

**PRIORITY ONE SERVICES, INC.  
HEALTH AND WELFARE BENEFIT PLAN**

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**SUMMARY PLAN DESCRIPTION**

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**Amendment and Restatement  
Effective October 1, 2008**

## ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Priority One Services, Inc. Health and Welfare Benefit Plan (the "Plan"). We urge you to read this summary carefully.

This summary is the "Summary Plan Description" for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Priority One Services, Inc. (the "Employer") and are available to you for inspection at a time and place mutually agreeable to you and to the Employer.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

**PRIORITY ONE SERVICES, INC. HEALTH AND WELFARE BENEFIT PLAN**

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## GENERAL INFORMATION ABOUT THE PLAN

### Name of Plan

Priority One Services, Inc. Health and Welfare Benefit Plan

### Name and Business Address of Employer

Priority One Services, Inc.  
6600 Fleet Drive  
Alexandria, Virginia 22310

### Employer's Taxpayer Identification Number

52-485079

### Plan Number

502

### Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. All benefits are provided through insurance contracts.

### Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

### Insurance Issuer's Name and Business Address

UnitedHealthcare, P.O. Box 740800, Atlanta, GA 30374-0800 is the insurer and claims processor of your medical/prescription drug benefits under the Plan. The Plan's medical/prescription drug benefits are fully guaranteed under the policy of insurance issued by this company. If another insurance issuer replaces this issuer or the fully guaranteed nature of your medical/prescription drug benefits change, a new Benefits Booklet communicating the new information will be delivered to you (and any such Benefits Booklet is incorporated in this Summary by this reference).

Delta Dental, 4818 Starkey Road, SW, Roanoke, VA 24014 is the insurer and claims processor of your dental benefits under the Plan. The Plan's dental benefits are fully guaranteed under the policy of insurance issued by this company. If another insurance issuer replaces this issuer

or the fully guaranteed nature of your dental benefits change, a new Benefits Booklet communicating the new information will be delivered to you (and any such Benefits Booklet is incorporated in this Summary by this reference).

UnitedHealthcare Vision Claims Department, PO Box 30978, Salt Lake City, UT 84130 is the insurer and claims processor of your vision benefits under the Plan. The Plan's vision benefits are fully guaranteed under the policy of insurance issued by this company. If another insurance issuer replaces this issuer or the fully guaranteed nature of your dental benefits change, a new Benefits Booklet communicating the new information will be delivered to you (and any such Benefits Booklet is incorporated in this Summary by this reference).

### Plan Year

The Plan Year is the period beginning each October 1 and ending each September 30 during which the Plan is in effect.

### Name, Business Address and Telephone Number of Plan Administrator

Priority One Services, Inc.  
c/o Human Resources Department  
6600 Fleet Drive  
Alexandria, Virginia 22310  
703-971-5505

### Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

### Type of Plan

This Plan is a form of employee welfare benefit plan called a "cafeteria plan" because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. Because your salary is reduced before federal taxes (and, in most states, State taxes) are imposed, you pay less in taxes if you participate in the Plan.

### Eligibility

If you are a full-time regular employee of the Employer (i.e., if you are regularly scheduled to work at least thirty-five (35) hours per week, as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning on (i) the first day of the month following the month in which you become an employee of the Employer, in the case of your medical/prescription drug, dental and vision benefits and (ii) the day you become an Employee, in the case of all other benefits offered under the Plan (your "Participation Date").

Please note that leased employees and persons classified by the Employer as temporary employees of the Employer (as determined by the Employer) are not permitted to participate in the

Plan. If you are a full-time regular employee of the Employer (i.e., if you are regularly scheduled to work at least thirty-five (35) hours per week, as determined by the Employer) and you are a member of either of the following Unions you are eligible to participate in the Plan: Local Union 1757 of the Amalgamated Transit Union (AFL-CIO) and Local 4873 of Industrial, Technical and Professional Employees Union Affiliated with OPEIU-AFL-CIO. A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer. In addition, if the Employer is or becomes a sole proprietorship, a partnership, a limited liability company, a limited liability partnership or a subchapter S corporation, sole proprietors, partners, limited liability company principals, limited liability partners and 2% shareholders (as defined under applicable law) of the Employer and their dependents generally are not permitted to participate in the pre-tax salary reduction feature of the Plan.

