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I. GENERAL INFORMATION

This is the Summary Plan Description (“SPD”) for Ericsson Services Inc. (“Ericsson Services”) Medical, Dental, and Vision Plan (the “Plan”). The Plan is a component plan of the (“Ericsson Services”) Flexible Benefits Plan (“E-Flex Plan”). The E-Flex Plan, which includes the Plan, is sponsored by Ericsson Services.

The SPD describes certain provisions of the Plan applicable to Eligible Employees and Eligible Dependents. To understand what you and your Eligible Dependents are entitled to under the Plan, please read this information carefully.

The SPD is provided to explain to you, in easy to understand language, how the Plan works. It describes your benefits and rights, as well as your obligations under the Plan. You will find information about eligibility, how to enroll, when coverage begins and ends, and how you can continue coverage of certain benefits after you terminate your employment. In addition, the SPD describes provisions that impact coverage (such as coordination of benefits), procedures for filing a claim and appealing a claim decision and other important information.

All of the specific rules governing the Plan are contained in the official plan documents for the Plan and the E-Flex Plan and other Plan materials (such as contractual agreements with a health care or other service provider and insurance policies). Every effort has been made to accurately describe the complicated provisions of the Plan. In the event that there is a conflict or inconsistency between the SPD and the plan documents and other Plan materials, the plan documents and other Plan materials will control. It is the Plan Administrator’s responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan.

If you have any questions after reading this SPD, please contact the Ericsson Contact Center at 972-583-0085 or toll-free at 1-866-374-2272.

All capitalized terms used are defined in the section entitled “Words to Know” in Section II below.

II. WORDS TO KNOW

The terms below will help you better understand the Plan.

Adult Preventive Care means preventive care for individuals over age nineteen (19).

Benefit Dollars means the money that Ericsson Services allocates to each Participant according to the formula as determined by the Plan Administrator. The amount and distribution of Benefit Dollars is subject to change each Plan Year (or sooner if necessary) at any time, for any reason, and with or without notice, as determined by the Plan Administrator or Ericsson Services in its sole discretion.

Calendar Year means the time period beginning January 1 and ending on December 31.
**Centers of Excellence** means the health centers with demonstrated expertise in organ/cell transplant that are approved as such by Aetna. Centers of Excellence are determined separately for each organ. This means that a health center may be a “Center of Excellence” for heart transplants, but not kidney transplants.

**Children** means:

- An Employee’s biological children, legally adopted children, and/or children Placed for Adoption;

- An Employee’s stepchildren or an Employee’s Spouse’s or Domestic Partner’s biological children, provided that the children reside with the Employee (unless regularly attending an accredited educational institution) and the Employee financially supports the children;

- Children for whom the Employee is required, pursuant to court order or other legal document issued on or before the children’s 19th birthday, to provide support and care for such children; provided, however, that any such child must reside with the Employee (unless regularly attending an accredited educational institution) and the Employee must financially support the child; and/or

- Children for whom the Employee is required to provide health and welfare coverage pursuant to a Qualified Medical Child Support Order.

Children must qualify for dependency tax status as defined in the Code on the date a claim is incurred in order for coverage hereunder to be on a pre-tax to the Participant

**Claims Administrator** means the company that processes the claims, e.g., Aetna, VSP, and MHNet.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, currently codified at section 4980B of the Code and sections 601-608 of ERISA.

**Code** means the Internal Revenue Code of 1986, as amended.

**Coinsurance** means the portion of Covered Expenses that the Plan pays after satisfaction of applicable Copays and the Deductible.

**Committee** means the Plan Administrative Committee, which consists of three or more persons, appointed from time to time by the Board of Directors to administer the Plan.

**Common Law Spouse** means a person who the Participant can establish meets the requirements of a common law marriage in a state that recognizes common law marriages (a state may refer to this under a different term, such as “informal marriage”). The requirements to establish a common law marriage typically include: (a) an agreement between the two of you to be married; (b) cohabitation in the same primary residence;
and (c) representation to others that you are married. You may also be able to have your common law marriage established by other means, such as registering your common law marriage at a county clerk’s office. Please contact your local county clerk’s office for more information on how to establish a common law marriage in your state.

**Convalescent Facility** means an institution that is licensed to provide, and does provide, the following on an Inpatient basis for persons convalescing from disease or Injury:

(i) 24 hour a day professional nursing care by a Registered Nurse (RN), or by a Licensed Practical Nurse directed by a full-time RN;

(ii) physical restoration services to help patients to meet a goal of self-care in daily living activities;

(iii) Is supervised full-time by a Doctor/Physician or RN;

(iv) Keeps a complete medical record on each patient;

(v) Has a utilization review plan;

(vi) Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders; and

(vii) Makes charges.

**Copayment or Copay** means the amount of Covered Expenses you must pay to a provider for services.

**Covered Expenses** means the health care costs that are eligible for consideration as a basis for reimbursement from the Plan as set forth in section III hereof. Covered Expenses incurred with Network Care Providers are automatically considered to be Reasonable and Customary Expenses.

**Creditable Coverage**, with respect to an individual, means coverage of the individual under any of the following: a group health plan; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a State health benefits risk pool; a health plan offered under chapter 89 of title 5, United States Code; a public health plan (as defined in federal regulations); a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or state uninsured Children’s health insurance program. Such term does not include coverage consisting solely of coverage of benefits excepted under the Plan.
Custodial Care means services and supplies furnished to a person that are primarily intended to help him/her meet personal needs. Custodial Care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of Custodial Care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting the person;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Deductible means the amount of Covered Expenses you pay each Calendar Year before the Plan begins paying certain benefits. After the Deductible has been satisfied, the Plan pays a Coinsurance amount of the remaining Covered Expenses after any applicable Copay.

Doctor/Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under the Plan when performed by a Doctor/Physician.

Domestic Partners means a couple that: (a) is either same-sex or opposite-sex; (b) has lived together continuously for at least 12 months prior to enrolling in benefits; (c) is at least 18 years of age and mentally competent to consent to the Domestic Partnership; (d) is not legally married to or legally separated from any other person; (e) is not related by blood or adoption to a degree that would prohibit marriage; (f) is each other's sole Domestic Partner and intend to remain so indefinitely; (g) is financially interdependent; (h) has not had any other partner in the prior six months; and (i) is not together for the sole purpose of obtaining benefits coverage. In order to be recognized as a Domestic Partner for benefits under this Plan, you must properly complete and accept the
online Declaration of Domestic Partner Status and Ericsson Services must accept the form.

**Domicile** means a permanent legal residence. An Employee is considered to have a Domicile in the U.S. for purposes of the Plan if he currently resides in the U.S. or U.S. Virgin Islands or would reside in the U.S. or U.S. Virgin Islands except for his short term assignment (lasting for a period of less than 365 days) to a country outside the U.S. or the U.S. Virgin Islands.

**Effective Date** means the effective date of the SPD. The effective date of this SPD is January 1, 2010, unless specified otherwise.

**Eligible Dependent** means any one or more of the following individuals, provided that they have a Domicile in the U.S.:

- A spouse (including in some states a Common Law Spouse, but not a same-sex spouse or an opposite-sex or same-sex Domestic Partner) (“Spouse”);
- A Domestic Partner;
- Unmarried dependent Children from birth to the end of the pay period in which the nineteenth (19th) birthday occurs (excludes stillborn or unborn children);
- Unmarried dependent Children from the nineteenth (19th) birthday to the end of the pay period in which the twenty-fifth (25th) birthday occurs, if regularly attending school at an accredited educational institution (proof of enrollment to an accredited educational institution will be required). However, in the event that a covered dependent Child suffers from a serious Illness or Injury that results in his taking a medically necessary leave of absence from attending school at an accredited educational institution, he may continue coverage under the Plan until the earlier of one year after the first day of the medically necessary leave or the date on which coverage would otherwise terminate under the Plan;
- Unmarried dependent Children age nineteen (19) or over who are incapable of self-support as a result of physical or mental incapacity, so long as they became incapable of self-support either before age nineteen (19) or while covered as a dependent under the Plan. Aetna has fiduciary responsibility for determining eligibility based on an inability of the dependent to provide for his or her self-support because of physical or mental incapacity. Proof of disability must be provided when requested (no more than once a year); and
- Children of a Domestic Partner if they meet the requirements for coverage of dependent Children in general as set forth in the definitions above and if the Domestic Partner is also covered or being enrolled for coverage.

However, notwithstanding the above, the term “Eligible Dependent” shall not include any: (i) person with a Domicile outside of the United States; (ii) person in the military or similar forces of any country or a subdivision of any country; or (iii) other dependents.
(grandparents, parents, friends, brothers, sisters, etc.) who do not meet the requirements of an Eligible Dependent.

