthing center, Home Health Care Agency, Hospice, and Extended Care Facility.

Health Professional
An individual who:

- has undergone formal training in a health care field;
- holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and
- has professional experience in providing direct patient care.

Home Health Aide
A person, other than a licensed registered nurse (R.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency
A Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

Home Health Care Plan
A program of home care that:

- is required as the result of a Sickness or injury; and
- prevents, delays, or shortens a Hospital confinement or Extended Care Facility confinement; and
- is documented in a Written plan of care; and
- is reviewed and certified by a Doctor to be necessary.

Hospice
A facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage Hospice Care Programs; and
- arranges, coordinates, and/or provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program
A program:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Doctor; to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team
A group that provides coordinated Hospice Care Services and normally includes:

- a Doctor/Physician;
- a patient care coordinator (Doctor or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

**Hospital**
A hospital is a public or private institution or facility licensed as a hospital in the state in which it is located and which meets the following conditions:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
- provides for a fee from its patients, diagnostic, medical, or surgical facilities for the care and treatment of people who are injured or ill;
- has a staff of one or more Doctors available on a 24-hour a-day basis;
- has 24-hour-a-day services of R.N.’s or other nursing services reporting to the Doctor in charge;
- has Inpatient facilities.

For Surgery Benefits under the Plan, hospital includes freestanding Outpatient surgical centers licensed in the state in which treatment is received.

A hospital is not an institution that is primarily a rest home, Extended Care Facility, or home for the aged or disabled.

**Hospital Room Maximum**
Charges by a hospital for room and board while confined but not to exceed the hospital room maximum for each day of confinement in a private room. The hospital room maximum includes room and board charges up to:

- The hospital’s most frequent semiprivate room rate if the hospital has semiprivate rooms; or
- The hospital’s most frequent private room rate, if the hospital has no semiprivate rooms; or
- The hospital’s daily billed room rate if the charge is less than the semiprivate room rate.

**Hospital Admission Deductible**
A hospital admission deductible is applicable to non-preferred provider admissions, for you or your covered dependent if you participate in the Comprehensive Medical Plan. In addition to the Plan Deductible, you pay this hospital admission deductible under your Medical Plan each time you or your covered dependent is admitted to and confined in a non-preferred provider facility.

The hospital admission deductible will not be applied towards the:

- Plan Deductible;
- Family Deductible;
- the Carry-over Deductible;
- the Common Accident Deductible;
- co-insurance (maximum out-of-pocket expenses);
- any other Deductible amount.

**Initial Clinical Review(er)**
A Clinical review conducted by appropriate licensed or certified Health Professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

**Inpatient**
Inpatient means a person who is admitted to a Hospital and confined for at least 23 consecutive hours.
L.P.N.
An L.P.N. is a full-time licensed practical nurse, other than a Close Relative, who is recognized by the state in which care is given as qualified to perform limited nursing functions.

Medically Necessary
Medically necessary means that the services, care, treatment or supplies must be determined by the Plan or its delegate to meet all of the following conditions:

- prescribed by a Doctor and required for the screening, diagnosis or treatment of a medical condition; and
- consistent with the diagnosis or symptoms; and
- not excessive in scope, duration, intensity or quantity; and
- the most appropriate level of services or supplies that can safely be provided; and
- determined by the Plan Administrator or its delegate to be Generally Accepted.

The Plan or its delegate has final discretionary authority to determine all questions of medical necessity. The Plan or its delegate may use consultant services, peer review or other sources to assist in making that determination. The Plan or its delegate will not make medical or treatment decisions for you or your covered dependents. The right to make these decisions remains at all times with you or your covered dependent. The Plan’s or its delegate’s determinations of medical necessity will not constitute a medical or treatment decision.

Medicare
Medicare is Health Insurance for the Aged and Disabled, established by Title XVIII, United States Social Security Act, as now in effect and as it may be amended in the future.

If you are currently eligible or may become eligible in the near future for Medicare, Federal law gives you more choices about your prescription drug coverage. Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. If you decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage through TSRI, be aware that you may not be able to get this coverage back. For additional information regarding the Medicare Part D Prescription Plan, contact Benefits Administration.

Network Provider
A network provider is a Doctor, nurse, Hospital, ambulatory surgical or medical center, Home Health Care Agency, or any other Health Care Provider who is participating in the preferred provider arrangement under the Plan.

Noncertification
A decision by the Utilization Management Provider that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Utilization Management Provider's requirements for Medically Necessary Care, appropriateness, health care setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

Non-Emergency Admission
Non-emergency admission is an elective admission that is scheduled prior to you or your covered dependent's entering the Hospital.

Non-Network Provider
A non-network provider is a Doctor, nurse, Hospital, ambulatory surgical or medical center, Home Health Care Agency, or any other Health Care Provider who is not participating in the preferred provider arrangement under the Plan.

Non-Participating Dentist
A non-participating dentist is a Dentist who has not signed an agreement with Delta Dental and whose fees therefore, have not been accepted as Reasonable and Customary.
Notification of Utilization Review Services
Receipt of necessary information to initiate review of a request for Utilization Review services to include the patient’s name and your name (if different from patient’s name), attending Physician’s name, treating facility’s name, diagnosis, and date of service.

Ordering Provider
Any Physician or other provider who specifically prescribes the health care service being reviewed.

Orthodontic Treatment
Orthodontic treatment means essential services required for straightening misaligned teeth by the use of braces.

Outpatient
Outpatient is a patient who receives diagnosis or treatment at a facility, but does not incur room and board charges.

Participating Dentist
A participating dentist is a Dentist who has a signed agreement with Delta Dental. These Dentists have filed their usual fees that have been accepted by Delta as Reasonable and Customary. They agree to charge Delta patients these accepted fees.

Peer Clinical Review(er)
A clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the peer clinical reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Period of Hospital Confinement
Period of hospital confinement is all hospital confinements for the same or related Sickness or Accidental Injury. Unless otherwise stated in your Summary Plan Description, a new period begins:

- for your covered dependent when the periods are separated by at least 30 days;
- when you or your covered dependent is confined for a new Sickness or Accidental Injury.

Plan
The Plan refers to The Scripps Research Institute's Medical or Dental Plan.

Plan Administrator
The Plan Administrator is responsible for interpreting and administering the terms and provisions of the Benefit Plans. The Plan Administrator and any representative whom it chooses to assist it to carry out its responsibilities under the Plan shall have the maximum discretionary authority permitted by law to interpret, construe, and administer the Plan. In addition, the Plan Administrator has the right to make determinations regarding Plan participation, enrollment and eligibility for Benefits, to evaluate and determine the validity of Benefit claims, and to resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive Benefits and payments pursuant to the Plan. The decisions of the Plan Administrator and its representatives shall be given the maximum deference permitted by law.

Post-Service Review
A Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of treatment.
Pre-Admission Certification (for the Medical Plan)
When using a Non-Network Provider, or if enrolled in the Catastrophic Medical Plan, you must obtain approval for admission prior to entering the Hospital in order to receive the optimal Benefit. You must initiate this process through the Utilization Management Provider. TSRI’s Preferred Provider network is UHC. The Utilization Management Provider must approve all Hospitalizations and surgeries for you to receive optimal Benefit coverage, even if you are enrolled in the Catastrophic Medical Plan.

Pre-Authorization Deductible
You pay this Deductible each time you or your covered dependent is admitted to the Hospital, and pre-authorization is not obtained from the Utilization Management Provider. There is no pre-authorization deductible in the Comprehensive Medical Plan when a Network Provider is used.

Pre-Determination
A pre-treatment determination is a statement from the Claims Administrator to the attending Dentist, which indicates the required procedures and the cost associated with the treatment prior to the commencement of such treatment.

Preferred Provider
A preferred provider is a Doctor, nurse, Hospital, ambulatory surgical or medical center, Home Health Care Agency, or any other Health Care Provider who is participating in the preferred provider arrangement under the Plan.

Pre-Service Review
A Utilization Review conducted prior to a patient’s stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or precertification.

Reasonable and Customary
Reasonable and customary describes those charges for Medically Necessary services or supply that fall within the usual range of charges for the same service or supply in a geographical area as determined by the Claims Administrator using proprietary data that is provided by a reputable company or entity and is updated no less frequently than annually.

The Plan will not always pay Benefits equal to or based on the Doctor’s or other Health Care Provider’s actual charge for services or supplies. This is because the Plan covers only reasonable and customary charges for health care services and supplies. For this Plan, an actual charge for a treatment or service will be in excess of reasonable and customary charges only if, as determined by the Claims Administrator, 90% or more of all other charges reported to the Claims Administrator for the same (or a similar) treatment or service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

Any unusual charges for a service or supply will be considered usual when additional time, skill, and experience have been required because of any special circumstances or medical complications involved in providing that service or supply.

If you elect the Comprehensive Medical Plan option and use a Preferred Provider, that provider’s charge will be deemed to be reasonable and customary under the Plan.

For drugs and medicines requiring a Doctor’s prescription and considered a covered treatment or service, if the reasonable and customary charge cannot be determined as described above, Average Wholesale Price will be applied.

For the Dental Plan, this is an allowance determined by Delta Dental for services provided by a Dentist who is not a Delta DPO Dentist.

R.N.
An R.N. is a full-time registered graduate nurse, other than a Close Relative, who is recognized by the state in which care is given to perform all nursing functions.
Sickness
A sickness is any physical illness, mental illness, normal pregnancy, or Complication of Pregnancy.

Single Procedure
A single procedure is a dental procedure to which the Claims Administrator has assigned a separate procedure number; for example, a three-surface amalgam restoration of one permanent tooth (procedure 613) or a complete upper denture, including adjustments for a 6-month period following installation (procedure 700).

Student Dependent
A student dependent is a dependent who has his or her chief place of residence with you, does not have a regular full-time job, and is a full-time student physically attending classes at a school with a regular teaching staff, curriculum, and student body.

The Plan considers "full-time" to be the number of credits or courses required for full-time students by the school your dependent is attending.

Summary Plan Description
Summary Plan Description means this document, which summarizes the Plan and its provisions as the Plan applies to you. The term also includes any certificate riders and revisions to the Plan.

Surgery
Surgery is the branch of medicine that treats diseases, injuries, and deformities by cutting or instrumental operations.

Transplant Network
Any network of providers that TSRI determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule.

UHC
The network of Doctor’s and facilities contracted with United Healthcare to provide medical services. To search for a provider in your area, visit www.umr.com and review the directory for UHC. Click on “Find a Provider”, then “Medical”, then “UnitedHealthcare Options PPO”. Your PPO network will then be listed and you can continue to follow the prompts. A list of UHC Doctors and facilities can also be obtained by calling the claims administrator’s customer service number at (800) 834-3482.

Urgent Review
A Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to your or the patient’s life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of your or the patient’s medical condition, would subject you or the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the Utilization Management Provider’s decision using the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Utilization Review (UR)
Utilization review is used for both cost and quality control of Medical Plans through a variety of mechanisms including pre-authorization for Hospitalization, and review of treatment.

Written, In Writing
Written, In Writing means signed, dated, and received at the appropriate Plan's Claims Administrator's home office, as listed in the "General Information" section, in a form the Claims Administrator accepts.
Mental Health and Substance Abuse Plan

Participants and dependents covered through TSRI’s Medical Plan are eligible for mental health and chemical dependency benefits provided by United Behavioral Health (UBH). If you enroll in the TSRI Comprehensive or Catastrophic Medical Plans, you are subsequently enrolled in this Plan.

What This Plan Pays

Benefits are payable for Covered Expenses incurred by a covered Person for Behavioral Health Services received from either Network or Non-Network Providers.

For outpatient services from a Network Provider, each Covered Person must satisfy certain Copayments before any payment is made for Behavioral Health Services. Care received from Non-Network Providers requires the Covered Person to pay a Percentage of Covered Expenses.

Schedule of Benefits

<table>
<thead>
<tr>
<th></th>
<th>Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td>90%</td>
<td>70% after a $200 copay</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maximum Benefits

| Out-of-Pocket Max (per calendar year) | $1,500/person | $3,000/person |
|                                      | $3,000/family | $6,000/family |

ALL BENEFITS MAY BE SUBSTITUTED AND/OR CONVERTED TO ALTERNATIVE LEVELS OF CARE WITH CARE MANAGEMENT APPROVAL.

NON-NETWORK BENEFITS ARE LIMITED TO USUAL & CUSTOMARY REIMBURSEMENT FOR THE SERVICES PROVIDED.