If your employment terminates while you are a participant in the Plan and you are later rehired, you will again become a participant in the Plan (i) the first day of the month following your rehire date in the case of the medical/prescription drug, dental and vision benefits under the Plan and (ii) your rehired date in the case of all other benefits under the Plan. However, if you are rehired during the same Plan Year and within 30 days after your previous period of employment ended, you generally will not be permitted to make a new election of benefits, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include this information.

### Dependent Eligibility

For Plan purposes, your eligible dependent is anyone who is a "dependent" as those terms are defined in the Benefit Booklets delivered in connection with this Summary.

If anything in this section conflicts with the Benefit Booklets, the Benefit Booklets will prevail.

For purposes of the Plan's dependent eligibility requirements, an employee's "spouse" is a person of the opposite sex who is treated as the spouse of the employee under applicable law. Notwithstanding the preceding, for purposes of determining if someone is eligible for coverage as a spouse, the Plan does not recognize common law marriages, regardless of whether the marriage is recognized in any State.

In addition, your spouse, domestic partner or child will not qualify as an eligible dependent while on active duty in the armed forces of any country. Also, no one who is not a citizen or national of the United States will qualify as an eligible dependent unless he or she is a resident of the United States. However, the preceding sentence will not apply to exclude your legally adopted child from being an eligible dependent, if that child is a member of your household and resides in your home and you are a citizen or national of the United States.

Medical/prescription drug benefits are available under the Plan to domestic partners of employees and children of domestic partners who live with you and are your tax dependent or your domestic partner's tax dependent. For purposes of those benefits, an employee's "domestic partner" is someone who qualifies as his or her domestic partner under the Employer's domestic partner policy. For more information about that policy, please contact the Plan Administrator. Coverage provided for a domestic partner or a child of a domestic partner generally is subject to federal and state income tax, unless the domestic partner or child qualifies as your dependent for tax purposes.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan's dependent eligibility rules, subject to the Employer's final approval. The Employer may require you to provide proof that an individual satisfies the Plan's eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility.

If an employee and his or her spouse or dependent are both employees of the Employer and both of them meet the Plan's eligibility requirements to participate in the Plan as employee/participants, each employee may elect employee-only medical/prescription drug, dental, or vision coverage or one of them can elect family (or employee and spouse or dependent) coverage. However, no employee can be covered under the Plan's medical/prescription drug, dental, or vision coverage as another employee's spouse or dependent at the same time that he or she is also covered under the Plan as an employee/participant.

For purposes of the Plan's medical/prescription drug, dental, or vision coverage, if a child would otherwise be a dependent of more than one participant, the child may be treated as the dependent of only one participant. If this applies to you, you and your spouse must decide who will elect coverage for the child.

For any medical coverage offered under the Plan that is subject to the portability requirements of the Health Insurance Portability and Accountability Act of 1996 (as determined by the Employer), the Plan will not impose any preexisting condition exclusion on a newborn child, or a child (under 18 years of age) adopted by or placed for adoption with an eligible employee (i.e., an employee who is eligible for Plan coverage at the date of the adoption or placement for adoption), if the child is covered under creditable coverage at any time during the first 30 days after the birth, adoption or placement for adoption (whichever is applicable) and the child is enrolled in the Plan's medical coverage, under the terms of the Plan, without experiencing a significant break in coverage after the birth, adoption or placement for adoption.

All Qualified Medical Child Support Orders that provide Plan coverage for so-called "Alternate Recipients" will be honored by the Plan. (These orders are a type of order by a divorce court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" which is to be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a copy of these procedures.