Notwithstanding the above, if any Eligible Dependent does not qualify as the Participant’s tax dependent, any contributions you make toward their coverage under the Plan must be made on an after tax basis. Furthermore, any portion of the cost of coverage paid by Ericsson or contributed as Benefit Dollars will be taxable as income to you for federal income tax purposes.

A Participant who claims a Domestic Partner as an Eligible Dependent must complete a declaration claiming the Domestic Partner as an Eligible Dependent.

**Eligible Employee** means an Employee who meets the eligibility requirements in the “Who is Eligible” section of this SPD.

**Emergency Medical Condition** means a sudden, unexpected, onset of a non-occupational bodily injury or severe illness which could reasonably be expected by a layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of Emergency Conditions include severe chest pain or squeezing sensations in the chest, uncontrolled bleeding, suspected overdose of medication or poisoning, seizures, strokes, loss of consciousness, sudden paralysis or slurred speech, burns, cuts and broken bones.

**Employee** means a person who is a common law employee of Ericsson Services or any other affiliated entity that adopts the Plan with Ericsson Services’ consent and upon any terms and conditions that may be imposed by Ericsson Services.

**Employer** means Ericsson Services and any other affiliated entity that adopts the Plan with Ericsson Services’ consent and upon any terms and conditions that may be imposed by the Ericsson Services, pursuant to Article XI of the Plan.

**Enrollment Date** means the first day of coverage in the Plan.

**Ericsson** means Ericsson Inc.

**Ericsson Services** means Ericsson Services Inc.


**Experimental or Investigational** means any unproven or still being tested or tried drug, device, treatment, or procedure, or one used for discovery, including, without limitation:

- Any service, drug, practice, or treatment not approved for reimbursement by the Centers for Medicare and Medicaid Services (CMS) or considered by the CMS Medicare Coverage Issues Manual to be Experimental, Investigational, not reasonable and necessary, or not Medically Necessary;
• Any drug, device, treatment, or procedure not widely accepted within the organized medical community as proven or effective;

• Any treatment subject to an ongoing Phase I, II, or III clinical trial or under study to determine its maximum tolerated dose, toxicity, or efficacy;

• Any drug or device not approved by the United States Food and Drug Administration (FDA) for public use;

• Any procedure, treatment, device, or drug furnished or performed in connection with education or research;

• A drug, device, procedure, or treatment for which there are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or Injury involved; or if required by the FDA, approval has not been granted for marketing;

• Where a recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental, Investigational, or for research purposes; or where the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same networks drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is Experimental, Investigational, or for research purposes.

**GCL Assignee** means an Employee who has permanent residence outside the U.S. and who is on a long term assignment in the U.S. or the U.S. Virgin Islands under the terms and conditions of the Ericsson General Conditions of Long Term Assignment.

**Home Health Care Agency** means an agency that:

- Is licensed and operated according to the laws governing Home Health Care Agencies;

- Primarily provides skilled nursing services and other medical care and therapeutic services in the patient’s home under the supervision of a Doctor/Physician or Registered Nurse; and

- Keeps clinical records on all patients.

A “Home Health Care Program” is a program of care coordinated to provide benefits by a Home Health Care Agency. “Home Health Care” includes benefits provided through a Home Health Care Program.
**Hospice Program** means a centrally coordinated program of Medically Necessary services provided at home or as an Inpatient by an interdisciplinary team and directed by a Doctor/Physician. The program must be based on the following:

- The recommendation of the attending Doctor/Physician;
- Proof that the Illness is unresponsive to currently available treatment;
- A statement by the Doctor/Physician indicating that the life expectancy of the patient is twelve months or less; and
- Treatment that attempts only to relieve the symptoms of an Illness, not to provide ultimate care.

“Hospice Care” includes benefits provided through a Hospice Program.

**Hospital** means a legally operated institution that is:

- Accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;
- Supervised by a staff of Doctor/Physicians with twenty-four (24) hour-a-day nursing services; and
- Primarily engaged in providing general or specialized Inpatient medical care through medical, diagnostic, and major surgical facilities on its premises or under its control or specialized Inpatient medical care and treatment through medical, diagnostic (including x-ray and laboratory) and major surgical facilities on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under the Plan as a Hospital) or with a specialized provider of these facilities.

In no event will the term “Hospital” include a nursing home or an institution, or part of one, that:

- Is a Convalescent Facility;
- Is primarily a facility for convalescence, nursing, rest, or the aged;
- Furnishes primarily domiciliary or Custodial Care, including training in daily living routines; or
- Is operated primarily as a school.

**Illness or Injury** means a nonoccupationally caused condition marked by a pronounced deviation from the normal healthy state. All such conditions existing simultaneously, which are due to the same or related causes, shall be considered one Illness or Injury. Furthermore, if an Illness or Injury is due to causes, which are the same as, or related to, the causes of a prior Illness, and if there has been no recovery from the prior Illness, the Illness shall be considered a continuation of the prior Illness and not a separate Illness. The term “Illness” includes pregnancy and complications of pregnancy.

**In-Network** means a service or other benefit provided to a Participant or Eligible Dependent by a Network Care Provider.

**Inpatient and Outpatient** means either the setting in which medical care is given or to a
person who is receiving care in that setting.

- “Inpatient” means that the care is furnished to a person while the person is confined in a facility as a registered bed patient; and
- “Outpatient” means that the care is furnished to a person while the person is not so confined.

**Lifetime Maximum** means the total amount of Covered Expenses the Plan will pay for an individual while the individual is covered under the Plan.

**Medically Necessary** means a service or supply furnished by a particular provider is Medically Necessary if the Claims Administrator determines that it is appropriate for the diagnosis, care, or treatment of the disease or Injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or Injury involved and the person’s overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or Injury involved and the person’s overall health condition; and
- As to diagnosis, care and treatment, be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the Claims Administrator will take into consideration:

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

In no event will the following services or supplies be considered Medically Necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional;
- Those furnished mainly for the personal comfort or convenience of the covered person, any person who cares for him or her, any person who is part of his or her family, or any healthcare provider or healthcare facility;
- Those furnished solely because the covered person is an Inpatient on any day on which the covered person’s disease or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a Doctor/Physician’s or a dentist’s office or other less costly setting.

**Medicare** means the benefits provided under Title XVIII of the Social Security Amendments Act of 1965.

**Morbid Obesity** means a body mass index (BMI) exceeding forty (40) or greater than thirty-five (35) in conjunction with severe medical conditions including, but not limited to: diabetes, hypertension, cardiovascular disease, etc.

**Negotiated Charge** means the maximum amount a Network Care Provider has agreed to charge for service or supply for the purpose of the benefits under the Plan.

**Network Care Provider** means a health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Claims Administrator’s consent, included in the network directory as a Network Care Provider for the service or supply involved. You may view each carrier’s directory by accessing their website.

**Non-Network Care Provider** means a health care provider that has not contracted to furnish services or supplies for a Negotiated Charge.

**Non-Occupational Illness** means an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers’ compensation law; and
- Is not covered for that illness under such law.

**Non-Occupational Injury** means an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

**Nurse** means a person who is a Registered Nurse, a Licensed Vocational Nurse, or a
Licensed Practical Nurse.

**Occupational Injury** means an accidental bodily Injury that arises out of (or in the course of) any work for pay or profit or results in any way from an Injury that does.

**Occupational Disease** means a disease that arises out of (or in the course of) any work for pay or profit or results in any way from a disease that does.

**Open Enrollment** means the period prior to the beginning of the Plan Year when Eligible Employees may enroll or change their elections in the Plan without a Qualified Status Change.

**Out-of-Area** means the Aetna medical option that is offered to Participants who do not live in the Aetna Choice™ POS II zip code area as determined by the Claims Administrator.

**Out-of-Network** means a service or other benefit provided by a health care provider that has not contracted to furnish services or supplies for a Negotiated Charge.

**Out-of-Pocket Maximum** means the limit on how much you have to pay for medical care covered by the Plan, excluding Copays.

**Outpatient Surgical Facility** means a legally licensed facility that:

- Has a medical staff of Doctor/Physicians, Nurses, and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room;
- Has equipment to treat Emergency Medical Conditions;
- Has a blood supply;
- Maintains medical records; and
- Has agreements with Hospitals for immediate acceptance of patients who need Inpatient Hospital confinement.

**Participant** means an Eligible Employee who has satisfied the eligibility conditions as specified in the Plan, and has not, for any reason, become ineligible to participate in the Plan.