In addition to the information here, the Mental Health and Substance Abuse Insurance Plan publishes a "Certificate of Insurance" that outlines:

- the services available to enrolled members - as well as the Plan's benefit limitations and exclusions;
- the conditions that must be satisfied in order to receive those services;
- the conditions that must be satisfied to be insured;
- the circumstances under which services may be denied; and
- the procedures for reviewing claims for services that are denied.
The terms of the Mental Health and Substance Abuse Insurance Plan Certificate of Insurance are incorporated into this Summary Plan Description by reference, and made a part of this description, as though fully set forth herein. Before enrolling in the Mental Health and Substance Abuse Plan, you may want to review the Plan's Certificate of Insurance. You can obtain a copy of the Plan's Certificate of Insurance from Human Resources at no charge. You will also receive a copy of the Plan's Certificate of Insurance when you enroll.

**Employee Assistance Program (EAP)**

The Employee Assistance Program provided by United Behavioral Health has been established to provide no-cost confidential, professional counseling services to benefit eligible employees, graduate students and their dependents (including domestic partners) whose personal problems may be affecting their lives and work/academic performance. Enrollment in the plan is automatic and eligibility for services begins as of the employee’s/graduate student’s date of hire/enrollment and continues unless a change in benefit eligibility occurs due to a change in employment/enrollment status. The program also provides information on community resources and referrals, if necessary.

Non-emergency counseling by a licensed professional is available at no charge for such issues as:

- Marital or relationship difficulties
- Parenting issues
- Elder/adult care services
- Drug and alcohol-related problems
- Emotional concerns
- Financial or legal difficulties
- Job-related issues
- Stress

What you discuss is held in the strictest confidence in accordance with professional ethics and state/federal law. All records are maintained separately from medical and personnel/department files and are not released without your written consent. Employee, student and dependent participation in the program is voluntary. Supervisors may suggest counseling to employees and students when they perceive that personal problems may be affecting work/academic performance.

To seek help, contact United Behavioral Health (UBH) at (866) 374-6061 as soon as you recognized that there is a problem that is too difficult to handle alone. Early intervention provides an opportunity to deal with and resolve difficulties before there is a significant impact on work, school or home life.

If the situation is life threatening go directly to a hospital emergency room or call 9-1-1 for assistance. For those TSRI employees, graduate students and covered dependents covered by the Mental Health Plan through United Behavioral Health (UBH) there is a 24-hour psychiatric help line available through UBH at 1-800-888-2998. There may be a charge for these services depending on the level of care provided and the type of services provided. Please refer to the Mental Health and Substance Abuse Plan and/or the Medical Plan section of the appropriate TSRI Health and Welfare Plan Summary Plan Description for more information.

There are no fees to employees, graduate students or covered dependents for any services provided through the Counseling and Postdoctoral Services Department. Therefore, there is no need to file claims for payment/reimbursement. Referral to other programs may be partially covered under TSRI’s Medical or Mental Health and Substance Abuse Plan. Please refer to the appropriate section of this Health and Welfare Summary Plan Description or contact Benefits Administration at 858-784-8487 or benefits@scripps.edu for more information about the coverage provided under these plans.

If you are no longer eligible for coverage because you cease active employment/enrollment, cease to be in an eligible job classification, or you begin to work fewer hours than required under the definition of an eligible
participant in the plan, your coverage may be continued pursuant to law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). If coverage for your dependents ends because of your termination of employment, ceasing to be in an eligible job classification, or reduction in hours, your death, your divorce or legal separation, or dependent child’s loss of dependent status, your dependent’s coverage under the plan may also be continued under COBRA. However, domestic partners are not eligible for COBRA coverage.

COBRA allows participants to continue coverage under an employer’s group health plan for a limited period by paying the appropriate premium for continuation coverage. If the premium is not paid on time, your coverage stops at the end of the period for which your contributions were paid. Please see the Continuation of Health Care Benefits Under COBRA section of this Health and Welfare Plan Summary Plan Description for further information. Provisions for continued coverage for a covered employee who is absent from work due to active service in the armed forces of the United States are also explained in this section.

**Vision Benefit**

Participant and dependents covered through TSRI's Medical Plan are eligible for the Vision Benefit. This benefit is provided through Vision Service Plan (VSP), referred to throughout this section as the "Claims Administrator." Participants and their dependents have a choice of utilizing "Participating Providers" or "Non-Participating Providers.” Benefit levels differ depending on which type of provider you use. A list of Participating Providers is available from Human Resources, or through the Claims Administrator (please see the table at the end of the Summary Plan Description entitled "General Information" for contact information).

**Eligibility**

Information regarding eligibility for yourself and your dependents can be found in the Medical Benefit section. Please refer to the following sections under the Medical Plan for specific information:

"Eligibility"
"Effective Date of Your Coverage"
"Termination of Coverage"
"Continuation of Coverage through COBRA"
"Dependent/Domestic Partner Eligibility"
"Domestic Partners"
"Effective Date of Dependent Coverage"
"Responsibility for Determining Ineligible Dependents'"
"Qualified Medical Child Support Orders (QMSCO)"
"Termination of Dependent Coverage"
"Termination of Eligibility as a Student Dependent"
"Continuation of Coverage for Dependents"
"Handicapped Dependent Children"

**How to Use the Plan**

Participants and their dependents can find a VSP Participating Provider at 1-800-877-7195 or by visiting their website at [www.vsp.com](http://www.vsp.com). A $10 co-payment applies to services received from both Participating Providers or from Non-Participating Providers. The co-payment does not apply to contacts.

If covered services are rendered by a Non-Participating Provider, reimbursement will be made to you up to the Schedule of Allowances. You, or the provider, should submit an itemized billing and a copy of your prescription with the claim form to the Claims Administrator.
Schedule of Allowances

Participating Providers

The Vision Plan provides coverage for the following services, less a $10 co-payment, when you go to a Participating Provider:

- One comprehensive examination in any 12 consecutive months;
- One pair of standard lenses in any 12 consecutive months. (Standard lenses fit any frame with an eye size less than 61mm.)
- One standard frame in any 24 consecutive months. (A standard frame is any frame that has a maximum retail cost of $110.00 or less.)

OR

- One pair of contact lenses in any 12 consecutive months. This benefit is in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Plan will pay up to $100.00 in any 12 consecutive months toward their cost. Any balance is your responsibility. If you spend less than the $100 allowance, the unused portion will not be “credited” toward future purchases. The Plan will pay up to $40 for the contact lenses fitting fee.

If contact lenses are medically necessary, they are a fully covered benefit under the medical portion of your plan following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except through the use of contacts; or when necessitated by anisometropia or keratoconus. Prior authorization from the Claims Administrator is required.

VSP also offers extra discounts and savings for the following:

**Prescription Glasses**
- Polycarbonate lenses for dependent children are covered in full.
- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
- 20% off additional prescription glasses and sunglasses provided you utilize the same VSP provider who provided your eye exam within the last 12 months.

**Contacts**
- 15% off cost of contact lens exam (fitting and evaluation) provided you utilize the same VSP provider who provided your eye exam within the last 12 months.

**Laser Vision Correction Discounts**
- Laser vision correction (PRK and LASIK surgery) is available through contracted laser centers. Program availability may vary based on location.

Non-Participating Providers

If covered services are provided by a Non-Participating Provider the Benefits will not exceed the following Schedule of Allowances, less the $10 co-payment:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>$40.00</td>
</tr>
<tr>
<td>Lenses (per pair):</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$30.00</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$50.00</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$65.00</td>
</tr>
<tr>
<td>Lenticular or Aphakic</td>
<td>$125.00</td>
</tr>
<tr>
<td>Contact Lenses (per pair):</td>
<td></td>
</tr>
</tbody>
</table>
Medically Necessary $250.00
Cosmetic or Convenience $100.00
Frame $40.00
Contact Lens Fitting Fee $40.00

**Limitations**

Lenses or frames which were furnished under this Plan and which have been lost, stolen or broken will not be replaced, except when benefits are otherwise available.

Progressive (blended type) bifocal lenses, coated lenses, tints or oversized lenses will be limited to the Schedule of Benefits.

**Exclusions**

- Eye examinations required by an employer as a condition of employment;
- Any covered services provided by another vision plan;
- Conditions covered by Workers’ Compensation;
- Medical or surgical treatment of the eyes;
- Services, which begin prior to Participant’s effective date or after benefits have terminated;
- Services and materials in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) wear;
- Contact lens insurance or care kits;
- Covered services for which the participant is not legally obligated to pay;
- Covered services required by any government agency or program, federal, state or subdivision thereof;
- Covered services performed by a close relative or by an individual who ordinarily resides in the participant’s home;
- Services that are experimental or investigational in nature;
- Services for treatment directly related to any totally disabling condition, illness or injury.

**Claims/Authorization Procedures**

**Types of Claims or Requests for Authorization**

The requirements for processing your claim or request depends on the type of claim or request submitted. A claim or request is defined by the Employee Retirement Income Security Act (ERISA) to be in one of the following categories: urgent, pre-service, post-service or concurrent.

**Urgent** - A claim or request for service is considered “urgent” when a delay in the decision might pose an imminent and serious threat to your health, including but not limited to potential loss of life, limb, or major bodily function, or severe pain that cannot be managed without the care or treatment that is the subject of the claim.

Covered services under your Vision Plan administered by the Claims Administrator do not apply to this category. Claims arising for eye services considered “urgent” may be covered by the Medical Plan (please see the "Medical Benefits" section).

**Pre-Service** - A Pre-Service claim is a request for authorization of medical care or treatment that you have not yet received, which is conditioned in whole or in part on the Claims Administrator’s approval of coverage in advance of obtaining the medical care. This category applies to Medically Necessary contact lenses only for certain conditions of keratoconus, anisometropia, astigmatism, aphakia, etc.
**Post-Service** - A Post-Service claim is a request for payment or reimbursement of costs for health care that has already been provided, and which is not an Urgent Care Claim.

**Concurrent** - A concurrent request is a request for authorization of an extension or modification to an approved course of treatment that is already in progress, such as an inpatient hospitalization.

Covered services under your Vision Plan administered by the Claims Administrator do not apply to this category. Claims arising for eye services considered “Concurrent” may be covered by the Medical Plan (please see the "Medical Benefits" section).

**Submitting a Claim/Requests for Authorization**

All actions you may take may also be taken by your duly authorized representative (“Authorized Representative”), which may, for example, be your physician. The Claims Administrator may require evidence it deems reasonably necessary to verify any such representative.

Proof of claim for charges made by a Participating Provider, for benefits payable under this Plan, will be made by the Participating Provider on the member’s behalf. However, you must present the Participating Provider with a claim form at the time of your visit, which the Participating Provider will complete and submit for you. Claim forms are available through TSRI Benefits Administration. Payment of expenses for benefits payable under this Plan, received from a Participating Provider, will be made directly to them in accordance with the Schedule of Benefits. You will pay any applicable co-pay as stated in this Summary Plan Description at the time of your office visit.

If you incur expenses for benefits payable under this Plan from a Non-Participating Provider, you will be required to pay the full cost at the time of the purchase and then file the claim with the Claims Administrator for reimbursement of the covered charges. To file a claim, you or your Authorized Representative must file a written claim on the appropriate form, which is available through TSRI Benefits Administration. Alternatively, you can submit Proof of Claim consisting of:

- Itemized receipt from the provider
- Date of service
- Name of the provider
- Charges incurred from such provider
- Participant’s name
- Participant's social security number
- Group policy number
- Employer's name

Proof of Claim for expenses incurred for charges made by a Non-Participating Provider, for benefits payable under this Plan, must be furnished to the Claims Administrator within 90 days after the date of service. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Payment for expenses incurred by you for charges made by a Non-Participating Provider, which are payable under this Plan, will be made to you.

**Overpayment**

If the Plan pays a benefit and it is later shown that a lesser amount should have been paid, the Plan will be entitled to a refund of the excess. This applies to payments made to you, your covered dependent, or to the provider of eye services.
Failure to Follow Procedures in Submitting a Claim/Request for Authorization

If you fail to follow the proper procedures when filing a claim or request for authorization, the Claims Administrator will notify you regarding the proper procedures to be followed within 5 days of their receipt of your claim or request for pre-service authorization.

Insufficient Information

If the Claims Administrator requires additional information in order to make a determination, you will be notified regarding what information is necessary and given a reasonable amount of time to provide the Claims Administrator with the requested information.

Notice of Determination

Note: The Claims Administrator reserves the right to extend the time periods specified below as allowed by law if such extension is necessary due to matters beyond the control of the Plan.

Pre-Service - For pre-service request, you will be notified regarding the Claims Administrator’s decision as soon as possible, but no later than 15 calendar days after its receipt of your request.

The Claims Administrator reserves the right to extend this 15-day period a single time for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of the time and date by which it expects to render a decision.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Post-Service Claims - For post-service claims, you will be notified regarding the Claims Administrator’s decision as soon as possible, but no later than 30 calendar days after its receipt of your request.