## Participation

You may become a participant on your Participation Date, provided you properly submit an Election Form to the Plan Administrator before that date and during the period designated by the Plan Administrator as your initial "enrollment period" and provided the Employer determines you have the status of an active employee of the Employer on your Participation Date. For purposes of medical benefits only, you will be treated as an active employee on that date even if you are absent from work if your absence occurs because of a health condition (as determined by the Employer).

(a) Election Form: Initial Election Period. You must properly complete and submit an initial Election Form to the Plan Administrator before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period" in order to enroll in the Plan for your initial coverage period (i.e., the period beginning on your Participation Date and ending on the last day of the Plan Year in which falls your Participation Date). Your benefit elections made on the initial Election Form will be effective from your Participation Date until the last day of the Plan Year in which falls your Participation Date. Your election generally is irrevocable during the initial election period, unless you or your dependents experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below). You must elect medical/prescription drug coverage unless you are able to demonstrate that you have other medical coverage.

If you fail to properly complete and submit an Election Form to the Plan Administrator during the initial election period, you will automatically receive Employer-paid life insurance/accidental death and dismemberment ("AD&D") coverage, short term disability and long term disability coverage and you will be enrolled in the lowest cost medical/prescription drug coverage (unless you are able to demonstrate that you have other medical coverage), but you will not participate automatically in any other feature of the Plan. You may become a participant in other coverages available under the Plan during the Plan Year only as provided in Sections (e) through (f).

(b) Annual Election Periods After Initial Election Period. After you complete the initial Election Form, you must complete and submit an Election Form to the Plan Administrator for each new Plan Year during the period preceding such Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your election will be effective for the next Plan Year and is irrevocable unless you or your dependents experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below). If you fail to complete and submit a new Election Form, you will not automatically participate in the Plan for the next Plan Year (except for any benefits that are provided automatically as described in (a) above).

(c) Changes of Election to Reflect Status Change. Within 30 days after a Status Change, you may, with the approval of the Plan Administrator and subject to conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form, provided that the change you make to your elections is consistent with the Status Change.

The Employer will determine whether, under applicable law, a requested change is consistent with the Status Change you experience. For example, if you become eligible for health

coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan. However, for purposes of group term life insurance/accidental death or dismemberment insurance or disability coverage, any change you wish to make because of a Status Change, such as increasing coverage, decreasing coverage or dropping coverage, will be treated as consistent with the Status Change.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective for the balance of the Plan Year in which the new election is made.

You will be deemed to have a Status Change if:

- (1) your marital status changes through marriage, the death of your spouse, divorce, legal separation or annulment;
- (2) there is an event which causes you to gain or lose a dependent;
- (3) you, your spouse or your dependent terminates or begins employment;
- (4) there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;
- (5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);
- (6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage under the Plan due to attainment of age, student status, or similar circumstance;
- (7) there is a change in location of the residence or worksite of you or your spouse or other dependent; or
- (8) for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change.

Under applicable law, to be permitted to make a change of election relating to your coverage for a benefit due to a Status Change (among other requirements) the Status Change must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within a reasonable time after your right to change your election arises (as determined by the Plan Administrator, in its discretion). Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective for the balance of the Plan Year in which the new election is made.

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

(i) Significant Cost Changes. If the cost that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the cost that you are required to pay for a benefit option significantly decreases (as determined by the Employer) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

You may change your elections because of a significant cost change, as described above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the Employer or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Coverage Changes. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the Employer).

If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the Employer), and the significant curtailment amounts to a complete loss of coverage (as determined by the Employer), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual or lifetime limit. The Employer, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

If the Employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the Employer), you may change your

elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes that your spouse or a dependent makes to his or her benefit elections under a benefit plan offered by his or her employer. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's annual election period, you may change your benefit elections to correspond to the changes elected by your spouse during his or her employer's annual election period. Also, if your spouse's employer has a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and your spouse makes one of those permitted changes, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made by your spouse. For example, if your spouse revokes a benefit election for a health plan offered by his or her employer because of the increase in cost, you could change your election under a health plan offered by this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

The rights described in paragraphs (i) through (iv) above do not apply to elections involving a health care flexible spending account. You may not make an election change for any benefit option because of a change in cost or coverage under a health care flexible spending account maintained by the employer of your spouse or dependent.