**Placed for Adoption or Placement for Adoption** means the assumption and retention by a Participant of a legal obligation for total or partial support of an individual in anticipation of adoption of such child prior to the date on which such individual attains age eighteen (18). The child’s placement with such person terminates upon the termination of such legal obligation.

**Plan** means the Ericsson Services Medical, Dental, and Vision Plan, as amended from time to time.

**Plan Administrator** means Ericsson Services, which may delegate its duties to the Committee pursuant to the terms of Article VII of the Plan. The Plan Administrator
shall be a named fiduciary under the Plan for purposes of ERISA. The Plan Administrator may engage the services of third parties (including one or more Claims Administrators) to render advice or provide such services as are necessary or appropriate to perform the Plan Administrator’s duties.

**Plan Year** means the Calendar Year commencing each January 1 and ending each December 31.

**Precertification or Precertified** means the procedure you must follow for consideration of benefits for certain medical treatments or conditions under the Plan.

**Pre-existing Condition** means a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received or for which medications were prescribed or taken six (6) months prior to the Participant’s Enrollment Date. A Pre-existing Condition does not include pregnancy.

**Qualified Beneficiary** means (1) any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day a Participant; (2) any one of the following individuals who, on the day before a Qualifying Event, were covered under the Plan by virtue of being an Eligible Dependent: A Spouse; unmarried dependent Children from birth to the end of the pay period in which the nineteenth (19th) birthday occurs (excludes stillborn or unborn children); unmarried dependent Children from the nineteenth (19th) birthday to the end of the pay period in which the twenty fifth (25th) birthday occurs, if regularly attending school at an accredited educational institution (proof of enrollment to an accredited educational institution will be required) unless such person is on a medically necessary leave of absence not to exceed one year; unmarried dependent Children age nineteen (19) or over who are incapable of self-support as a result of physical or mental incapacity, so long as they became incapable of self-support either before age nineteen (19) or while covered as a dependent under the Plan; or (3) a dependent child who is born to, adopted by, or Placed for Adoption with Participant during continuation coverage.

**Qualified Status Change** means an event as listed in the Changing Coverage section that allows a Participant to change his or her election during a Plan Year.

**Reasonable and Customary (R&C) Expenses** means the amount that is commonly charged by the majority of providers in your geographic area for medical expenses, taking into account complexity, degree of skill needed, type of specialty of the provider, range of services or supplies provided by a facility, and/or prevailing charge in other areas. Any Out-of-Network or Out-of-Area charge that exceeds R&C Expenses will not be considered a Covered Expense and you will be responsible for paying the full amount of the excess fee.

**Routine Pregnancy** means an uncomplicated maternity case where services include prenatal visits, initial and subsequent history, physical examinations, monitoring of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and examinations
at a prescribed frequency, delivery and postpartum care.

**Special Enrollment Period** means the thirty-one (31) days following an event listed in the Special Enrollment for Loss of Other Coverage section when a Participant can enroll certain individuals in the Plan.

**SPD** means Summary Plan Description.

**Surgical Expense** means fees for surgery performed by a licensed Doctor/Physician in or out of a Hospital.

**Urgent Care** means medical, surgical, dental, Hospital and related health care service and testing which is provided to treat a condition that is:

- Less severe than an Emergency Medical Condition;
- Requires immediate medical attention; and
- Is unforeseen.

**Urgent Care Facility** means a part of a Hospital or a free-standing walk-in medical treatment facility that is open twenty-four (24) hours a day or has extended hours, for Urgent Care treatment.
III. WHO IS ELIGIBLE

You are an Eligible Employee if you are:

- A regular Employee on Ericsson’s or Ericsson Services’ U.S. payroll who has a Domicile in the U.S. and is (i) regularly scheduled to work at least thirty (30) hours per week; or (ii) a regular Employee on an approved, paid leave of absence but who was scheduled to work at least 30 hours per week prior to the paid leave of absence; or

- a GCL Assignee during a long term assignment in the U.S. or the U.S. Virgin Islands.

Notwithstanding anything to the contrary above, the term “Eligible Employee” shall not include any:

(i) Employee scheduled to work less than thirty (30) hours per week on average or hired for a limited period of time or for a specific task;

(ii) co-op, seasonal, or student intern employee;

(iii) nonresident alien with no U.S. source income;

(iv) independent contractor (based on the Employer’s designation, regardless of any recharacterization by a court or governmental agency);

(v) leased employee;

(vi) member of a collective bargaining unit (unless the collective bargaining agreement governing the terms and conditions of such unit’s employment provides for participation herein); or

(vii) an Employee who is on an approved long term assignment outside of the U.S., notwithstanding the preceding, the Eligible Dependents of such Employee remaining in the U.S. or the U.S. Virgin Islands are eligible to continue their participation in the Plan.

Your Eligible Dependents, as defined in the Words To Know section, may also be covered under the Plan if you elect coverage for them.

However, notwithstanding the above, the term “Eligible Dependent” shall not include any: (i) person with a Domicile outside of the U.S.; (ii) person in the military or similar forces of any country or a subdivision of any country; or (iii) other dependents (grandparents, parents, friends, brothers, sisters, etc.) who do not meet the requirements of an Eligible Dependent.

If you transferred from Ericsson Inc. and were eligible to participate in the Retiree Medical Plan prior to your transfer from Ericsson Inc., you and your Eligible Dependents
may be eligible to participate in the Retiree Medical Plan. Additional information may be found in the Summary Plan Description for the Retiree Medical Plan, which is posted on the Ericsson Online Benefits Tool.

IV. COVERAGE

Enrolling for Coverage

The Plan offers the following coverage options:

- Aetna Choice™ POS II or the Aetna Out-of-Area option;
- Aetna Dental PPO;
- Vision Service Plan; and
- No Coverage.

Ericsson Services recommends that Eligible Employees (and their Eligible Dependents) should have at least a basic level of medical coverage to protect against financial catastrophe.

Any Eligible Employee who elects the No Coverage option is required to certify that he or she has coverage under another medical plan or understands that he is electing to waive any coverage under this Plan and the potential consequences of such waiver of coverage. Any Eligible Employee who has a family and elects to participate in the Plan with Employee Only coverage (does not elect family medical coverage) should be sure that the family members have coverage under another medical plan.

Following are the coverage categories under Aetna Choice™ POS II and the Aetna Out-of-Area options:

- Employee Only;
- Employee + One Dependent;
- Employee + Two Dependents; and
- Employee + Three or More Dependents.

Upon first becoming eligible for the Plan, you must make your election for medical, dental, and vision benefits under the Plan within thirty-one (31) days of the date you first become eligible. If you do not timely make your elections under the Plan, your coverage will default to no coverage for medical, dental and vision benefits.

Your elections remain in effect for the remainder of the Plan Year, unless you have a Qualified Status Change, as explained below in the Changing Coverage section.

If you are a rehired employee, enrollment occurs as follows:

- If you are rehired in the same Plan Year and your rehire date is within ninety (90) days of your termination date, you will be reinstated in the Plan as if you had not terminated employment.
• If you are rehired in the same Plan Year and your rehire date is ninety-one (91) days or more from your termination date, you will make elections the same as a new hire.
• If you are rehired in a different Plan Year, you will make elections the same as a new hire.

When Coverage Begins

If you are a newly hired Eligible Employee and you enroll within thirty-one (31) days of your hire date, coverage for you and your enrolled Eligible Dependents will begin on your first day of active employment. If you are a newly Eligible Employee and you enroll within thirty-one (31) days of the date your hire date, coverage for you and your enrolled Eligible Dependents will begin on the date you became an Eligible Employee and are actively working. Coverage for enrolled Eligible Dependents generally begins on the same date the Participant’s coverage begins.

Covering your Domestic Partner

Provided that the Declaration of Domestic Partner Status is submitted on the Ericsson Online Benefits Tool, a Domestic Partner can be added to the Plan as follows:

- During your initial enrollment period;
- During the annual Open Enrollment period;
- As a Qualified Status Change if the Domestic Partner is a tax dependent and
  - Loses coverage under his/her own medical plan, or
  - If there is a significant cost or coverage change in your Domestic Partner’s employer’s health plan, to the extent permitted by Treasury regulations or other IRS guidance.

A Domestic Partner must/can be removed from the Plan as follows:

- If the Domestic Partner relationship is terminated, you must remove the Domestic Partner through a Qualified Status Change;
- If your Domestic Partner gains other coverage, you can remove the Domestic Partner through a Qualified Status Change.

See below section, “Changing Coverage”, for information on how to make a Qualified Status Change.