The Claims Administrator reserves the right to extend this 30-day period a single time for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of the time and date by which it expects to render a decision.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

If Your Claim or Request Is Denied

If your claim or request is denied, delayed or modified due to determination that the services or treatment were not medically necessary or appropriate, either in whole or in part, you will receive a written notice explaining the reasons for the determination including:

- The specific reason or reasons why your claim was denied, delayed or modified.
- Reference to the specific Vision Plan provisions on which the decision is based.
- If more information is needed, a description of any material necessary to process the claim properly and why the materials are needed.
- A description of the Claims Administrator appeals process and any time limits applicable to such procedures.
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal.
• A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in denying your claim, or a statement that a copy will be provided to you free of charge upon request.

• If your claim or request was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of your Vision Plan to your medical circumstances or a statement that such an explanation will be provided to you free of charge upon request.

**Appeal Procedure If Your Claim or Request Is Denied**

After receiving a denial, to appeal it, you or your authorized representative must submit a written request for reconsideration by the Claims Administrator and/or TSRI as the Plan Administrator. The request must be made within 180 days and should be accompanied by documents or records in support of the appeal.

As part of the review procedure, you or your authorized representative are entitled to:

• Examine and obtain copies, free of charge, of all health plan documents, records and other information that were used in making the determination.

• Submit written comments, documents, records, and other information relating to your claim or request.

• Obtain information identifying the medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the denial of your claim or request. (You are entitled to this information even if the Claims Administrator did not rely on the information in making its determination).

• Have someone act as your representative in the review procedure, if you wish.

In addition, the Claims Administrator’s review of your appeal must be conducted in accordance with the following rules:

• The Claims Administrator may not defer to the initial denial of your claim or request. Review of your appeal must be conducted by the Claims Administrator’s Management or Medical Director who is neither the individual who initially denied your claim or request, nor a subordinate of such individual.

• If denial of your initial claim or request was based in whole or in part on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate), a Claims Administrator Medical Director must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial decision on your claim or request, nor the subordinate of such an individual.

The Claims Administrator will notify you of the decision on your appeal:

• For Pre-service claims: Within a reasonable period of time, but not later than 30 days after the Claims Administrator’s receipt of your appeal.

• For Post-service claims: Within a reasonable period of time, but not later than 60 days after the Claims Administrator’s receipt of your appeal.

If your appeal is denied, a written notice containing the information set forth below will be provided to you:

• The specific reason or reasons for the denial of your appeal.

• Reference to the specific Vision Plan provisions on which the denial is based.

• A statement that you are entitled to receive, upon request and free of charge, access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

• A statement explaining your right to bring a civil action under Section 502(a) or ERISA following the denial of your claim on appeal, that you and the Claims Administrator may have other voluntary alternative dispute resolution options such as arbitration or mediation, and that you should contact the U.S. Department of Labor to find out what alternatives may be available.
• If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that rule, guideline, protocol or criterion, or a statement that a copy will be provided to you free of charge upon request.
• If your claim or request was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of your Vision Plan to your medical circumstances or a statement that such an explanation will be provided to you free of charge upon request. Under California law, you have a right to a voluntary independent medical review of denials for medical necessity or experimental/investigational services, conducted by an independent review organization contracted by the Department of Managed Health Care for HMO/POS plans and the Department of Insurance for PPO and indemnity plans. For additional information on these procedures, contact your healthcare provider.

Coordination of Benefits

Coordination of Benefits applies when a participant has coverage with more than one vision plan. The benefits payable under the secondary plan shall be reduced so that the sum of such reduced benefits and all other benefits payable do not exceed the total allowable expenses.

Effect on Vision Benefits

The Coordination of Benefits provision applies when the participant or the participant's covered dependent has vision coverage under more than one plan. If this provision applies, the benefit determination rules state whether this Plan pays before or after another plan.

The benefits of this Plan:
• will not be reduced when this Plan is primary;
• may be reduced when another plan is primary and this Plan is secondary. The benefits of this Plan are reduced so that they and the benefits payable under the other plan do not exceed 100% of the allowed expenses; and
• will not exceed the benefits payable in the absence of other coverage.

Plans Subject to Coordination of Benefits

Plans subject to Coordination of Benefits are:
• this Plan;
• any group, blanket, or franchise health coverage;
• a group contractual pre-payment or indemnity plan;
• a labor-management trustee plan or a union welfare plan;
• an employer or multi-employer plan or Participant benefit plan;
• a government program;
• coverage required or provided by statute.

Plans not subject to Coordination of Benefits are any individual or family policies or contracts or public medical assistance programs.

Primary Plan/Secondary Plan

When this Plan is primary, its benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan’s benefits. Under Coordination of Benefits, you or your covered dependent will not receive more than the allowed expenses for a loss. When there are more than two plans, this Plan may be primary to one and may be secondary to another.
Order of Benefit Determination Rules

The Plan determines its order of benefits by using the first of the following that applies:

General - A plan that has no Coordination of Benefits provision pays before a plan with said provision.

Non-dependent/Dependent - The plan that covers the person as a participant, member, or subscriber (other than a dependent), is the primary plan and determines Benefits first. The plan that covers the person as a dependent is the secondary plan.

Dependent Child/Parents Not Separated or Divorced - When this Plan and another plan provide coverage for the same dependent, the primary coverage for the dependent is determined as follows:

- The primary plan is the plan of the parent whose birthday (month and date) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, the plan that covered the parent for the longer period is the primary plan; the plan that covered the parent the shorter time period is the secondary plan.

Dependent Child/Separated or Divorced Parents - When this Plan and another plan provide coverage for the same dependent and that dependent is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- first, the plan of the parent with custody of the child;
- then, the plan of the spouse of the parent with custody;
- finally, the plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, that plan is the primary plan. This paragraph does not apply with respect to any Benefit Period or plan year during which any benefits are actually paid or provided before the entity has actual knowledge.

Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

Active/Inactive Participant - The primary plan is the plan that covers the person as a participant who is neither laid off nor retired (or as that participant's dependent). The secondary plan is the plan that covers that person as a laid off or retired participant (or as that participant's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

Continuation of Coverage - If coverage is provided for a person under a right of continuation according to Federal or state law and the person is also covered under another plan, the following will be the order of benefit determination:

- First, the benefits of a plan covering the person as a participant, member or subscriber (or as that person's dependent);
- Second, the benefits under the continuation coverage.

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

Miscellaneous Provisions

Right to Receive and Release Information
Certain facts are needed to Coordinate Benefits. Medical Eye Services, in their capacity as Claims Administrator, has the right to decide which facts it needs. The Claims Administrator may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

**Prescription Benefit**

Participants and dependents covered through TSRI’s Medical Plan are eligible for the Prescription Drug Plan. The Claims Administrator for the Plan is CAREMARK®. Please see the section entitled "General Information" for contact information. All eligible participants will be issued a Benefits Card that must be presented to the pharmacy when filling a prescription. The co-payment and level of coverage for prescriptions is determined by the type of prescription being filled (generic, preferred name brand, or non-preferred name brand), and if you are obtaining the prescription from a CAREMARK® network or non-network retail pharmacy or the mail order pharmacy.

**Eligibility**

Information regarding eligibility for yourself and your dependents can be found in the Medical Benefit Plan section. Please refer to the following sections under the Medical Plan for specific information:

- "Eligibility"
- "Effective Date of Your Coverage"
- "Termination of Coverage"
- "Continuation of Coverage through COBRA"
- "Dependent/Domestic Partner Eligibility"
- "Domestic Partners"
- "Effective Date of Dependent Coverage"
- "Responsibility for Determining Ineligible Dependents"
- "Qualified Medical Child Support Orders (QMSCO)"
- "Termination of Dependent Coverage"
- "Termination of Eligibility as a Student Dependent"
- "Continuation of Coverage for Dependents"
- "Handicapped Dependent Children"

**Prescription Drug Co-Payment and Coverage Level**

The co-payment is the amount payable by you or your covered dependent for eligible prescription drug expenses. The co-payment must be paid each time a prescription drug is obtained. The co-payment is based on whether a drug is classified as a generic or name brand. A generic drug is a pharmaceutical product manufactured and sold under its chemical, common, or official name. A preferred name brand drug is a name brand drug that is considered to be clinically appropriate and cost effective. A drug included on the preferred name brand list is a subset (i.e., a shorter list) of the formulary list. Non-preferred name brand drugs would be all other name brand drugs that are not included on the preferred name brand drug list.

The co-payment will not be applied towards the following Medical Plan provisions:

- the Plan Deductible;
- the Carry-over Deductible;
- the Common Accident Deductible;
- any other Deductible amount.
Network Retail Pharmacy

For prescriptions received at a network retail pharmacy, the maximum supply dispensed is 90-days. The co-payment is $10 for generic prescriptions per 30-day supply, $25 for preferred name brand prescriptions per 30-day supply, and $50 for non-preferred name brand prescriptions per 30-day supply. However, the co-payment for fertility medication is 30% up to a lifetime maximum of $2,000 per covered individual. A directory of participating pharmacies is available free of charge through the Human Resources Department or you may receive a list via e-mail by visiting www.caremark.com on the Internet.

Non-Network Retail Pharmacy

For prescriptions filled at a retail pharmacy that is not part of the network, you must pay the full cost of the prescription at the time that it is filled. Then you may submit a CAREMARK® direct claim form for reimbursement of the expense. You will be reimbursed the actual cost of the prescription per 30-day supply less $10 for generic, $25 for preferred name brand, or $50 for non-preferred name brand. However, the co-payment at a non-network retail pharmacy for fertility medication is the fertility drug cost less 30% up to a lifetime maximum of $2,000 per individual. The amounts you pay are considered co-payments under the Prescription Drug Plan.

Mail Order

Medication, which is taken regularly to treat acute or chronic health conditions, may be filled through the CAREMARK® Mail Order Pharmacy. You may receive up to a 90-day supply for a co-payment of $20 for generic prescriptions, $50 for preferred brand name prescriptions, and $100 for non-preferred brand name prescriptions. Please note that if a prescription is filled for less than a 90-day supply, the same co-pay of $20 for generics and $50 for preferred brand names, and $100 for non-preferred brand names will apply. Prescriptions are delivered in 5-14 days from the date you mail the prescription. The prescriptions are delivered by U.S. Mail or UPS 2nd Day Service. Mail order prescription order forms may be obtained from the Claims Administrator or the Human Resources Department.

Covered Drugs

- Legend drugs, except as noted under “Exclusions” in this section. Legend drugs are defined as any medicinal substance requiring under the Federal Food, Drug and Cosmetic Act, a label that reads: "Caution: Federal law prohibits dispensing without a prescription";
- Insulin;
- Disposable needles/syringes;
- Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape);
- Lancets;
- Tretinoin topical (e.g., Retin-A) for individuals through the age of 25 years;
- Compounded medication of which at least one ingredient is a legend drug;
- Any other drug, which under the applicable states law, may only be dispensed upon the written prescription of a physician or other lawful prescriber;
- Legend oral contraceptives, other hormonal contraceptives such as the ring or patch and diaphragms;
- Anorectics (any drug used for the purpose of weight loss) for treatment of morbid obesity, when pre-authorized by the Claims Administrator. Morbid obesity means having an initial Body Mass Index (BMI) of >30kg/m², or per the current standard as updated from time to time by the FDA. Prescriptions will be pre-authorized using a clinical evaluation of the participant’s initial BMI, involvement in a structured weight loss program, progress of weight loss during the program, health status of the participant and the FDA approved indication of the requested drug. Pre-authorization decisions are at the sole discretion of CAREMARK®. Body Mass Index (BMI) is calculated by taking an individual’s weight (in kilograms) and dividing that weight by the individual’s height (in meters squared).
Exclusions

- Prescriptions not approved by the U.S. Food and Drug Administration;
- Contraceptives, physician administered dosage forms (i.e., Depo-Provera or Norplant), except for diaphragms;
- Anorectics (any drug used for the purpose of weight loss), except when pre-authorized by Caremark. See above description under “Covered Drugs”;
- Anti-wrinkle agents (e.g., Renova®);
- Dermatologicals, hair growth stimulants;
- DESI Drugs: Drugs determined by the U.S. Food & Drug Administration as lacking substantial evidence of effectiveness;
- Fluoride supplements;
- Growth hormones;
- Hematinics;
- Immunization agents, blood or blood plasma;
- Interferon Beta-1B (Betaseron);
- Levonorgestrel (Norplant), however, this is covered under TSRI’s Medical Plan;
- Mineral and nutrient supplements;
- Non-legend drugs other than those listed above;
- Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorette, Nicoderm, etc.);
- Tretinoin topical (e.g., Retin-A) for individuals 26 years of age or older;
- Vitamins, singly or in combination. Exceptions: Legend prenatal and pediatric vitamins are covered;
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above;
- Charges for the administration or injection of any drug;
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order;
- Prescriptions/supplies purchased through a direct manufacturer and/or suppliers are not covered.
Schedule of Prescription Benefits

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<td><strong>Prescription Dispensed at Retail Pharmacy</strong></td>
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<td>• Co-pay per 30-Day Supply:</td>
<td>• Pay full cost of prescription at pharmacy</td>
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<tr>
<td>♦ $10.00 Generic</td>
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<tr>
<td>♦ $25.00 Preferred Name Brand</td>
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<td>• 30% co-payment for fertility medication up to a lifetime maximum of $2,000 per individual</td>
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<td>♦ $100 Non-Preferred Name Brand</td>
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<tr>
<td>• Supply Dispensed:</td>
<td>New drugs are developed and introduced into the marketplace almost daily. As the U.S. Food and Drug Administration approves these new drugs for use in the United States, TSRI, in conjunction with the Claims Administrator, will assess the feasibility of covering the drug as well as the application of any coverage limitations or restrictions.</td>
</tr>
<tr>
<td>♦ Up to 90-days or as per Doctor’s Direction</td>
<td></td>
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<tr>
<td>♦ Mail Order Service (800) 966-5772</td>
<td></td>
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**Claims Procedures**

**Network Pharmacies**

If you are using a network pharmacy, you must present your Benefits Card to the pharmacist along with a prescription. The Card displays information necessary for the pharmacist to recognize the program and to submit the claim correctly to the Claims Administrator.