(e) Other Election Changes. If you are entitled to an election change described below, you must request the change within a reasonable time after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, subject to the Employer's approval, the Plan Administrator may change your health coverage election if the Plan is required by the order to provide such coverage and may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

If you or your spouse or dependent becomes eligible for continued health coverage under the Employer's health plan as provided under COBRA or any similar State law, you may change your election to pay for that COBRA coverage with salary reduction contributions.

Finally, if you take leave under the Family and Medical Leave Act of 1993 ("FMLA"), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You (or your dependent) will be treated as losing eligibility for other coverage if the coverage is no longer available because you (or your dependent) have reached a lifetime limit for all benefits under that coverage. In that case, you must request enrollment within 30 days of the date that a claim is denied, in whole or in part, because of reaching that lifetime limit, or, if the other coverage is COBRA continuation coverage, within 30 days after a claim that would exceed the lifetime limit is incurred.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

### Termination of Participation

Coverage for a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment in the case of life insurance/AD&D, short term disability and long-term disability benefits.

(b) The last day of the month in which the participant terminates employment in the case of medical/prescription drug, dental and vision benefits.

(c) Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant in the case of life insurance/AD&D, short term disability and long-term disability benefits.

(d) Except in the case of certain leaves of absence, the last day of the month in which the participant ceases to qualify as an eligible employee of the Employer or a participant in the case of medical/prescription drug, dental and vision benefits.

(e) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(f) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.

(g) The day on which all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment in the case of life insurance/AD&D, short term disability and long-term disability benefits.

(b) The last day of the month in which the participant terminates employment in the case of medical/prescription drug, dental and vision benefits.

(c) Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant in the case of life insurance/AD&D, short term disability and long-term disability benefits.

(d) Except in the case of certain leaves of absence, the last day of the month in which the participant ceases to qualify as an eligible employee of the Employer or a participant in the case of medical/prescription drug, dental and vision benefits.

(e) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(f) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.

(g) The day on which all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

(h) The last day of the month in which the eligible dependent ceases to be an eligible dependent.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). You will be required

to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

### Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a change to your elections or benefits, you will be notified.

Medical/Prescription Drug Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. You must elect medical/prescription drug coverage unless you are able to demonstrate that you have other medical coverage. Any salary reduction contributions you may be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Pediatric vaccine coverage under the Plan will not be less than the Plan's pediatric vaccine coverage, if any, on May 1, 1993. In addition, the Plan's terms will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets. Any salary reduction contributions you may be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Vision Coverage. If you are eligible to participate in the Plan, you may purchase vision coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you may be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Life Insurance/AD&D Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense life insurance/accidental death and dismemberment coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Long Term Disability Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Short Term Disability Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense short term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

### Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the Federal law known as "COBRA".

### Continuation Coverage Under COBRA (COBRA Notice)

This "COBRA Notice" section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, "Plan" refers only to the medical/prescription drug, dental, and vision benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You are receiving this notice because you are covered under a group health plan offered under the Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to carefully read this notice.)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator at the address provided in this notice.

#### *What is COBRA Continuation Coverage?*

COBRA continuation coverage is a continuation of health coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

#### *When is COBRA Coverage Available?*

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

#### *You Must Give Notice of Some Qualifying Events*

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date the qualifying event occurs or (2) the date coverage would end because of the qualifying event. This notice must be provided, along with any required documentation to:**

Priority One Services, Inc.  
 c/o Human Resources Department  
 6600 Fleet Drive  
 Alexandria, Virginia 22310

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.

- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: "By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter."
- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

#### *How is COBRA Coverage Provided?*

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as described in the next two sections of this Notice.

#### *Disability Extension of 18-Month Period of Continuation Coverage*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*", including providing documentation of the Social Security Administration's decision), you

and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

#### *Second Qualifying Event Extension of 18-Month Period of Continuation Coverage*

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

#### *Additional Continuation Coverage Election Period for "TAA-Eligible Individuals"*

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit of 65% of the cost of premiums paid for qualified health insurance. You should consult with a financial advisor if you have questions about the tax credit.

#### *If You Have Questions*

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator at the address indicated below. 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](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

### *Keep Your Plan Informed of Address Changes*

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### *Plan Contact Information*

If you have questions or need more information about COBRA continuation coverage under the Plan, please contact the Plan Administrator at the address or phone number provided in this Summary.

### Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan.

### Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

### Medical Benefits Following Childbirth

Federal or state law requires that the Plan's medical benefit options that provide hospitalization benefits in connection with childbirth provide for certain minimum levels of coverage for the mother and newborn child following childbirth. The particular requirements that apply depend on whether your coverage is insured or not and, for insured coverage (including coverage provided through an HMO), on what state law applies to the insurance (or HMO coverage).

If your medical coverage is insured under a policy issued in **Virginia**, the following applies under State law:

The Medical Plan and any health insurance company insuring health benefits under the Plan that provide coverage for obstetrical benefits will include benefits for inpatient care and a home visit (or visits) in accordance with medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Any changes in those Guidelines or Standards will be applied by the Plan within six months of the publication of those changes.

## Claims Procedures

Please note that the following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures Regulations and should be interpreted accordingly. In the event of any conflict between this summary and those Regulations, the Regulations shall control. In addition, any changes in those Regulations will apply to the Plan automatically effective on the date of those changes.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for Short Term Disability benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

### *Initial Claims*

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claimant's claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails 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, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's

receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the Reviewer will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

a. For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

b. For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan

receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

- (i) A description of the specific reasons for the denial;
- (ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;
- (iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);
- (iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;
- (v) A statement of the Claimant's right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial.

In addition, for a denial of health benefits or disability benefits, the following will be provided to the Claimant:

- (i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

(For an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than 3 days after the oral notification.)

### *Reviews of Initially Denied Claims*

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse benefit determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination 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 professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of the initial adverse determination by the Plan.

(ii) Other Health Benefit Claims.

a. For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.

b. For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice that includes:

(i) a description of its decision;

(ii) an description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;

(v) a statement describing the Claimant's right to bring an action for judicial review under ERISA §502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

#### *Calculation of Time Periods*

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary, the period for making the determination will be "frozen" from the date the notification requesting the additional information is sent to the Claimant until the day the Claimant responds.

#### *Claimant's Failure to Follow Procedures*

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

#### *Plan's Failure to Follow Procedures*

If the Plan fails to follow the claims procedures described above, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

#### *Insured Benefits and State Law*

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

### Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

### Termination or Amendment of Plan

The Employer expects to maintain the Plan indefinitely as a program of employee benefits. However, the Employer has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

### No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

### Non-Assignment of Benefits

Except as may be required pursuant to a "Qualified Medical Child Support Order" that provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefits.

### Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payors.

### Subrogation/Right of Reimbursement

As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually

signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

### Your Rights Under ERISA

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

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.
- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied after review and reconsideration by the Plan or is 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 considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

You may have the right to continued health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage.

You have the right to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another health plan. You should receive a certificate of creditable coverage, free of charge, from the group health plan when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases. You are also entitled to receive a certificate of coverage if you request it before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

### Further Information

If you have further questions regarding the Plan or this Summary Plan Description, please contact the Plan Administrator at 703-971-5505. Copies of all Plan documents are on file with the Plan Administrator and, upon reasonable request, are available to participants and their beneficiaries for examination during regular business hours.