Your Declaration of Domestic Partner Status as well as the termination of such Domestic Partner’s coverage, will be shared with certain designated benefits and human resources department personnel for the purposes of implementing and administering the Plan and other benefits, and as required by and in accordance with applicable laws.
Obtaining Domestic Partner benefits and the execution of the required declaration may affect the liability of you and your Domestic Partner to each other, to taxing authorities, and to third parties. You and your Domestic Partner should consult with your own respective tax and/or legal advisors regarding these and other potential consequences.

**Changing Coverage**

Your Plan elections will remain in effect for the entire Plan Year. Changes will be allowed only if you have a “Qualified Status Change.”

The following is a list of Qualified Status Changes:

- Marriage, divorce, or legal separation;
- Death of an Eligible Dependent;
- Birth of an Eligible Dependent;
- Adoption of child, Placement for Adoption, or legal custody with intent to adopt;
- Disqualification of an Eligible Dependent;
- Eligible Dependent becomes qualified to participate in the Plan;
- Eligible Dependent gains or loses outside medical coverage;
- Spouse becomes employed;
- Judgment, decree, or order resulting from a divorce, legal separation, amendment, or change in legal custody that requires health coverage for an Eligible Dependent child; and
- A significant cost or coverage change in your Spouse’s employer’s health plan, to the extent permitted by Treasury regulations or other IRS guidance.

In the case of a marriage, birth, adoption, or Placement for Adoption, you may enroll yourself (if not already covered) at the same time you enroll your Eligible Dependents.

To make a Qualified Status Change, access the “Make a Qualified Status Change” option on the Ericsson Online Benefits Tool. You can access the Ericsson Online Benefits Tool through the Internet (Explorer) at https://ericsson.wwwhrt.com. You will need your Social Security number and password to gain access to the Ericsson Online Benefits Tool. If you do not have access to a computer, call the Ericsson Contact Center toll free at 1-866-374-2272 for assistance with your Qualified Status Change. Under IRS rules, any change must be both on account of and consistent with the change event allowing the mid-year election change.

You cannot make a Qualified Status Change more than thirty-one (31) days after the event until the next annual Open Enrollment.

**Special Rules That Apply to Children Who Must Be Covered Due to a Qualified Medical Child Support Order**

Federal law requires Ericsson Services to recognize Qualified Medical Child Support Orders for the purpose of providing health coverage to Eligible Dependents of a...
Participant. In order for Ericsson Services to recognize a Qualified Medical Child Support Order, the order must be a judgment, decree, court order or National Medical Support Notice relating to health benefits coverage for an Eligible Dependent child (“Alternate Recipient”) of a Participant or; the order or notice must specify:

- The name and address of the Participant;
- The name and mailing address of each Alternate Recipient (or designated state official or political subdivision) covered by the order;
- A reasonable description of the type of coverage afforded by the Plan;
- The beginning period for which the order applies; and
- The name and address of each Alternate Recipient.

Upon receipt of a medical child support order, the Employee will promptly be notified of the receipt of the order and disposition of the order.

If Ericsson Services determines the order to be a Qualified Medical Child Support Order, coverage shall commence upon either the date specified in the order or the date the Employee becomes eligible for coverage, if later. Ericsson Services may be required to take automatic payroll deductions to cover the cost of coverage ordered by a Qualified Medical Child Support Order.

The claim may be filed by the non-custodial parent, the custodial parent or the provider. Benefits for such claim will be paid to the Participant (to the extent not paid directly to the provider).

**Special Enrollment for Loss of Other Coverage**

If you or your Eligible Dependent lose other medical or dental coverage and are otherwise eligible for, but not enrolled in the Plan, you and your Eligible Dependent may enroll in the Plan if the following conditions are satisfied:

- You and your Eligible Dependent were covered under another group plan or had other insurance coverage at the time coverage was previously offered under the Plan;
- The expiring prior coverage was exhausted (in the case of COBRA coverage) or terminated due to loss of eligibility (in the case of a change in employment status or other change in health coverage for you or your Eligible Dependent), or employer contributions to such coverage ceased; and
- You request coverage under the Plan no later than thirty-one (31) days after the termination of other coverage.

Your Eligible Dependent can only be enrolled under the provisions of this section if you are already enrolled or will enroll simultaneously in the Plan. The change should be made within thirty-one (31) days of the date you or your Eligible Dependent loses coverage and the coverage is effective the day following the loss of coverage. As necessary, you may
request a change in the coverage category, from Employee only coverage to Employee plus dependent coverage.

To make this change, access the “Make a Qualified Status Change” option on the Ericsson Online Benefits Tool. You can access the Ericsson Online Benefits Tool through the Internet (Explorer) at https://ericsson.wwwhrt.com. You will need your Social Security number and password to gain access to the Ericsson Online Benefits Tool. Under IRS rules, any change must be both on account of and consistent with the change event allowing the mid-year election change.

Special Enrollment Rights Under the Children’s Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, new special enrollment rights became available to Eligible Employees and Eligible Dependents who are eligible but not enrolled in coverage under the Plan. Eligible Employees and Eligible Dependents may enroll in the Plan during the Plan Year under the following circumstances:

- The Eligible Employee or Eligible Dependent is covered under a Medicaid or state Children’s Health Insurance Program (CHIP) plan and coverage of the Eligible Employee or Eligible Dependent is terminated as a result of loss of eligibility (rather than non-payment) for such coverage, and the Eligible Employee requests coverage under the Plan not later than 60 days after the date of termination of such coverage; or

- The Eligible Employee or Eligible Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under a Medicaid or CHIP plan, if the Eligible Employee requests coverage under the Plan not later than 60 days after the Eligible Employee or Eligible Dependent is determined to be eligible for such assistance.

Note – This special enrollment right does not authorize Participants (who are already participating in the Plan) to make changes to elections based on eligibility for premium assistance.

If Your Spouse or Domestic Partner Also Works For Ericsson Services

If your Spouse or Domestic Partner is also employed by Ericsson, coordination is required to ensure that (i) an Employee is not covered as both an Employee and an Eligible Dependent of an Employee; and (ii) any Eligible Dependent Children are covered by only one Employee and not both Employees.

Open Enrollment

Ericsson Services conducts annual Open Enrollment periods, which are normally held during the last quarter preceding the Calendar Year for which the election will be in effect. During the Open Enrollment period, you may keep or change your elections under
the Plan. If you do not make an election, your current elections for medical, dental, and vision benefits (with coverage category) will remain in effect.

V. WHAT COVERAGE COSTS

Ericsson Services and/or the Plan Administrator establish annual premiums for each coverage category and the amount of such premium, if any, to be paid by Ericsson Services. Ericsson Services reserves the right to change the premium and Ericsson Services’ contribution at any time.

Ericsson Services provides you with Benefit Dollars to equal a percentage of the cost, as set by the Committee, of your medical and dental elections for you and your Eligible Dependents.

Specific information about the price of coverage may be found in the E-Flex Plan enrollment materials.

VI. NOT A GUARANTEE OF EMPLOYMENT, NO GUARANTEE OF NO CHANGES

Nothing in this SPD says or implies that participation in the Plan is a guarantee of continued employment with Ericsson Services, nor is it a guarantee that coverage options, the price of coverage, eligibility rules, or any other term or condition of the Plan will remain unchanged in future years. Ericsson Services reserves the right at any time to amend, suspend, or terminate the Plan, in whole or in part, for any reason, and to adopt any amendment or modification thereto, all without the consent of or prior notice to any Eligible Employee, Eligible Dependent or other person or entity.

VII. SITUATIONS AFFECTING PLAN BENEFITS

If You Go on Short Term Disability (STD) or a Family Medical Leave of Absence

Ericsson Services maintains the Ericsson Services Short Term Disability Plan (“STD Plan”) for employees who are unable to work due to disability. While on approved short term disability (“STD”), Eligible Employees are paid under the terms of the STD Plan.

Due to the Family and Medical Leave Act (FMLA), you may be eligible for up to twelve (12) weeks of FMLA leave during each Calendar Year if you have:

- At least twelve (12) months of total service with Ericsson Services;
- Received pay for at least one-thousand-two-hundred-fifty (1,250) hours in the previous twelve (12) months; and
- Qualify for FMLA leave, as provided in Ericsson’s Family and Medical Leave Act Directive.

During the STD and/or FMLA leave, medical, dental, and vision coverage may be continued, provided you arrange to pay any required Plan contributions during any
portion of the leave that is unpaid.

You are not entitled to benefits under the FMLA to care for your Domestic Partner. However, you may be entitled to FMLA leave to care for the child of your Domestic Partner, if you have day-to-day responsibilities to care for and financially support the child. In addition, you may be entitled to benefits under Ericsson’s Family and Medical Leave Directive to care for a newborn or newly adopted child of your Domestic Partner.