Claims for participating pharmacies are processed at the point-of-service and transmitted online to the Claims Administrator. The system verifies participant and pharmacy eligibility, drug coverage and pricing. Immediately, messages are transmitted advising the pharmacy of claim status (pay or deny), claim-payable amount, participant co-payment amount, and other coverage information.

The participant pays the pharmacy the co-payment at the point-of-service.
Other Claims

While the vast majority of prescription claims are submitted to the Claims Administrator electronically, there is a traditional paper claim submission process if you use a non-network pharmacy or if you do not have your Benefits Card available when you have a prescription filled. Under this process, you pay the full cost of the prescription at the pharmacy and submit a paper claim form to the Claims Administrator for reimbursement.

Once the Claims Administrator receives paper claims, the claims are adjudicated through the online claims processing system. All claims pass through an extensive computer edit process to check for completeness and accuracy and to confirm eligibility.

Urgent Care Claims

In the case of an Urgent Care Claim, the Claims Administrator will notify you of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan’s receipt of the Urgent Care Claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan.

In the case of such a failure by you to provide sufficient information, the Claims Administrator will notify you as soon as possible, but not later than twenty-four (24) hours after the Plan’s receipt of the Urgent Care Claim, of the specific information necessary to complete the Urgent Care Claim. You will be afforded a reasonable time, taking into account the circumstances, but not less than forty-eight (48) hours to provide the specified information.

The Claims Administrator will notify you of the Plan’s benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the Plan’s receipt of the specified information, or the end of the forty-eight (48) hour period afforded you to provide the specified information.

Non-Urgent Care Claims

In the case of a Non-Urgent Care Claim that is a Post-Service Claim, the Claims Administrator will notify you of the Plan’s determination within 30 days of receiving a claim. The Plan will either accept it or deny it (wholly or partially) and within that time notify you of acceptance or denial. The Plan may extend this period one time for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the Plan’s control and notifies you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be given at least forty-five (45) days from receipt of the notice within which to provide the specified information.

For paid claims, a check and an Explanation of Benefits (EOB) is produced automatically and mailed to you within one workday of the date on which the claim is adjudicated.

Denial of Claims

If a claim is denied, the appropriate National Council for Prescription Drug Programs (NCPDP) reject code displays on the processor's terminal. The claims processors generally correct any invalid information or locate the missing information online and resubmit the claim immediately. If the required information cannot be located, the processor may call the Plan Administrator or return the claim, along with a Request for Information (RFI) and an Explanation of Benefits (EOB) to the participant. If a claim is denied, and there appears to be no invalid or missing information, an EOB is sent to the participant within one workday of the date on which the claim is adjudicated.

If a claim is wholly or partially denied, you will receive written notice with:

- the specific reason(s) for denial;
specific reference(s) to pertinent Plan provisions on which any denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary;
- a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following denial on review;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial relates to an Urgent Care Claim, a description of the expedited review process applicable to Urgent Care Claims.

In the case of an adverse benefit determination concerning an Urgent Care Claim, the information described above may be provided to you orally within the time frame prescribed above; provided; however, that a written or electronic notice is provided to you in the manner set forth in this section not later than (3) days after the oral notification.

Claims Appeal Procedures

Overview

Once a claimant or their representative is notified that a claim is wholly or partially denied, they have the right to appeal.

- A claimant or their representative may submit an appeal to the Claims Administrator In Writing no later than 180 days after receiving an adverse benefit determination.
- The appeals process begins when the claimant or their representative calls the CAREMARK® Member Services department at (888) 727-5575. Once a claimant or claimant’s representative contacts the Claims Administrator with a request to appeal, they are instructed on how to submit an appeal.
- CAREMARK® Member Services representative mails the requestor the appropriate forms to complete. Claimants or their representatives may submit the appeal either on the CAREMARK® Prescription Claim Appeals/ERISA Clients form or in other written form. Acceptable submission methods would include fax or mail. In the case of Urgent appeals the participant’s physician may make the request by phone.
- Completed appeals forms and supporting documentation for an adverse decision are sent directly to the CAREMARK® Appeals department for processing. Analyst (QRA) in the CAREMARK® Medical Management department for processing.
- Appeals will be processed within the following time frames from the date complete information is received:
  - For a pre-service claim, which is a claim which requires approval in advance of obtaining medical care, appeals will be processed within 15 days.
  - For a post-service claim, which is a claim which the patient has received medication and is requesting reimbursement, appeals will be processed within 30 days.
  - For an urgent care claim, which is a claim which the physician specifies as urgent or the plan using judgment of a prudent layperson determines is urgent, appeals will be processed within 72 hours.
- Initial reviews of appeals are performed absed on TSRI’s prescription benefit plan and approved prior authorization criteria.

Initial Benefit Reconsideration: (1st level)
The review process includes the consideration of relevant and supporting documentation submitted by and for the claimant. Supporting documentation may include: a letter written by the health care practitioner in support of the appeal, a copy of the denial letter sent by the Claims Administrator, a copy of the claimant’s payment receipt or medical records, etc.
Upon receipt, the Appeals Analyst reviews and determines appeals relating to non-clinical benefits (e.g. eligibility determinations, copay issues, explicit exclusions under the prescription benefit plan). Appeals determination regarding clinical knowledge are reviewed by the Appeals Pharmacist.

**Medical Necessity Appeals/Independent Physician Specialist Review (2nd level)**
CAREMARK® has contracted with independent external review organizations (IRO) to conduct independent specialist physician reviews of denials of authorization of benefits when the Plan participant or beneficiary is entitled to obtain such a review. These reviews will only be performed for denials of Prior Authorization requests upheld on Initial Benefit Reconsideration. An additional request from the participant or their representative must be made for this review to occur.

For such appeals, the following will occur:
- CAREMARK® will forward or cause to have forwarded to the IRO applicable medical records, documentation, Plan language and specific criteria.
- The independent specialist selected by IRO to conduct the review will review documentation received with the case. If IRO considers additional information necessary or potentially useful in its review, IRO may contact the Plan participant’s or beneficiary’s provider to request such information.
- The independent specialist selected by IRO will review available medical records, review any additional information obtained from the provider, and will write an independent rationale in support of his or her final decision.
- The letter containing the rationale will be forwarded to CAREMARK® for communication to the participant or the participant’s representative.

**Appeal Determination Process**
- Once an appeal is decided, the determination is then communicated in writing to the claimant or their representative.
- If the original determination is overturned, the communication explains the basic steps or process that either the Claims Administrator or the claimant would need to follow.

In the case where the denial is upheld upon review, the notification will set forth, in a manner calculated to be under your:
- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provision on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant records;
- A statement of your rights to further legal action;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

**Continuation of Health Care Benefits Under COBRA**

**Eligibility for COBRA**
In compliance with Federal Law (PL 99-272) TSRI offers continuation coverage for you and your Dependents that are covered by the Medical Plan (which currently includes Prescription Drug, Mental Health, and Vision Benefits), the Dental Plan, and the Employee Assistance Program. This continuation coverage is called COBRA
(Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA offers continuation of these group health care benefits, subject to certain conditions.

NOTE: Domestic Partners are not eligible for COBRA continuation coverage. However, as described in more detail below, if the covered participant becomes entitled to and elects to continue coverage under COBRA, he or she may elect to continue coverage for his or her covered Domestic Partner. Also, Domestic Partners may, under certain circumstances, be eligible for continuation coverage (similar to COBRA continuation coverage) available under state law. Please contact the Human Resources Department for more information regarding the availability of continuation coverage for Domestic Partners.

This provision is intended to comply with COBRA but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent (as determined by TSRI in its sole discretion) will prevail over this summary.

If a covered Participant’s or a covered Dependent’s coverage under TSRI’s group health care Plans terminates due to a Qualifying Event, the covered Participant or Dependent will be eligible for continued coverage under the group health care Plans pursuant to the provisions of COBRA. Provisions for continued coverage for a covered Participant who is absent from work due to active service in the armed forces of the United States are explained later in this section.

A certificate of creditable coverage will be mailed to your home from Tri-Ad with the COBRA Qualifying Event notice. If you need to request an additional certificate of coverage, you will need to contact Tri-Ad at 888-844-1372.

Definitions

When capitalized in the COBRA section, the following items will have the meanings shown below:

**COBRA Administrator** – Tri-Ad is the COBRA Administrator. You should contact Tri-Ad if you have questions regarding COBRA continuation coverage as follows: Tri-Ad, 221 West Crest Street, Suite 300, Escondido, CA 92025-1737; Phone: (888) 844-1372; Fax: (760) 233-4742.

**Qualified Beneficiary** - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Participant, or the covered Dependent spouse or child of a covered Participant.

Any child who is born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverage the covered Participant has at the time of the child’s birth or placement for adoption, the same coverage that a Dependent child of an active Participant would receive. The Participant’s Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the TSRI group health care Plans on the day before a Qualifying Event because he was denied coverage or was not offered coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had such coverage and will be a “Qualified Beneficiary” if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual’s status as a covered Participant is attributable to a period in which he was a nonresident alien who received no earned income from TSRI that constituted income from sources within the United States. If such a Participant is not a Qualified Beneficiary, then a spouse or Dependent child of the Participant is not a Qualified Beneficiary by virtue of the relationship to the Participant.

**Qualifying Event** - Any of the following events, which would result in the loss of coverage under TSRI’s group health care Plans in the absence of COBRA continuation coverage:
- voluntary or involuntary termination of the Participant’s employment for any reason other than the Participant’s gross misconduct;
- reduction in a Participant’s hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not the Participant actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Participant is on FMLA leave, a Qualifying Event occurs at the time the Participant fails to return to work at the expiration of the leave, even if the Participant fails to pay his/her portion of the cost of coverage during the FMLA leave;
- for a Participant’s spouse or child, the Participant’s entitlement to Medicare. For COBRA purposes, “entitlement” means the effective date of enrollment in Medicare Part A or Part B, whichever occurs earlier;
- for a Participant’s spouse or child, the divorce or legal separation of the Participant and spouse;
- for a Participant’s spouse or child, the death of the covered Participant; and
- for a Participant’s child, the child’s loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

Non-COBRA Beneficiary - An individual who is covered under the Plan on an “active” basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Of Qualifying Event(s)

A Participant or Qualified Beneficiary is responsible for notifying Human Resources In Writing by submitting a Benefits Coverage Change Form within 60 days of the later of (i) the date one of the following Qualifying Events occurs, or (ii) the date coverage would terminate due to one of the following Qualifying Events:

- a Dependent child’s ceasing to be eligible under the requirements of the Plan; or
- a divorce or legal separation of the Participant from his/her spouse.

Once the COBRA Administrator is notified of the occurrence of one of these Qualifying Events, the Qualified Beneficiary(ies) will be mailed information explaining each Qualified Beneficiary’s continuation coverage rights as well as an enrollment form.

For all other Qualifying Events, the COBRA Administrator will notify the Qualified Beneficiary of the right to elect continuation coverage. Notification given to a spouse is treated as notification to all other Qualified beneficiaries residing with that person.