**If You Go on a Personal Leave of Absence**

In the event you are approved for an unpaid Personal Leave of Absence, medical, dental, and vision benefits will end at the end of the pay period in which you last worked. Benefits may be continued under COBRA at your expense.

**If You Go on a Military Leave of Absence**

Medical, dental, and vision coverage may continue for you and any currently covered Eligible Dependents at the regular Participant contribution rate during the period that the you are receiving “Differential Pay” (in accordance with Ericsson’s Military Leave Directive) under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Open Enrollment and Qualified Status Changes will apply during this time. After you have exhausted Differential Pay, you may continue coverage under the Plan for yourself and your Qualified Beneficiaries under COBRA for the lesser of eighteen (18) months or until the day after the deadline by which the Participant must apply for or return to employment with the Employer after his completion of military service, as determined by applicable law. The Participant must pay the applicable premium for such coverage. Your Domestic Partner and your Domestic Partner’s Children are also eligible for continuation coverage under the Plan, as detailed below in the Continuation of Coverage section.

**Short Term Assignment/Business Travel Outside of United States**

Ericsson has a Global Business Travel Insurance Plan that provides medical benefits while on short term assignment/business travel outside of the U.S. If you are on Ericsson short term assignment or business travel outside of the U.S. and need medical care, please contact Chartis Assistance/Lifeline Plus hotline, and a representative will direct you appropriately.

Coverage for foreign maternity claims incurred after the first 30 days of arrival and office visits for Non-Occupational Injury or Non-Occupational Illness will be processed by Aetna.

**Working Past Age 65**

If you continue to be actively employed by Ericsson Services after reaching age sixty-five (65), you must make some decisions regarding your medical coverage.

You may choose to continue medical coverage under the Plan. In that case, the Plan will
provide primary coverage and Medicare will provide secondary coverage. This means that if any of the same items and services covered by Medicare is also covered by the Plan, then the Plan will be the first to pay those expenses, and Medicare will process the expense as a secondary payer.

If you work past age sixty-five (65), you may also choose not to continue medical coverage under the Plan. This means no further benefits will be available from the Plan, and Medicare would be your source of health care coverage.

**Medical and Dental Benefits During Long Term Disability**

If you become totally disabled and are receiving benefits under the Ericsson Services Long Term Disability Plan ("LTD Plan"), Ericsson Services will continue the medical and dental benefits for you and your Qualified Beneficiaries under the Plan, with Ericsson Services continuing to pay its contribution and provided that you continue to pay your monthly premium for coverage. Domestic Partners and Domestic Partners’ Children may continue coverage under the Plan through COBRA, as provided below in the Continuation of Coverage section.

Medical and dental benefits will continue until the earliest of the following: you no longer pay your required premiums for coverage; you are no longer receiving disability benefits under the terms of the LTD Plan and you have exhausted the Maximum Benefit Period under the LTD Plan; or Ericsson Services amends or terminates the Plan or the LTD Plan. Medical benefits will cease if you elect Medicare Part D, prescription drug benefits, while you are a LTD participant.

Generally, the number of months during which your medical and dental benefits are continued, because you are receiving benefits under the LTD Plan, will run concurrently with the coverage period allowed under COBRA.

If you are eligible for Medicare, you will generally receive primary coverage from Medicare, while the Plan will provide secondary coverage. However, the Plan will generally be primary during the first thirty (30) months of either kidney dialysis treatment or a kidney transplant for end stage renal disease ("ESRD"), unless Ericsson Services is notified that you do not wish to continue your benefits, or benefits for your enrolled Eligible Dependents, under the Plan.

Additional information may be found in the Summary Plan Description for the LTD Plan located on the Ericsson Services Intranet under HR SSC Dallas, E-Flex Benefits, Long Term Disability.

**Medical Benefits After Disability Ends**

When a Participant is no longer disabled under the terms of the LTD Plan, the Participant will be eligible for medical coverage under the Plan if he remains employed by Ericsson Services and he meets the eligibility criteria outlined earlier.

If the Participant is no longer employed by Ericsson Services, he can elect coverage
through COBRA up to the maximum amount of time allowed under COBRA less the time covered as an LTD Participant.

**Rights Pursuant to Genetic Information Nondiscrimination Act of 2008 (GINA)**

Ericsson Services complies with GINA and, therefore, does not:

- Increase group premium or contribution amounts based on genetic information;
- Request or require an individual or family members to undergo genetic testing; or
- Request, require, or purchase genetic information prior to or in connection with enrollment or at any time for underwriting purposes.

“Genetic information” is information about (1) an individual’s genetic tests; (2) the genetic tests of an individual’s family members; (3) the manifestation of a disease or disorder in an individual’s family members; or (4) any request or receipt by the individual of his or her family members of genetic information. Genetic information does not include blood tests that are not designed to obtain information relating to genotypes, mutations, or chromosomal changes; cholesterol tests; or information about the age or sex of an individual or family member.

**If Coverage Ends or Is Modified**

Ericsson Services, which is the Plan Sponsor, has reserved the right to amend or terminate the Plan in whole or in part at any time without the consent or prior notice of any party, as approved by the Board of Directors of Ericsson Services. This means the Plan may be discontinued in part or in its entirety or modified to provide different benefits or different levels of benefits, eligibility rules or the price of coverage may be changed, or any other modifications may be made. Ericsson Services has delegated authority to the Committee to amend the Plan to the extent that such amendment either (i) is necessary and appropriate to comply with applicable law; or (ii) does not result in any material cost increase to Ericsson Services. Ericsson Services has not delegated authority to the Committee to terminate the Plan.

**VIII. WHEN COVERAGE ENDS**

**Participant**

Medical, dental, and vision coverage for you will cease as of the end of the pay period in which the first of the following events occurs:

- Your employment terminates for any reason and you are not receiving benefits under the LTD Plan ("LTD Participant") at the time of your termination;
- You are no longer an Eligible Employee;
- You retire;
- You begin an unpaid leave of absence that does not qualify for coverage (for example, a personal leave);
• You begin active service in any branch of the military and your period of Differential Pay ends under Ericsson’s Military Leave Directive;
• You stop making required contributions;
• Your Domicile is no longer in the U.S.;
• You elect to receive Medicare Part D, prescription drug benefits while you are receiving benefits under the Plan as an LTD Participant; or
• The Plan is terminated.

Eligible Dependent

Medical coverage for an Eligible Dependent will cease as of the end of the pay period in which the first of the following events occurs:

• Your Eligible Dependent no longer qualifies for coverage as an Eligible Dependent under the Plan;
• Your enrolled Eligible Dependent begins active service in any branch of the military;
• Your Eligible Dependent’s Domicile is no longer in the U.S.;
• The Participant is no longer enrolled in the Plan;
• Your enrolled Eligible Dependent elects to receive Medicare Part D, prescription drug benefits while you are receiving benefits under the Plan as an LTD Participant or;
• The Plan is terminated.

In the case of a termination of a Domestic Partner relationship, if your Domestic Partner relationship is terminated, your Domestic Partner no longer meets the criteria to qualify as your Domestic Partner, or your Domestic Partner dies, you must process, via the Ericsson On-line Benefits Tool, a Qualified Status Change for the termination of the Domestic Partner status within 31 days.

Upon loss of coverage, you and your Eligible Dependents will receive a Certificate of Creditable Coverage detailing your coverage history under the Plan.

IX. CONTINUATION OF COVERAGE (COBRA)

When you and/or your Qualified Beneficiary’s coverage ends, coverage may be continued under COBRA. If you are laid off and eligible for COBRA benefits paid by Ericsson Services through an Ericsson severance plan, you must elect coverage through COBRA in order for the coverage to continue after your active employee benefits termination date. Upon your execution of a Release and Severance agreement, Ericsson Services will subsidize your medical and dental premiums.

COBRA coverage for you and/or your Qualified Beneficiaries may continue for up to eighteen (18) months if health benefits are lost because of one of the following reasons:
• Your employment ends, voluntarily or involuntarily, for any reason other than gross misconduct;
• Your hours of employment are reduced below thirty (30) hours a week;
• You begin a leave of absence without health coverage.

Qualified Beneficiaries may continue their COBRA health coverage for up to thirty-six (36) months if they lose coverage because of one of the following reasons:
• You die while covered by the Plan;
• You and your Spouse become legally divorced or separated, or your marriage is annulled, while covered by the Plan;
• Your Eligible Dependent child is no longer eligible for coverage; or
• You become entitled to Medicare.

Your Qualified Beneficiaries may be entitled to coverage due to multiple qualifying events, but their total coverage period under COBRA cannot exceed thirty-six (36) months.

The COBRA administrator for the Plan will notify you and your Qualified Beneficiaries within fourteen (14) days after receiving notification from Ericsson Services of the event if coverage ends because of termination, death, a reduction in work hours, or your entitlement to Medicare. If you become divorced or legally separated, or your enrolled Qualified Beneficiary no longer meets the eligibility requirements, you are responsible for notifying Ericsson Services within sixty (60) days of the event. Ericsson Services will then provide notice to each individual of his or her rights. In the event that Ericsson Services is not notified within sixty (60) days of the event, the Participant’s Qualified Beneficiaries will not be offered COBRA coverage under the Plan.

COBRA coverage must be elected within sixty (60) days of the later of loss of coverage or the date of notification of continuation rights. The first payment, covering all back months, must be made within forty-five (45) days of the coverage election. Thereafter, premiums must be paid monthly in advance, and are delinquent after thirty (30) days, in which event all coverage will end. Once COBRA coverage ends, it cannot be reinstated.

Children born or adopted during the COBRA continuation period may also be eligible for COBRA coverage if you add the Qualified Beneficiary under COBRA.

In general, your Domestic Partner and your Domestic Partner’s Children are not a “Qualified Beneficiary” or “Qualified Beneficiaries” and are not entitled to COBRA coverage. Though not required by COBRA, Ericsson Services will allow Domestic Partners and Domestic Partners’ Children to continue coverage under the Plan, but only if the Domestic Partner Participant is also eligible for continuation of coverage under COBRA at that time and the Domestic Partner and the Domestic Partner’s Children elect continuation coverage within 60 days of receiving notice of the ability to elect continuation coverage; such continuation coverage for Domestic Partners and Domestic Partners’ Children will be for the cost stated below and may be continued for 18 months, but the continuation coverage will cease upon the satisfaction of any of the events that
would cause the Domestic Partner or Domestic Partner’s Children to no longer be entitled to continue coverage had he or she been a Qualified Beneficiary.

Continuation of Coverage in Case of Disability

If you or your enrolled Qualified Beneficiary is disabled (as determined by Social Security) within sixty (60) days after COBRA begins, and the disabled person would otherwise be entitled to eighteen (18) months of COBRA coverage, coverage may continue for the disabled person and all other covered family members for an additional eleven (11) months through COBRA (up to twenty-nine (29) months), if the disability continues throughout this period.

In order to qualify for the additional eleven (11) months of coverage, the disabled person must be approved for Social Security disability benefits and must notify the COBRA administrator within sixty (60) days of the date he or she receives a determination of eligibility for Social Security disability benefits, and before the initial eighteen (18) months of COBRA coverage expire.

Cost of COBRA Continued Coverage

The cost for continued coverage under COBRA will be the full cost (without a subsidy by Ericsson Services) of the coverage plus a two percent (2%) administrative fee. For those who are disabled and entitled to an additional eleven (11) months of coverage, the cost during this additional period will be one hundred and fifty percent (150%) of the full cost of coverage.

When COBRA Coverage Ends

There are certain circumstances under which COBRA coverage will end automatically:

- Premiums for continued coverage are not paid in a timely manner;
- A person receiving COBRA coverage becomes covered under another group medical plan that does not exclude or limit benefits for any preexisting condition the person may have (or any such exclusion or limitation is eliminated due to prior Creditable Coverage);
- The person receiving COBRA coverage or his or her Qualified Beneficiary becomes entitled to Medicare;
- The extension period for which the covered person is eligible ends;
- The Plan ends, or the Employer’s participation in the Plan ends;
- For those receiving the additional eleven (11) months of COBRA disability coverage, the disability ends; or
- COBRA coverage may not continue for more than thirty-six (36) months, even if multiple qualifying events occur.
## X. MEDICAL PLAN OVERVIEWS

### Benefits Summary

Following is a summary of benefits for medical services under the Aetna options of the Plan. The Aetna options do not have any exclusion for Pre-existing Conditions. You may receive the highest level of benefits when you receive health care services through the Network Care Providers available through the Aetna Choice™ POS II option. You and your Eligible Dependents may also have the choice of using Non-Network Care Providers and receiving a lower benefit level. Participants who do not live in the Aetna Choice™ POS II network areas are eligible for the Aetna Out-of-Area option. All Out-of-Network and Out-of-Area charges are subject to Reasonable and Customary (R&C) Expense limitations.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>POS II</th>
<th>POS II</th>
<th>Out-of-Area</th>
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<tbody>
<tr>
<td>Lifetime Maximum</td>
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<td><strong>Calendar Year Deductible</strong></td>
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<td>Non-compliance penalties, facility Copays, pharmacy Copays or Coinsurance, charges in excess of R&amp;C Expenses, and any expense not covered by the Plan</td>
<td>Non-compliance penalties, facility Copays, pharmacy Copays or Coinsurance, charges in excess of R&amp;C Expenses, and any expense not covered by the Plan</td>
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<td>Once the Out-of-Pocket Maximum has been reached, benefits for accident or sickness (excluding Mental Health/ Substance Abuse benefits and pharmacy benefits) are paid at 100% of In-Network services, and 100% of Reasonable &amp; Customary Expenses of Out-of-Network/Out-of-Area services, excluding Copays, for the rest of the Calendar Year.</td>
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<td>Out-of-Area</td>
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<td>Out-of-Network</td>
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<tr>
<td>Doctor/Physician’s Office Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor/Physician’s Office Visits</strong>&lt;br&gt;Office visit for Illness/Injury and minor surgical procedures performed in office</td>
<td>100% of Covered Expenses after $15 per visit Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Allergy Treatment&lt;br&gt;Office Visit with injection</td>
<td>100% of Covered Expenses after $15 per visit Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Serum/Injection (no charge for Office Visit)</td>
<td>100% of Covered Expenses</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Preventive Care</strong>&lt;br&gt;The Preventive Care Benefits Schedule follows this summary.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care for Children (including immunizations)</td>
<td>100% of Covered Expenses after $15 Copay per visit subject to the Preventive Care Benefits Schedule</td>
<td>70% of R&amp;C Expenses, after Deductible; maximum benefit $250 per Calendar Year after age 19</td>
<td>80% of R&amp;C Expenses, after Deductible; maximum benefit $500 per Calendar Year after age 19</td>
</tr>
<tr>
<td>Well Woman Care (including Pap Test, associated lab work and Mammograms)</td>
<td>100% of Covered Expenses after $15 office visit Copay for the associated well woman exam</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible; combined Well Woman Care and Adult Preventive Care benefit of $250 per Calendar Year</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible; combined Well Woman Care and Adult Preventive Care benefit of $500 per Calendar Year</td>
</tr>
<tr>
<td>Exams may be earlier or more frequently than recommended in the guidelines if required by Doctor/Physician</td>
<td>If the mammogram and associated lab work is performed at a network Independent Lab or X-Ray facility the benefit will be paid at 100%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Preventive Care - see the Preventive Care Benefits Schedule.</td>
<td>100% of Covered Expenses after $15 Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible; combined Well Woman Care and Adult Preventive Care benefit of $250 per Calendar Year</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible; combined Well Woman Care and Adult Preventive Care benefit of $500 per Calendar Year</td>
</tr>
<tr>
<td>Benefits</td>
<td>POS II In-Network</td>
<td>POS II Out-of-Network</td>
<td>Out-of-Area</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td><strong>Preadmission Testing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Physician’s Office</td>
<td>100% of Covered Expenses after $15 Copay if an office visit is charged. If an office visit is not charged, there is no Copay.</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Facility Other than Doctor/Physician’s Office</td>
<td>100% of Covered Expenses</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Percertification Required within 48 hours of the Hospital admission. See Aetna Precertification information on this summary.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Facility Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Facility Services</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td>Semi-private room</td>
<td>Limited up to the semi-private room rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private room</td>
<td>Limited up to the semi-private room rate, except when the Hospital is constructed without semiprivate rooms. If the facility is not in network, the Plan will determine the average semi-private room rate for the state the hospital is located.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>Limited to Negotiated Charge</td>
<td>Limited to ICU daily rate</td>
<td>Limited to ICU daily rate</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Doctor/Physician’s Visits/Consultations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Doctor/Physician’s Visits/Consultations</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Radiologist</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>90% of billed charges after satisfying the Deductible</td>
<td>80% of billed charges after satisfying the Deductible</td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multiple Surgical Reduction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeons who perform two or more surgical procedures through the same site during a single operation are subject to a reduction in their reimbursement per the following reduction schedule. Percentages are based on 1(^{st}) procedure, 2(^{nd}) procedure, 3(^{rd}) procedure performed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of Covered Expenses Payable</strong></td>
<td>100%, 50%, 25%</td>
<td>100%, 50%, 25%</td>
<td>100%, 50%, 25%</td>
</tr>
<tr>
<td>Benefits</td>
<td>POS II In-Network</td>
<td>POS II Out-of-Network</td>
<td>Out-of-Area</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient Surgical Services</strong></td>
<td>90% of Covered Expenses after $100 per incident Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Surgical Facility Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Multiple Surgical Reduction</strong></td>
<td>Surgeons who perform two or more surgical procedures through the same site during a single operation are subject to a reduction in their reimbursement per the following reduction schedule. Percentages are based on 1^st^ procedure, 2^nd^ procedure, 3^rd^ procedure performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of Covered Expenses Payable</strong></td>
<td>100%, 50%, 25%</td>
<td>100%, 50%, 25%</td>
<td>100%, 50%, 25%</td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>90% of billed charges after satisfying the Deductible</td>
<td>80% of billed charges after satisfying the Deductible</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Physician's Office</td>
<td>100% of Covered Expenses after $15 Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Hospital Emergency Room (when Medically Necessary)</td>
<td>100% of Covered Expenses after $75 per visit Copay, waived if admitted and subject to Inpatient Hospital Facility Services benefit</td>
<td>100% of billed charges after $75 per visit Copay, waived if admitted and subject to Inpatient Hospital Facility Services benefit</td>
<td>100% of billed charges after $75 per visit Copay, waived if admitted and subject to Inpatient Hospital Facility Services benefit</td>
</tr>
<tr>
<td><strong>Penalty for non-emergency use of Emergency Room is “No Coverage”</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hospital Emergency Room Doctor/Physician</td>
<td>100% of Covered Expenses</td>
<td>100% of billed charges</td>
<td>100% of billed charges</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% of Covered Expenses</td>
<td>100% of billed charges</td>
<td>100% of billed charges</td>
</tr>
<tr>
<td><strong>Penalty for non-emergency use of ambulance for transportation to ER or a transfer that is not Medically Necessary is “No Coverage”</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Benefits</td>
<td>POS II In-Network</td>
<td>POS II Out-of-Network</td>
<td>Out-of-Area</td>
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<tr>
<td>----------</td>
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<td>-------------</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>100% of Covered Expenses after $15 Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
</tbody>
</table>