Election and Election Period

To elect COBRA continuation, a Qualified Beneficiary must complete the election form and return it to the COBRA Administrator within 60 days of the later of:

- The date the Qualified Beneficiary would otherwise lose coverage under TSRI's group health care Plans due to a Qualifying Event; or
- The date the COBRA continuation coverage election materials were mailed to the Qualified Beneficiary.

IMPORTANT!

If you don’t elect continuation coverage during the initial enrollment period, you may not elect it at a later date.

If the COBRA election of a covered Participant or spouse does not specify “self-only” coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation
coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary’s estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

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

Effective Date of Coverage

COBRA continuation coverage will be effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, provided:

- The Qualified Beneficiary(ies) returns the election form to the COBRA Administrator within the 60-day election period described above; and
- The Qualified Beneficiary(ies) pays the initial COBRA continuation coverage premium within 45 days of the date the Qualified Beneficiary(ies) elects continuation coverage.

See "Election and Election Period" above for exceptions to effective date of coverage when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his/her waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits

COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

As discussed above, Domestic Partners are not eligible for COBRA continuation coverage. However, if a covered Participant experiences a Qualifying Event and elects COBRA continuation coverage, the Participant may elect to continue coverage for his or her covered Domestic Partner as a dependent. The Domestic Partner’s coverage will end when the covered Participant’s coverage ends unless terminated earlier in accordance with the terms of the Plan or applicable law.

Open Enrollment rights, which allow Non-COBRA Beneficiaries to choose among any available coverage options, are also applicable to each Qualified Beneficiary. Similarly, the “special enrollment rights” of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Participants not participating in the Plan have such rights under HIPAA.

If the Plan includes a deductible requirement, a Qualified Beneficiary’s deductible amount at the beginning of the COBRA continuation period must be equal to his/her deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that TSRI makes available to active Participants and that provides service in the relocation area must be offered to the Qualified Beneficiary.
Cost of Continued Coverage

A Qualified Beneficiary is responsible for paying the full cost of continuation coverage, plus a 2% administrative charge. This cost includes both the Participant and employer portion of the applicable premium amount. In other words, the cost is 102% of the total Plan cost for similarly situated Non-COBRA Beneficiaries.

If continuation coverage is extended because of disability, the cost to cover the disabled Qualified Beneficiary for months 19 through 29 (or months 19 through 36 of coverage, if a second Qualifying Event occurs after the initial 18 months of continuation coverage) will be 150% of the total Plan cost. The cost to cover any associated Qualified Beneficiaries whose coverage is also extended may also increase to up to 150% of the total Plan cost. You should contact the COBRA Administrator for more information on the cost of continuing coverage in the event of an extension due to a Qualified Beneficiary’s disability.

Payment Information

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary.

IMPORTANT!

If you do not make your initial premium payment within the 45-day period, your COBRA election will be null and void and you will lose your right to continue coverage under COBRA.

The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable).

Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment.

IMPORTANT!

Suspension of Coverage: COBRA premiums are due on the first day of the month. If your premium is paid late (but within the 30-day grace period), your continuation coverage will be suspended until the payment is received. You will be responsible for health care costs incurred during any such suspension, however, you could apply for reimbursement of these costs after your continuation coverage payment is received.

Termination of Coverage: Your COBRA continuation coverage will end if you do not pay all premiums on a timely basis (i.e., within 30 days of the due date) – so make sure you follow the billing instructions carefully.

Maximum Coverage Periods

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- If the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period for the covered Participant and/or his/her Dependents who are Qualified Beneficiaries is up to 18 months from the date coverage would end due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months may be extended to up to 29 months;
- If the Qualifying Event is a divorce or legal separation, Dependent child’s loss of dependency status, death of the covered Participant or the covered Participant’s entitlement to Medicare, the maximum coverage period for Dependents who are Qualified Beneficiaries is up to 36 months from the date coverage would end due to the Qualifying Event.
If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period may be expanded to up to 36 months, but only for individuals other than the covered Participant who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be more than 36 months from the date coverage would end due to the first Qualifying Event.

For example, a Dependent child who was originally eligible for continuation coverage due to termination of the covered Participant’s employment (a Qualifying Event) and who was enrolled for continuation coverage as a Qualified Beneficiary would be entitled to up to 18 months of continuation coverage. If, during this 18-month period, the Dependent child reaches the upper age limit of the Plan (a second Qualifying Event), the Dependent child may be eligible to extend coverage for up to 36 months from the date coverage would end due to the original Qualifying Event (the termination of the covered Participant’s employment), provided the Covered Participant or Qualified Beneficiary properly notifies the COBRA Administrator of the child’s loss of dependency status (see "Notification of Qualifying Event(s)” above).

If the covered Participant becomes entitled to Medicare (even if his/her entitlement to Medicare is not a Qualifying Event) before a termination of employment or reduction in hours (Qualifying Events), a Qualified Beneficiary other than the covered Participant may be eligible for continuation coverage for up to the longer of:

- 36 months from the day on which the covered Participant became entitled to Medicare; or
- 18 months from the date coverage would end due to the covered Participant’s termination or reduction in hours.

If the covered Participant becomes entitled to Medicare within the 18-month period following a termination of employment or reduction in hours (Qualifying Events) and such entitlement would, but for the COBRA continuation coverage, result in a loss of his or her coverage, a Qualified Beneficiary other than the covered Participant may be eligible for continuation coverage for up to 36 months from the date coverage would end due to the covered Participant’s termination or reduction in hours.

**Disability Extension**

If the covered Participant or any other associated Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA continuation coverage, the disabled Qualified Beneficiary and all associated Qualified Beneficiaries may be entitled to up to 29 months of continuation coverage, measured from the date coverage would end due to the covered Participant's termination or reduction in hours (the initial Qualifying Event). In order to elect this extension of continuation coverage, the disabled Qualified Beneficiary must:

- satisfy the legal requirements for being totally and permanently disabled under Title II or Title XVI of the Social Security Act; and
- be determined and certified to be so disabled by the Social Security Administration.

To elect a disability extension, the covered Participant or Qualified Beneficiary must furnish the COBRA Administrator with proof of the Social Security Administration determination of disability no later than 60 days after (i) the date of the Social Security Administration’s determination, (ii) the date on which the Qualifying Event occurs, or (iii) the date on which the Qualified Beneficiary loses (or would lose) coverage due to the Qualifying Event. This notice must be provided within the first 18 months of continuation coverage.

Unless coverage terminates on an earlier date (see "When COBRA Coverage Ends” information below), this period of extended continuation coverage will end on the earlier of:
• 29 months from the date coverage would have otherwise ended due to the original Qualifying Event (i.e., the covered Participant’s earlier termination or reduction in hours); or
• the end of the month following a period of 30 days after the Social Security Administration’s final determination that the qualified Beneficiary is no longer disabled.

The Qualified Beneficiary must notify the COBRA Administrator In Writing of a final determination by the Social Security Administration that he or she is no longer disabled within 30 days of any such determination.

Termination of COBRA Continuation Coverage

Continuation coverage ends on the earliest of the following events:

• the end of the 18-, 29- or 36-month continuation coverage period, as applicable (or, in the case of the health care spending account, the end of the calendar year in which the Qualifying Event occurs);
• the last day of the month following a 30-day period after the Social Security Administration’s final determination that a Qualified Beneficiary is no longer disabled. You MUST inform the COBRA Administrator within 30 days of that final determination;
• the date following the initial continuation coverage election, on which the Qualified Beneficiary first becomes entitled to Medicare coverage. In this case, coverage ends ONLY for the Qualified Beneficiary who is entitled to Medicare;
• the date, after the date of the initial continuation coverage election, on which the Qualified Beneficiary first becomes covered under another group health Plan (as a Participant or otherwise) — unless the other group plan contains any exclusions or limitations for pre-existing conditions. In this case, coverage can be continued as long as the Qualified Beneficiary is affected by the limitation or exclusion, or until eligibility for continuation coverage otherwise ends;
• the end of the premium period if the Qualified Beneficiary fails to make the required premium payments within 30 days of the due date; and
• the date TSRI stops offering group health Plans to its Participants.

COBRA continuation coverage may end earlier for any of the same reasons applicable to Non-COBRA Beneficiaries.

Consequences of Failure to Elect Continuation Coverage

Your decision whether to elect continuation coverage will affect the future rights of Qualified Beneficiaries under COBRA to portability of group health coverage, guaranteed access to individual health coverage and special enrollment rights under Part 7 of Title I of ERISA. You should contact the COBRA Administrator for more information on these important rights.

Keep the Plan Informed of Address Changes

In order to protect your family’s rights, you should keep Human Resources and the COBRA Administrator informed of any changes in your address or the addresses of your dependents. You should always keep a copy for your records, of any notices you send to the COBRA Administrator.

If You Have Questions

Questions concerning TSRI’s group health plans should be sent to Human Resources. Questions concerning your COBRA continuation coverage rights should be sent to the COBRA Administrator as described above. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)
Claims

If your claim for COBRA coverage is denied, you can ask for an appeal review. The section of this Summary Plan Description entitled “Statement of ERISA Rights” provides information about your rights under ERISA and tells you how to initiate an appeal review.

Annual Enrollment

The COBRA Administrator will notify COBRA participants of plan premium changes, along with contact information should you wish to add or drop Dependent(s) during Annual Enrollment.

Mid-Year Enrollment of Dependents

Each COBRA Participant may enroll otherwise eligible Dependents during the Plan year due to one of the following events:

- **Marriage.** If a COBRA Participant marries during the Plan year, the COBRA Participant can enroll his or her new spouse and any eligible Dependent children acquired as a result of the marriage by properly filing an enrollment application within 31 days of the marriage. Coverage will be effective as soon as administratively practicable but in no event later than the first day of the month following the date TSRI receives a properly filed enrollment form and provided such form is received within 31 days of the date of marriage.

- **Domestic Partnership.** If a COBRA Participant acquires a new Domestic Partner during the Plan year, the COBRA Participant can enroll his or her Domestic Partner and any eligible Dependent children acquired as a result of the Domestic Partnership by properly filing an enrollment application within 31 days of entering into the Domestic Partnership. Coverage will be effective as soon as administratively practicable but in no event later than the first day of the month following the date TSRI receives a properly filed enrollment form and provided such form is received within 31 days of the date of the Domestic Partnership.

- **New Child.** If a COBRA Participant or his or her spouse/Domestic Partner acquires a new Dependent child, either by birth, adoption or placement for adoption during the Plan year, the COBRA Participant can enroll the new child (as well as his or her spouse/Domestic Partner if not already enrolled) by properly filing an enrollment application within 31 days of the child’s birth, adoption or placement for adoption. Coverage will be effective retroactive to the date of the birth, adoption or placement provided TSRI receives a properly filed enrollment form within 31 days of the birth, adoption or placement.

- **Termination of Medicaid/CHIPs Coverage or Eligibility for Premium Assistance.** If a COBRA Participant’s eligible Dependent is covered under a Medicaid plan or under a Children’s Health Insurance Program (CHIP) and coverage is terminated or a COBRA Participant’s eligible Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, the COBRA Participant can enroll his or her eligible Dependent by properly filing an enrollment application within 60 days of the occurrence of one of the foregoing events. Coverage will be effective as soon as administratively practicable but in no event later than the first day of the month following the date TSRI receives a properly filed enrollment form and provided such form is received within 60 days of the occurrence of one of the foregoing events.

- **Qualified Medical Child Support Order.** A COBRA Participant may be required to enroll a child for coverage under a health Plan providing Medical benefits as directed by a qualified medical child support order.

If the covered Participant retires from TSRI, is at least age 59 ½ and otherwise meets the criteria for Early Retiree Medical Benefits, he or she may be eligible to extend continuation coverage beyond the maximum COBRA continuation coverage period (see “Continuation Coverage and Early Retiree Medical Benefits” information below).

Continuation of Coverage and Early Retiree Medical Benefits
If a Participant retires from TSRI and otherwise meets the criteria for Early Retiree Medical Benefits, the Participant may be eligible to enroll himself/herself and any eligible Dependents for an extended period of continuation coverage beyond the maximum period of coverage permitted under COBRA. To be eligible for Early Retiree Medical Benefits, the Participant must:

- Retire directly from TSRI,
- Be vested in the TSRI Cash Balance Plan or the TSRI Faculty and Management Retirement Plan,
- Be at least age 59 ½ and less than age 65,
- Have a combined age and service requirement of at least 70 years,
- Not be eligible for, or actively participate in, health benefits from another source,
- Be an active participant in one of the TSRI medical Plans at the time of retirement, and
- Elect and pay for COBRA continuation coverage under a Medical Plan providing Early Retiree Medical Benefits until such coverage is exhausted.

A Participant who is eligible for Early Retiree Medical Benefits will be offered the option of Early Retiree Medical Benefits for himself/herself and any eligible Dependents who are covered under a TSRI Medical Plan on the day before the Participant’s retirement. Any election of Early Retiree Medical Benefits must be made in writing prior to the Participant’s last day of active work. If the Participant timely elects Early Retiree Medical Benefits, such coverage may begin after the maximum COBRA coverage period is exhausted, provided the Participant continues to be eligible for and pays for Early Retiree Medical Benefits. Early Retiree Medical Benefits are not offered under COBRA.

Importantly, an Early Retiree must timely enroll and remain enrolled to continue coverage for himself/herself and any eligible Dependents. An Early Retiree who terminates coverage during the Plan year will never again be eligible for Early Retiree Medical Benefits. Except as provided below under “Mid-Year Enrollment of Dependents”, an Early Retiree who terminates coverage during the Plan year for his/her eligible Dependent(s) will never again be eligible to enroll such Dependent(s) for Medical Plan coverage under the Early Retiree Medical Benefits program.

Please note this benefit is not intended to substitute a Participant’s eligibility for COBRA coverage, but is intended to supplement it by extending the usual 18 months of coverage until the Participant reaches Medicare entitlement.

**Termination of Early Retiree Medical Benefits**

An Early Retiree’s coverage will end on the first of the following dates:

- the date the Plan is amended to terminate the eligibility of any class of Eligible Early Retirees of which the Participant or former Participant is a member;
- the end of the last period for which the Eligible Early Retiree has made the required contribution;
- the last day of the month in which the Eligible Early Retiree attains age 65;
- the last day of the month in which the Eligible Early Retiree becomes entitled to Medicare (either Part A or Part B);
- the last day of the month in which the Eligible Early Retiree becomes eligible for or becomes covered under any other health care coverage, regardless of the source of such coverage;
- the date the Eligible Early Retiree dies (coverage ends on date of death);
- any other date provided under the terms of the particular Medical Plan; or
• the effective date of any Plan amendment eliminating Early Retiree Medical Benefits.

A Dependent’s coverage will end on the first of the following dates:

• the date the Early Retiree’s coverage terminates for any reason;

• the date the Plan is amended to terminate the eligibility of any class of Dependent of which such Dependent is a member;

• the end of the last period for which required contributions have been paid;

• the date the Dependent is no longer eligible to participate under the terms of the Plan or any Medical Plan;

• the last day of the month in which the Dependent becomes entitled to Medicare (Part A or Part B);

• the last day of the month in which the Dependent becomes eligible for or becomes covered under any other health care coverage, regardless of the source of such coverage;

• the last day of the month in which the Eligible Early Retiree dies (coverage for the Eligible Participant ends on date of death);

• any other date provided under the terms of the particular Medical Plan; or

• the effective date of any Plan amendment eliminating Early Retiree Medical Benefits.

Mid-Year Enrollment of Dependents

Each Early Retiree may enroll otherwise eligible Dependents during the Plan year due to one of the following events:

• Marriage. If an Early Retiree marries during the Plan year, the Early Retiree can enroll his or her new spouse and any eligible Dependent children acquired as a result of the marriage by properly filing an enrollment application within 31 days of the marriage. Coverage will be effective as soon as administratively practicable but in no event later than the first day of the month following the date TSRI receives a properly filed enrollment form and provided such form is received within 31 days of the date of marriage.

• Domestic Partnership. If an Early Retiree acquires a new Domestic Partner during the Plan year, the Early Retiree can enroll his or her Domestic Partner and any eligible Dependent children acquired as a result of the Domestic Partnership by properly filing an enrollment application within 31 days of entering into the Domestic Partnership. Coverage will be effective as soon as administratively practicable but in no event later than the first day of the month following the date TSRI receives a properly filed enrollment form and provided such form is received within 31 days of the date of the Domestic Partnership.

• New Child. If an Early Retiree or his or her spouse/Domestic Partner acquires a new Dependent child, either by birth, adoption or placement for adoption during the Plan year, the Early Retiree can enroll the new child (as well as his or her spouse/Domestic Partner if not already enrolled) by properly filing an enrollment application within 31 days of the child’s birth, adoption or placement for adoption. Coverage will be effective retroactive to the date of the birth, adoption or placement provided TSRI receives a properly filed enrollment form within 31 days of the birth, adoption or placement.

• Termination of Medicaid/CHIPs coverage or Eligibility for Premium Assistance. If an Early Retiree’s eligible Dependent is covered under a Medicaid plan or under a Children’s Health Insurance Program (CHIP) and coverage is terminated or an Early Retiree’s eligible Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, the Early Retiree can enroll his or her eligible Dependent by properly filing an enrollment application within 60 days of the occurrence of one of the
foregoing events. Coverage will be effective as soon as administratively practicable but in no event later than the first day of the month following the date TSRI receives a properly filed enrollment form and provided such form is received within 60 days of the occurrence of one of the foregoing events.

- Qualified Medical Child Support Order. An Early Retiree may be required to enroll a child for coverage under a health Plan providing Early Retiree Medical Benefits as directed by a qualified medical child support order.

TSRI reserves the right to amend or to terminate Early Retiree Health Benefits at any time and for any reason, by action of its Board of Directors or by action of a committee of individual(s) acting pursuant to a valid delegation of authority by the Board of Directors.

Continuation of Coverage During Military Service

Right to Continuation Coverage: In accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), a covered participant who goes on an unpaid military leave of absence may continue to participate in TSRI’s group health care Plans during the USERRA leave until the earlier to occur of:

- the end of the 24-month period beginning on the date on which the participant’s absence begins; or
- the period ending on the day after the date on which the participant fails to apply for or return to a position of employment with TSRI, as determined in accordance with USERRA.

If the USERRA leave is 31 days or longer, the participant may be required to pay up to 102% of the required contributions. If the USERRA leave is for less than 31 days, the participant’s required contributions will remain the same as similarly situated active participants.

If the participant elects to continue group health care coverage, the participant must pay contributions in the same amount (not to exceed 102% of the total cost of coverage under the particular Plan), form and manner as provided for those individuals who elect to continue coverage under COBRA. Coverage provided under USERRA will run concurrently with any right to continue coverage under COBRA.

If, after going on an unpaid leave of absence approved by TSRI, the participant fails to make the required contributions to continue coverage under TSRI’s group health Plans, his or her participation shall cease on the last day of the payroll period for which required contributions were last paid.

Please contact Human Resources for more information on military leaves and continuing your group health Plan coverage.

For more information on your rights under USERRA and military leaves, a VETS directory and additional information is available at [www.dol.gov/vets](http://www.dol.gov/vets). You can also contact Human Resources for information.

If your claim for continuation coverage is denied, you can ask for an appeal review. The section of this Summary Plan Description entitled “Statement of ERISA Rights” provides information about your rights under ERISA and tells you how to initiate an appeal review.
Dependent Care Spending Account

The Dependent Care Spending Account allows you to pay for qualified Dependent expenses with pre-tax gross income instead of after-tax net income. Consequently, you do not pay Social Security tax, Medicare tax, and federal income tax or, in most areas, state and local income tax on the gross income used to pay for dependent care, up to a certain amount.

Participation in the Dependent Care Spending Account is completely voluntary. You make the decision to participate in the account annually. During orientation you have the opportunity to enroll in this program. If you do not enroll during the initial enrollment period, you will have an opportunity each year during the Open Enrollment period.

The choice you make will become effective the later of:

- the first day of the next administratively practicable pay period following the date Human Resources receives your completed Benefits Change Form,
- the first date you become eligible under the Plan, or
- if you elect to participate during Open Enrollment, the following January 1.

All elections will remain in effect until December 31 of that year. You will not be able to change, start or stop contributions during the year, unless a qualified status change has occurred.

You must re-enroll in this Plan each year. If you do not enroll during the annual Open Enrollment period, you will not be able to participate in this Plan for that year unless you have a qualified status change.

Schedule of Benefits

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<th>Dependent Care Spending Account</th>
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<tr>
<td>Single or married filing jointly</td>
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<tr>
<td>Married filing separately</td>
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*Maximum contributions per household per calendar year.

**Assumes you receive a salary equal to or greater than the maximum contribution.

The minimum annual contribution is $120.00.

Eligibility

The benefits offered under the Dependent Care Spending Account will be available to active full-time and part-time (regularly scheduled to work at least 20 hours a week) Research Associates. As an eligible participant you must also satisfy the following requirements imposed by the Internal Revenue Service:

- you must be a single working parent; or
- you must be married and both you and your spouse work; or
- you must be a working parent and your spouse must be a full-time student during at least nine months of the year; or
- you must be working and your spouse must be a Qualifying Individual who is physically or mentally incapable of caring for himself or herself; and
- you are paying someone to provide dependent care services for one or more Qualifying Individuals and the provision of the dependent care services by another person or company is necessary to enable you to be gainfully employed.

**Dependent Eligibility**

Eligible participants may use this account to reimburse themselves for dependent care expenses for the following Qualified Individuals for whom they are entitled to claim a tax exemption:

- Dependent children under the age of 13; or
- Dependents or Spouses of any age who are physically or mentally incapable of self-care and who live with you for more than half the year

In addition, Qualified Individuals must meet the following IRS definition of a qualifying child or relative:

A qualifying child is one who:
- Is the participant’s daughter, son, stepchild, sibling, stepsibling or a descendant of any of these individuals and
- Has the same principal residence as the participant for over half the year and
- Doesn’t provide more than half of his or her own support.

A qualifying relative is one who:
- Is not a qualifying child and
- Has the same principal residence as the participant and is a member of the participant’s household and
- Has a gross income under the amount specified by the IRS for that year and
- Receives more than half of his or her support from the participant.

**Eligible Expenses: A Partial List**

Expenses that meet the requirements of the program include:

- in-home dependent care;
- care provided at a day care center or other location outside your home;
- before and after-school care; and
- summer day camp (if the cost is reasonable compared to other alternatives and the main purpose is to provide for the child’s well being).

**Ineligible Expenses: A Partial List**

Expenses that do not meet the requirements of the program include:

- school expenses for children in kindergarten or over;
- food provided for your Dependent*;
- clothing;
- registration fees, field trips, entertainment, etc.;
- expenses for care provided by your spouse, your child under age 19, or someone you claim as a Dependent for tax purposes;
- overnight camp expenses;
- transportation costs, with the exception of transit provided by the caregiver between the child’s school and the provider’s home/center.
May be covered if charges are "built in" to the actual childcare. If charged separate from the childcare, the expenses cannot be included as eligible for the Plan.

Qualified Providers

Qualified providers under the Dependent Care Spending Account include day care facilities and family day care homes that are in compliance with applicable state and local laws, as well as individuals who are neither your children under 19 nor your spouse’s Dependents (for federal income tax purposes). Qualified providers also include:

- daycare in an individual’s home, as long as the individual provides you with their tax identification number (social security number); and
- care by a housekeeper whose services include, in part, providing care for an eligible Dependent.

Enrollment into the Dependent Care Spending Account

As a condition to participation under this Plan, you must:

- execute and deliver an election form and authorize payroll deductions in the required amount;
- observe all rules and regulations of this Plan;
- agree to inquiries by TSRI with respect to any services covered by this Plan; and
- submit to TSRI, in a timely manner, all reports and other information that TSRI may reasonably require (including the amount by which your dependent care benefits in a particular year exceed the Internal Revenue Service limits).

Enrollment Steps

To enroll in the Dependent Care Spending Account, you must follow these important steps:

Step 1 Determine the total amount of qualifying dependent care expenses you paid throughout last year.

Step 2 Estimate the total amount you will be likely to pay in the coming year for such expenses.

Step 3 Complete the appropriate election form, indicating the amount to be allocated toward dependent care expenses for the year (this amount will be deducted equally between 24 pay periods).

Step 4 File the election form with Human Resources

Claims Procedures

Scope of Claims Procedures

These claims procedures apply to issues related to the pre-tax benefits available under the Dependent Care Spending Account. (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility and participation matters under Dependent Care Spending Account).

Reimbursement Steps

You will be reimbursed for all Eligible Expenses up to the amount actually deposited into your account as of the date the claim was received. The request for reimbursement must be for services already rendered. Future dates of service cannot be reimbursed.
Reimbursement is obtained by properly completing the reimbursement form, along with providing a receipt from the provider with the dates of service, the amount and the provider’s tax identification number. You may send the request for reimbursement via regular mail, or via facsimile. You should receive reimbursement as soon as administratively practicable, but in no case later than 30 days after receipt of the claim by the Claims Administrator. Reimbursement forms are available from Human Resources. You may file claims as often as you like.

The check that you receive from your reimbursement account will be payable to you only. You may elect to have your reimbursement directly deposited in your checking or savings account.