**Convalescent Facility**

*Precertification Required – See Aetna Precertification information on this summary.*

Must follow a 3 day minimum Hospital confinement & must begin within 14 days of the Hospital discharge.
Up to a maximum of 120 days per Calendar Year

<table>
<thead>
<tr>
<th>Convalescent Facility</th>
<th>POS II In-Network</th>
<th>POS II Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Independent Lab and X-ray Services (Facility and Professional Services)**

It is the Employee’s responsibility to ensure that a network Lab or X-ray facility is utilized in order for the claim to be processed at the In-Network level. Services received at a non-network facility will be processed at the Out-of-Network level.

<table>
<thead>
<tr>
<th>Independent Lab and X-ray Services</th>
<th>POS II In-Network</th>
<th>POS II Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of Covered Expenses</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Outpatient Rehabilitation**

Covered When Medically Necessary – Short-Term Rehabilitative Therapy services are subject to Plan limits. Treatment beyond 25 visits is subject to additional review and must be approved by the Plan Administrator in order for continued visits to be covered. Therapy should follow a specific treatment plan that details the treatment, specifies frequency, duration, provides ongoing reviews and is renewed only if continued therapy is appropriate.

<table>
<thead>
<tr>
<th>Outpatient Rehabilitation</th>
<th>POS II In-Network</th>
<th>POS II Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of Covered Expenses after $15 per visit Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
</tbody>
</table>

-31-
<table>
<thead>
<tr>
<th>Benefits</th>
<th>POS II In-Network</th>
<th>POS II Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td><em>Precertification Required – See Aetna Precertification information on this summary.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum 150 visits per Calendar Year (1 visit equals up to 4 hrs)</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient Private Duty Nursing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum 70 shifts per Calendar Year (1 shift equals up to 8 hrs)</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hospice</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Precertification Required – See Aetna Precertification information on this summary.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Facility</td>
<td>90% of Covered Expenses after $300 annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after $300 annual Copay and satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient Setting</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity: Applies to dependents of dependents if IRS rules are met</strong></td>
<td>Note: Services for treatment of complications of pregnancy, including sonograms, and Illness not related to the pregnancy will be subject to additional Copays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doctor/Physician Charges: Initial visit to determine pregnancy</td>
<td>100% of Covered Expenses after $15 per visit Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doctor/Physician Charges: All subsequent Prenatal visits, Postnatal visits and Delivery.</td>
<td>100% of Covered Expenses *</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Facility</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birthing Centers</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td></td>
</tr>
</tbody>
</table>