To be sure that you have enough time to submit all your claims, you are allowed a 180-day grace period after the end of the year (until June 30) in which to submit claims for Eligible Expenses incurred through December 31 of the previous year.

IMPORTANT!

All claims for Eligible Expenses incurred during the Plan year must be presented to the Claims Administrator for payment before June 30 following the close of the Plan year.

Claim for Benefits

Any Participant, beneficiary, or his duly authorized representative may file a claim for a benefit to which the claimant believes that he is entitled. Such a claim must be In Writing and delivered to the Claims Administrator in person, by mail, postage paid, e-mail or by facsimile. Within 30 days after receipt of such claim, the Plan Administrator shall send to the claimant, by mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 30-day period. The Claims Administrator shall have discretionary authority to deny or grant a claim in whole or in part.

Notification of Denied Claim

The Claims Administrator shall provide a written notice to every claimant who is denied a claim for benefits. Such written notice shall set forth in a manner calculated to be understood by the claimant and include:

- the specific reasons for the denial;
- specific references to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary;
- an explanation of the Plan’s appeal procedure;
- a statement of the claimant’s right to submit written comments and have them considered;
- a statement of the claimant’s right to review relevant documents and other information on request and at no charge; and
- a statement of the claimant’s right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the denied claim.

Appeal of Denied Claims

Within 180 days after the receipt by the claimant of written notification of the denial (in whole or in part) of his claim, the claimant or his duly authorized representative may make a written request to the Claims Administrator, in person or by certified mail, postage prepaid, to be afforded a review of such denial. If the claimant does not appeal within the 180-day period, the claimant shall lose the right to appeal the denial and the right to file suit in court. The request for review shall:

- be In Writing;
• state the reasons why the claim should not have been denied; and
• include any facts or documents pertinent to the claim.

The claimant or his authorized representative shall have the opportunity ask additional questions to the Plan Administrator, submit written comments to the Claims Administrator and review and request documents and other information relevant to his appeal at no charge.

**Review of Denied Claims**

The Claims Administrator shall review and decide a request for a review in a reasonable time not later than 60 days after the Claim Administrator's receipt of the request for a review unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 60 days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 60-day period. If the Claim Administrator affirms the initial denial of a claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

• the specific reasons for the denial;
• specific references to pertinent Plan provisions on which the denial is based;
• a statement of the claimant’s right to review relevant documents and other information on request and at no charge; and
• a statement of the claimant’s right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the denied claim.

**IRS Requirements**

**Forfeiture of Dependent Care Expenses**

*If you do not use the amount you elect to reduce your salary by prior to the end of each Plan year, you lose it.* This amount is not refundable. Any portion of the non-refundable election that has not been utilized by you under the Plan provisions will be used to cover the administrative cost of this Plan. It is advisable to plan conservatively and take into account vacation time, personal days and possible illness.

**Limitations to Deduction Changes**

You may only change the amount allocated for the Dependent Care Spending Account **prior** to the beginning of each Plan year. It may not be changed at any other time during the Plan year, **except** in the case of a qualified change in status.

Any changes made due to a qualified change in status must be consistent with the change in status, as determined by TSRI in its sole discretion. An election change generally satisfies this requirement if the qualified status change results in you or your eligible Dependents becoming eligible or ineligible for coverage under this Plan or a similar plan offered by your Dependent’s employer and the change in your election corresponds with the change in eligibility for coverage. An election change may also satisfy the consistency requirement if the qualified change in status affects the amount of qualifying dependent care expenses and the election change corresponds with the change in the amount of expenses.

Human Resources may request that you provide proof of a qualified change in status (e.g., birth certificate, marriage certificate, etc.). Please see the section below entitled "Qualified Change in Status" for further information.

An election to reduce your salary is valid for one Plan year only. If you want to change the amount of your salary reduction or continue your election for the next Plan year, you must file and complete the appropriate enrollment form during Open Enrollment with Human Resources **on or prior to** the date specified by TSRI.
Limitations to Covered Expenses

This Plan covers only Eligible Expenses incurred:

- after you become a participant; and
- during the applicable Plan year (the calendar year), subject to the leave of absence rules discussed below.

This Plan does not cover amounts incurred by you for care rendered by either a Dependent with respect to whom you or your spouse are allowed a deduction on your federal income tax return or a child/Dependent of yours who is under the age of 19. For example, payment to your 15-year-old daughter for baby-sitting your son would not be covered by this Plan.

Status Changes

The IRS recognizes that when you elect to join the Dependent Care Spending Account at the beginning of each Plan year, you cannot predict certain events that may affect your dependent care expense estimate. For example:

- If you give birth to, adopt or become legal guardian to another child/Dependent during the year, you may need to increase the amount you allocated for dependent care costs or enroll in this Plan.
- In the event of the death of your Dependent, you may need to stop or decrease the amount allocated for dependent care costs.
- If you are a single parent and get married during the year to a non-working spouse, you may no longer need or be eligible to obtain benefits under the Dependent Care Spending Account.
- If you and your non-working spouse divorce and you have Dependents, you may join the Dependent Care Spending Account.
- If there is a significant change in the cost of your dependent care provider’s services (except services provided by a relative), you may need to change the amount you allocated for dependent care costs.
- If there is a significant change in the hours or services of your dependent care provider, you may need to change the amount you allocated for dependent care costs.
- If you or your current provider change residence or day care address, you may need to change the amount you allocate for Dependent Care costs.
- Any other IRS recognized status change as it relates to the Dependent Care Spending Account.

If any of these types of events occur, you may be permitted to change your election contribution mid-year. Changes to your Dependent Care Spending Account must be made within 31 days of the qualified status change and will be effective on the first day of the next administratively practicable pay period following the date Human Resources receives the signed and properly completed Benefits Coverage Change Form, provided such Form is received within 31 days of the qualified change in status. Changes in status are the only types of events that will enable you to change your election during the course of a Plan year.

Allowable Deductions

The Internal Revenue Service imposes certain limitations on the amounts that may be excluded each year from a participant's income for purposes of determining the participant's taxes. If these limitations (which are set forth below) are exceeded in any calendar year, the excess will be taxable to you.

- If you are single, your annual dependent care allocation cannot exceed the lesser of $5,000 or your annual earned income.
- If you are married and filing jointly, your aggregate annual dependent care allocation for that year cannot exceed the lesser of:
  - $5,000;
  - your annual earned income for such year; or
● your spouse's annual earned income for such year.
● If you are married and filing separately, your annual dependent care allocation cannot exceed the lesser of $2,500 or your earned income.

For purposes of the above determination, if your spouse is a full-time student or is physically or mentally incapable of caring for himself or herself during the year, your spouse will be considered to have earned income of $250 per month if there is one Qualifying Individual with respect to you or $500 per month if there are two or more Qualifying Individuals with respect to you.

TSRI will not withhold federal, state, or Social Security taxes from amounts allocated to your Dependent Care Spending Account unless the Plan Administrator determines that the $2,500 or $5,000 (as applicable) limitation has been exceeded. You, in turn, will have an obligation to notify TSRI, In Writing, of the amount by which the dependent care benefits you received during the preceding year exceeded the IRS limits set forth above.

As a condition to receiving the pre-tax benefits made available under the Dependent Care Spending Account, you are required to report on your tax return under Form 2441 the correct name, address and taxpayer identification number (or Social Security number) of your dependent care provider and the amounts paid to the provider. It is your responsibility to make sure that expenses submitted for dependent care reimbursement are eligible. You will be held responsible for taxes and penalties associated with ineligible expenses if the IRS audits you. Dependent care expenses that are reimbursed from your account cannot be claimed as a tax credit on your income tax return.

**Tax Credit**

Federal tax law allows you to take a credit on your income tax return for eligible dependent care expenses. This credit is based on your adjusted gross income. For the 2010 tax year, the credit ranges from 20% to 35% of your eligible dependent care expenses and is limited to $3,000 a year for one Dependent or $6,000 a year for two or more Dependents.

The Family Support Act of 1988, passed by Congress in September 1988, has limited your ability to take advantage of both the tax credit and the Dependent Care Spending Account. Under the law, the dollar amount of expenses eligible for the tax credit ($3,000 in the case of one Qualifying Individual and $6,000 in the case of two or more Qualifying Individuals) is reduced, dollar for dollar, by the amount by which you elect to reduce your salary under the Dependent Care Spending Account.

For example, assume that you have one Dependent, your total dependent care expenses are $3,600, and you elect to put $3,000 through the Dependent Care Spending Account. The remaining $600 of dependent care expenses would not be eligible for the tax credit, since the tax credit, which is otherwise available to you ($3,000), must be reduced by the amount you exclude from income under the Dependent Care Spending Account ($3,000), resulting in an available tax credit of zero. By contrast, if you elect to put only $1,000 of dependent care expenses through the Dependent Care Spending Account, then $2,000 of such expenses ($3,000 minus $1,000) would be eligible for the tax credit.

You are responsible for determining whether the Dependent Care Flexible Spending Account or the tax credit is more beneficial for you. The answer will depend on your personal situation. Generally, if you have one child receiving qualified care, in excess of $3,000, the Dependent Care Flexible Spending Account may be more beneficial. If your childcare expenses for one child are less than $3,000 and your adjusted gross income is less than $27,000, it may be to your advantage to use the tax credit. If you have two or more children receiving qualified care and your adjusted gross income is greater than $37,000, the Dependent Care Flexible Spending Account may be more beneficial for the first $5,000 of expenditures. If your qualified child care expenses exceed the $5,000 that have been directed to the Dependent Care Flexible Spending Account, you may have the opportunity to apply for the tax credit up to an additional $1,000.

This information is provided to you as a courtesy only, as TSRI does not provide tax advice. Each individual situation is different and the above information is only intended as a guide. You should therefore speak with your tax advisor before making a decision to participate in the Dependent Care Spending Account.
Leaves of Absence

Regardless of whether your leave of absence is a paid leave or an unpaid leave, your Dependent Care Spending Account election (i.e., your elected contributions) will terminate effective with the first day your leave begins. You may continue to be reimbursed for any dependent care expenses you incurred before your leave began. However, you may not be reimbursed for any dependent care expenses you incur while you are out on leave.

When you return from leave, you may once again contribute to the Dependent Care Spending Account by submitting a new Benefits Coverage Change Form to Human Resources within 31 days of your return from leave. Your contributions will be effective the first day of the next administratively practicable pay period after Human Resources receives your signed and properly completed Benefits Coverage Change Form, provided you submit the Form within 31 days of your return from leave.

Termination of Participation

Participation in the Dependent Care Spending Account will end on the earlier of:

- The last day of the month in which you are no longer eligible to participate in the Dependent Care Spending Account because you cease Active Work or you begin to work fewer hours than required under the definition of an eligible participant although you may continue to seek reimbursement of Eligible Expenses for the Plan year until June 30 after the end of the calendar year in which you are no longer eligible for participation;
- The first day of the next administratively practicable pay period after the date you are no longer eligible to participate in the Dependent Care Spending Account for reasons other than your cessation of Active Work or reduction in hours, although you may continue to seek reimbursement of Eligible Expenses for the Plan year until June 30 after the end of the calendar year in which you are no longer eligible for participation;
- the first day of the next administratively practicable pay period after the date you notify Human Resources, In Writing, of your intent to stop the Dependent Care Spending Account election due to a qualified status change (other than your cessation of Active Work or reduction in hours) by completing a Benefits Coverage Change Form;
- the date the Dependent Care Spending Account is terminated;
- on December 31 each year, unless you elect to re-enroll for the next year.

If you terminate with TSRI and you are rehired as an eligible Participant within 30 days of your termination and within the same calendar year, your previous Dependent Care Spending Account elections will automatically be reinstated effective the first day of the next administratively practicable pay period following your return to TSRI.

If you terminate with TSRI and are rehired as an eligible Participant after 90 days of your termination but still within the same calendar year, you may elect to continue your previous Dependent Care Spending Account election or make a new election for the remainder of the calendar year by submitting a new Benefits Coverage Change Form to Human Resources within 30 days of your return to TSRI. Your election will be effective the first day of the next administratively practicable pay period after the date Human Resources receives your new signed and properly completed Benefits Coverage Change Form, provided you submit your new Form to Human Resources within 31 days of your return to TSRI.

Definitions

Claims Administrator - Please refer to the section of this Summary Plan Description entitled "General Information" to find out how to contact the Claims Administrator for the Dependent Care Spending Account.

Plan Administrator - The Scripps Research Institute (TSRI)
**Dependent** - In general, a person is your dependent for a particular year if he or she is closely related to you or is a member of your household and you provided more than one-half of his or her support during the year. The instructions to your federal income tax return discuss in some detail who qualifies as your dependent.

**Eligible Expenses** - The only expenses covered under this Plan are dependent care expenses for a Qualifying Individual and expenses that must be incurred in order for you to be gainfully employed.

**Plan** - The plan is The Scripps Research Institute’s Dependent Care Spending Account.

**Qualifying Individual** - A qualifying individual is an individual who meets any one of the following descriptions:

- your Dependent who is your son, daughter, stepson, or stepdaughter and who was 12 years of age or under during the entire year;
- any other of your Dependents who were 12 years of age or under during the entire year and whose income for the year was less than $2,000;
- your spouse or Dependent who is physically or mentally incapable of caring for him or herself and who lives with you at least eight hours a day and for whom you provide at least 50 percent of the support for their care.

**Statement of ERISA Rights**

**ERISA**

As a participant in the TSRI welfare benefit Plans described in this document, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974 as amended. ERISA provides that all Plan participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) filed by the Plans with the U.S. Department of Labor and available at the Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of documents governing the operation of the Plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated Summary Plan Description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report;
- continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plans as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review the section of this Summary Plan Description entitled "Continuation of Health Care Benefits Under COBRA" and the documents governing the Plans on the rules concerning your COBRA continuation coverage rights;
- reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under a plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in the Plan. See the "Medical Benefit" section entitled "Restrictions for Pre-existing Conditions" for additional information.

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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done and to obtain copies of documents relating to the decision without charge. You have the right to have the Plans review and reconsider your claim, 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 Plans and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials, and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you may 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).

If you have any questions about the Plans, 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 Area 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The benefits described in this Summary Plan Description are provided under the welfare Plans identified on the table at the end of the section of this Summary Plan Description entitled "General Information." TSRI reserves the right to amend or terminate the Plans at any time and for any reason, by action of its board of directors or by action of a committee of individual(s) acting pursuant to a valid delegation of authority by the board of directors. If the Plan(s) is amended or terminated, you and other participants may not receive benefits as described in this summary. You may be entitled to receive different benefits, or benefits under different conditions, or you may lose all benefit coverage. In no event will you become entitled to any vested rights under the Plans. The provisions of the Plans cannot be modified orally or in any manner other than a formal written amendment that is duly adopted by TSRI.

This Summary Plan Description describes benefits provided under the Plans. Every effort has been made to ensure this description is accurate as of the date it was prepared. In the event of any conflict between this description and the terms of the Plans (for example, due to a subsequent change in any of the Plans), the terms of the Plans will control.

General Information

The Scripps Research Institute Group Health and Welfare Benefit Plan incorporates the following Plans: Medical, Dental, Mental Health, Prescription, Vision, and Dependent Care Spending Account.

Amendments and Termination of the Plans

Although TSRI expects to continue The Scripps Research Institute Group Health and Welfare Benefit Plan and the Plans incorporated therein (the “Plan(s)”)) indefinitely, TSRI reserves the right to amend or to terminate the Plan(s) at any time and for any reason, by action of its board of directors or by action of a committee of individual(s) acting pursuant to a valid delegation of authority by the board of directors. If the Plan(s) is amended or terminated, you and other participants may not receive benefits as described in this summary. You may be entitled to receive
different benefits, or benefits under different conditions. However, it is possible for you to lose all benefit coverage. This may happen at any time, if TSRI decides to terminate the Plan(s) or your coverage under the Plan(s). In no event will you become entitled to any vested rights under the Plan(s). The provisions of the Plan(s) cannot be modified orally or in any other manner, except by properly adopted amendment.

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

This document is a Summary Plan Description of the Plan(s) that describes only the highlights of each Plan. The full terms of the Plan(s) are contained in the Plan texts on file with TSRI. You may obtain copies of these documents from Human Resources for a small fee.

The information presented here in this Summary Plan Description does not replace the detailed benefit plan texts that legally govern the Plan(s)’ operations. In the event of any conflict between this description and the terms of the Plan(s) (for example, due to a subsequent change in the Plan(s)), the detailed text of the particular Plan will control and be used to determine when, what and to whom benefits will be provided and/or paid.

**Claims Procedures**

The claims procedures applicable to a Plan benefit are set forth at the end of the section of this document describing the benefit or in the separately provided Certificate of Insurance for the benefit. Please call Human Resources if you have any questions regarding how to file a claim for benefits under the Plan.

**General Provisions**

**Payment of Claims to Others**

If any payment for covered charges under the Plan(s) would be payable to the estate of any person, or to any person who is a minor or otherwise not competent to give a valid release, the Plan Administrator or Claims Administrator (to the extent permitted by law) may distribute this benefit to any relative of the person by blood or marriage (or to any person who can demonstrate that the person paid your or your dependent’s medical expenses and is entitled to reimbursement) whom it deems to be entitled to the benefit. Any payment made by the Plan Administrator or Claims Administrator in good faith will discharge TSRI from all liability to such person to the extent of the payment.

If you have a claim for benefits under the Plan(s), you must follow the claims procedures applicable to the particular Plan. If you have any questions regarding how to make a claim for benefits under a particular Plan, please contact the Claims Administrator for that Plan (see the table at the end of this section) or Human Resources.

**No Assignment**

No benefit under the Plan may be voluntarily or involuntarily assigned or alienated. Notwithstanding the foregoing, the Plan will pay benefits in accordance with the terms of a Qualified Medical Child Support Order (QMCSO). See the "Medical Benefits" section for more information regarding QMCSOs. A copy of the Plan’s procedures for determining and implementing medical child support orders is available from the Claims Administrator.

**Governing Law**

This Plan shall be construed and enforced according to ERISA, the Internal Revenue Code and, to the extent applicable, according to the laws of the State of California.
Proof of Age, Financial Support and Marriage

TSRI or the Claims Administrator may require you or your dependents to furnish satisfactory proof of age, student status and financial support of dependents as a condition of maintaining coverage of such dependents and/or spouses under the Plan. TSRI or the Claims Administrator may also require proof of marriage in the case of a status change to add a spouse.

Worker’s Compensation

The Plan(s) is not in lieu of, and does not affect any requirements for coverage by Worker’s Compensation Insurance.

Employment Rights

Nothing in the Plan(s), this Summary Plan Description, or any benefit communication shall be deemed to give any person any right to remain in the employ of TSRI or to affect the right of TSRI to terminate the employment of any person at any time with or without cause. TSRI reserves the right to terminate your employment at any time for any reason.

Plan Administrator's Authority to Interpret Plan(s)

The Plan Administrator has the full and exclusive authority to interpret the terms of the Plan(s) and determine claims for benefits under the Plan(s), including claims for eligibility for coverage under the Plan(s). The decisions of the Plan Administrator are final, conclusive and binding on all persons.

The Plan Administrator may delegate its authority to determine claims for benefits under a particular Plan to the Claims Administrator for the Plan. The Claims Administrator, if any, for a particular Plan is identified on the table at the end of this section, along with the Claims Administrator's contact information.

For medical coverage, the Plan has been established on a noninsured basis; all liability for payment of benefits is assumed by TSRI. While UMR administers payment of claims, UMR has no liability for the funding of the benefit Plan.

While one of the functions of UMR is to process claims according to the Plan provisions, all claims under the Plan are paid by TSRI and TSRI owns the claim files. Therefore, the final decision on any disputed claim may involve review of these files by TSRI.

TSRI, as Plan Administrator has complete discretion to construe or interpret all provisions, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. TSRI's decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by the TSRI, TSRI shall be deemed to have exercised its discretion properly unless it is proved duly that TSRI has acted arbitrarily and capriciously.

The plan shall be construed and administered to comply in all respects with applicable federal law.

Plan Administration

Plan Sponsor

The Scripps Research Institute (TSRI)
10550 North Torrey Pines Road - TPC11
La Jolla, CA 92037
Telephone: (858) 784-8487
Employer Identification Number: 33-0435954
Plan Administrator

TSRI is the Plan Administrator within the meaning of the Employee Retirement Income Security Act of 1974, as amended (ERISA) for the Plan(s).

The Scripps Research Institute (TSRI)
10550 North Torrey Pines Road - TPC11
La Jolla, CA  92037
Telephone:  (858) 784-8487

If you have questions, contact Human Resources at (858) 784-8487.

Agent for Service of Legal Process

The Scripps Research Institute (TSRI)
10550 North Torrey Pines Road - TPC11
La Jolla, CA  92037
Telephone:  (858) 784-8487

Privacy of Your Health Information

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was previously distributed to you and is available from Human Resources.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of it business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or Participant benefit plan of the Plan Sponsor. However, the Plan is part of an “organized health care arrangement” under which the individual health benefits and the applicable service providers and insurers may share protected health information for treatment, payment and health care operations and may undertake joint activities to manage the organized health care arrangement’s operations and improve the quality of the health care it provides.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, if you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact TSRI Human Resources, Benefits Administration at (858) 784-8487.
<table>
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<tr>
<th>Name of Plan</th>
<th>Medical</th>
<th>Dental</th>
<th>Mental Health</th>
<th>Prescription</th>
<th>Vision</th>
<th>Employee Assistance Program</th>
<th>Dependent Care Spending Account</th>
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<tr>
<td>Type of Plan</td>
<td>Welfare plan providing medical benefits with the following coverage choices: Comprehensive Medical Plan - Catastrophic Plan</td>
<td>Welfare plan providing dental benefits</td>
<td>Welfare plan providing mental health benefits to Participants and dependents enrolled in a Group Medical Plan</td>
<td>Welfare plan providing prescription benefits to Participants and dependents enrolled in a Group Medical Plan</td>
<td>Welfare Plan providing vision benefits to Participants and dependents enrolled in a Group Medical Plan</td>
<td>Welfare plan providing no-cost confidential, professional counseling services</td>
<td>Welfare plan providing for reimbursement of eligible dependent care expenses</td>
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<td>The Medical Plans are self-insured by TSRI, which means that benefits under the Medical Plans are not guaranteed by a contract of insurance. The plan is currently funded by a combination of TSRI and Participant contributions. The total contributions are determined by TSRI. The Participant rate of contribution is set by TSRI and may be adjusted from time to time. The balance of the cost of the plans (if any) is currently paid by TSRI.</td>
<td>The Dental Plan is self-insured by TSRI, which means that benefits under the Dental Plan are not guaranteed by a contract of insurance. The plan is currently funded by a combination of TSRI and Participant contributions. The total contributions are determined by TSRI. The Participant rate of contribution is set by TSRI and may be adjusted from time to time. The balance of the cost of the plans (if any) is currently paid by TSRI.</td>
<td>The plan is insured by United Behavioral Health. The plan is currently funded by a combination of TSRI and Participant contributions. The premiums for plan benefits are set forth in or determined pursuant to the terms of each contract. The Participant rate of contribution is set by TSRI and may be adjusted from time to time. The balance of the cost of the plan (if any) is currently paid by TSRI.</td>
<td>The prescription plan is self-insured by TSRI, which means that benefits under the prescription plan are not guaranteed by a contract of insurance. The plan is currently funded by a combination of TSRI and Participant contributions. The total contributions are determined by TSRI. The Participant rate of contribution is set by TSRI and may be adjusted from time to time. The balance of the cost of the plans (if any) is currently paid by TSRI.</td>
<td>The vision plan is self-insured by TSRI, which means that benefits under the vision plan are not guaranteed by a contract of insurance. The plan is currently funded by a combination of TSRI and Participant contributions. The total contributions are determined by TSRI. The Participant rate of contribution is set by TSRI and may be adjusted from time to time. The balance of the cost of the plans (if any) is currently paid by TSRI.</td>
<td>The counseling and postdoctoral services program is self-insured by TSRI, which means that benefits under the counseling and postdoctoral services plan are not guaranteed by a contract of insurance. The plan is currently funded by TSRI contributions. The total contributions are determined by TSRI. The Participant rate of contribution is set by TSRI and may be adjusted from time to time. The balance of the cost of the plans (if any) is currently paid by TSRI.</td>
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<td>Plan Administrator</td>
<td>TSRI</td>
<td>TSRI</td>
<td>UBH</td>
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<td>Claims Administrator Address/Phone:</td>
<td>UMR PO Box 30541, Salt Lake City, UT 84130-0530 (800) 834-3482</td>
<td>Delta Dental P.O. Box 997330 Sacramento, CA 95869-7330 (800) 765-6003</td>
<td>UBH P.O. Box 30755 Salt Lake City, UT 84130 (800) 888-2998</td>
<td>CAREMARK® P.O. Box 52115 Scottsdale, AZ 85260 (800) 966-5772</td>
<td>VSP P.O. Box 977105 Sacramento, CA 95899-7105 (800) 877-7195</td>
<td>UBH P.O. Box 30755 Salt Lake City, UT 84130 (800) 888-2998</td>
<td>UMR P.O. Box 8022 Wausau, WI 54402-8022 (800) 826-9781</td>
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