*Additional charges for assistant surgeon fees will be subject to the applicable Deductible and Copay.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>POS II In-Network</th>
<th>POS II Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Elective Abortions are Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>90% of Covered Expenses after $100 per incident Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits including Tests and Counseling</td>
<td>100% of Covered Expenses after $15 Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Includes coverage for Depo Provera, implantable/injectable contraceptives</td>
<td></td>
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</tr>
<tr>
<td>Surgical sterilization procedures for Vasectomy/Tubal Ligations (excludes reversals)</td>
<td>90% of Covered Expenses after satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% of Covered Expenses after $100 per incident Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $100 per admission Copay and satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Infertility Treatment</strong></td>
<td>Please Note: Services for in vitro fertilization, artificial insemination, or embryo transfer procedures are excluded under the Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Physician’s Office Visit</td>
<td>100% of Covered Expenses after $15 per visit Copay for office visit</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Laboratory &amp; X-ray Services (Limited to tests for fertility and procedures for correction of infertility.)</td>
<td>100% of Covered Expenses for x-ray/lab if billed by a separate facility</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td>Benefits</td>
<td>POS II In-Network</td>
<td>POS II Out-of-Network</td>
<td>Out-of-Area</td>
</tr>
<tr>
<td>--------------------------------------</td>
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<td>------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after $100 per</td>
</tr>
<tr>
<td></td>
<td>Expenses after $100</td>
<td>after $100 per incident</td>
<td>incident Copay and satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td>per incident Copay</td>
<td>satisfying the</td>
<td></td>
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<td></td>
<td>and satisfying the</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>Infertility drugs – Oral &amp; injectables</td>
<td>$2500 Combined</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after $100 per</td>
</tr>
<tr>
<td></td>
<td>Calendar Year</td>
<td>after $300 Annual Copay</td>
<td>incident Copay and satisfying the Deductible</td>
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<tr>
<td></td>
<td>Maximum</td>
<td>and satisfying the</td>
<td></td>
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<td></td>
<td>payable only</td>
<td>Deductible</td>
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<td>through the</td>
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<tr>
<td></td>
<td>Prescription Drug</td>
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<tr>
<td></td>
<td>Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td></td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after satisfying the</td>
<td>and satisfying the Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Centers of Excellence</strong></td>
<td>100% - Includes</td>
<td>N/A</td>
<td>If a Participant or Eligible Dependent travels</td>
</tr>
<tr>
<td></td>
<td>travel and lodging</td>
<td></td>
<td>to a Center of Excellence, the In-Network</td>
</tr>
<tr>
<td></td>
<td>expenses up to</td>
<td></td>
<td>benefits will be paid</td>
</tr>
<tr>
<td></td>
<td>$10,000 for the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>covered patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and a companion,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50/day lodging</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment/Prosthetics</strong></td>
<td>100% - Includes</td>
<td>N/A</td>
<td>If a Participant or Eligible Dependent travels</td>
</tr>
<tr>
<td></td>
<td>travel and lodging</td>
<td></td>
<td>to a Center of Excellence, the In-Network</td>
</tr>
<tr>
<td></td>
<td>expenses up to</td>
<td></td>
<td>benefits will be paid</td>
</tr>
<tr>
<td></td>
<td>$10,000 for the</td>
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<tr>
<td></td>
<td>covered patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and a companion,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50/day lodging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after satisfying the</td>
</tr>
<tr>
<td>If billed by the Doctor/Physician’s</td>
<td>Expenses after</td>
<td>after satisfying the</td>
<td>Deductible</td>
</tr>
<tr>
<td>office, will be paid under the</td>
<td>Deductible</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>Doctor/Physician visit Copay.</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after satisfying the</td>
</tr>
<tr>
<td></td>
<td>Expenses after</td>
<td>after satisfying the</td>
<td>Deductible</td>
</tr>
<tr>
<td></td>
<td>satisfying the</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Prosthetic Appliances –</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after satisfying the</td>
</tr>
<tr>
<td>Initial artificial limbs or other</td>
<td>Expenses after</td>
<td>after satisfying the</td>
<td>Deductible</td>
</tr>
<tr>
<td>prosthetic devices and cost of</td>
<td>satisfying the</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>replacements when functionally</td>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>necessary.</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after satisfying the</td>
</tr>
<tr>
<td></td>
<td>Expenses after</td>
<td>after satisfying the</td>
<td>Deductible</td>
</tr>
<tr>
<td></td>
<td>satisfying the</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase and fitting of a hearing</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after satisfying the</td>
</tr>
<tr>
<td>aid needed for a hearing impairment</td>
<td>Expenses after</td>
<td>after satisfying the</td>
<td>Deductible</td>
</tr>
<tr>
<td>that is due to a congenital condition</td>
<td>satisfying the</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>or accident is paid as any other</td>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness</td>
<td>90% of Covered</td>
<td>70% of R&amp;C Expenses,</td>
<td>80% of R&amp;C Expenses, after satisfying the</td>
</tr>
<tr>
<td>Purchase and fitting of a hearing</td>
<td>Expenses after</td>
<td>after satisfying the</td>
<td>Deductible</td>
</tr>
<tr>
<td>aid needed for other than congenital</td>
<td>satisfying the</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>or accidental causes is covered once</td>
<td>Deductible; maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in any 24-month period.</td>
<td>benefit is $300</td>
<td>benefit is $300</td>
<td>maximum benefit is $300</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>POS II In-Network</td>
<td>POS II Out-of-Network</td>
<td>Out-of-Area</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td>Limited to accidental Injury of sound, natural teeth sustained while covered under the Medical plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist/Doctor/Physician's Office</td>
<td>100% of Covered Expenses after $15 per visit Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>90% of Covered Expenses after $100 per incident Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>As provided by the Claims Administrator, those procedures that are medical in nature and are deemed Medically Necessary by the Medical Plan. TMJ Surgical Expenses are covered under the Medical Plan. Non-surgical TMJ therapies are covered under the Dental Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Physician’s Office</td>
<td>100% of Covered Expenses after $15 per visit Copay</td>
<td>70% of R&amp;C Expenses, after satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after satisfying the Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% of Covered Expenses after $300 Annual Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $300 Annual Copay and satisfying the Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% of Covered Expenses after $100 per incident Copay and satisfying the Deductible</td>
<td>70% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
<td>80% of R&amp;C Expenses, after $100 per incident Copay and satisfying the Deductible</td>
</tr>
<tr>
<td><strong>Hearing Exam</strong></td>
<td>See Durable Medical Equipment/Prosthetics section for coverage of hearing aids.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Pharmacy Copays and Coinsurance do not apply toward the Medical Plan Deductible or Out-of-Pocket Maximum. <strong>Dispense As Written:</strong> If a Doctor/Physician writes DAW on the prescription, the member would only pay their Copay. If the member requests a brand name drug, the member would pay the Copay plus the cost difference between the brand and generic drug.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Prescriptions</strong></td>
<td><strong>30 day supply –</strong> Generic - 90% $5 min. (or cost of drug if less than $5) $200 Maximum out of pocket per Rx fill</td>
<td>70%</td>
<td>Same as POS II option</td>
</tr>
<tr>
<td></td>
<td><strong>30 day supply –</strong> Brand – 75%</td>
<td>70%</td>
<td>Same as POS II option</td>
</tr>
<tr>
<td>Benefits</td>
<td>POS II In-Network</td>
<td>POS II Out-of-Network</td>
<td>Out-of-Area</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
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<td>-------------------------------------</td>
</tr>
<tr>
<td></td>
<td>$5 min. (or cost of drug if less than $5)</td>
<td>$200 Maximum out of pocket per Rx fill</td>
<td>Same as POS II option</td>
</tr>
<tr>
<td></td>
<td>30 day supply –</td>
<td>Specialty Drugs – 75%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$200 Maximum out of pocket per Rx fill</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Contraceptive devices</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Insulin</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Insulin needles &amp; syringes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Glucose test strips</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lancets</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prenatal prescription vitamins</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fluoride preps</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Smoking Cessation Products</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Infertility drugs – Oral &amp; injectables</td>
<td>Yes ($2500 Combined Calendar Year Maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable drugs*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Growth hormone (with Precertification)*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Imitrix (48 kits/yr.) (with Precertification)*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Viagra – 8 tablets/month</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Retin A through Age 36</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mail Order Drugs</td>
<td>Aetna Rx Home Delivery</td>
<td>N/A</td>
<td>Aetna Rx Home Delivery</td>
</tr>
<tr>
<td>90 day supply</td>
<td>Generic: $10 Copay</td>
<td>N/A</td>
<td>Generic: $10 Copay</td>
</tr>
<tr>
<td>Certain drugs are not carried through the mail order program. If you have questions regarding your drug, contact Aetna Rx Home Delivery at 1-800-227-5720</td>
<td>Brand: $30 Copay</td>
<td>Brand: $30 Copay</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Aetna Specialty Pharmacy</td>
<td>N/A</td>
<td>Aetna Specialty Pharmacy</td>
</tr>
<tr>
<td>30 day supply –</td>
<td>75%</td>
<td>N/A</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>$200 Maximum out of pocket per Rx fill</td>
<td>N/A</td>
<td>$200 Maximum out of pocket per Rx fill</td>
</tr>
</tbody>
</table>
**Benefits POS II POS II Out-of-Area**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>POS II In-Network</th>
<th>POS II Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Precertification</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Admissions</td>
<td>Provider is responsible for Precertification</td>
<td>Employee is responsible for Precertification</td>
<td>Employee is responsible for Precertification</td>
</tr>
<tr>
<td>• Convalescent Facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home Health Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospice Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transplants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable medical equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Injectable Drugs may require Precertification</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Inpatient admissions must be Precertified within 48 hours of the Hospital admission. To Precertify benefits, call Aetna Member Services at 1-888-466-8857 and ask for the Precertification Department.

**Penalty:** If Precertification is not obtained for Out-of-Network or Out-of-Area benefits, Covered Expenses will be reduced to 50%, provided that Aetna determines the admission was Medically Necessary. If Precertification is requested and denied, but treatment is received, there will be no benefit paid.

**Confinements in a Convalescent Facility, Home Health Care, or under a Hospice Program (while not confined as an inpatient), and Transplants must be ordered or prescribed by your Doctor/Physician.**

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**Preventive Care Benefits Schedule**

The Plan will reimburse Covered Expenses for the below preventive care services as outlined in the Preventive Care section of the Benefits Summary above. Please Note: Procedures billed with the appropriate routine, preventive diagnosis codes will be considered under the preventive benefit. Procedures not billed as preventive are subject to the applicable deductible, copay and coinsurance.

<table>
<thead>
<tr>
<th>Age of Covered Person</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–12 months</td>
<td>Seven checkups, including routine immunizations, one hearing screening, flu vaccine as needed and Hepatitis A &amp; B Series every Calendar Year.</td>
</tr>
<tr>
<td>13–24 months</td>
<td>Three checkups, including routine immunizations, one hearing screening, flu vaccine as needed and Hepatitis A &amp; B Series every Calendar Year.</td>
</tr>
<tr>
<td>25–35 months</td>
<td>Three checkups, including routine immunizations, one hearing screening and one vision screening, flu vaccine as needed and Hepatitis A &amp; B Series every Calendar Year.</td>
</tr>
<tr>
<td>3–19 years</td>
<td>One checkup/physical exam every Calendar Year. One hearing screening and one vision screening for Children between the ages of 3 and 6. Routine immunizations every Calendar Year, flu vaccine as needed and pneumovax as prescribed by your Doctor/Physician up to age 20. Annual pap smear for females beginning at age 13 under Well Woman Care.* Hepatitis A &amp; B Series every Calendar Year.</td>
</tr>
<tr>
<td>Age of Covered Person</td>
<td>Covered Services</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>20–39 years</td>
<td>One physical exam every Calendar Year to include a PSA and DRE for men. Annual pap smear under Well Woman Care.* Tetanus-diphtheria booster every ten years. Mumps, measles, rubella vaccine for individuals born after 1956 if needed. Flu vaccine as needed and pneumovax as prescribed by your Doctor/Physician. Hepatitis A &amp; B Series.</td>
</tr>
<tr>
<td>40–64 years</td>
<td>One physical exam every Calendar Year, including occult blood analysis; one baseline EKG, PSA and DRE for men; one sigmoidoscopy or colonoscopy between ages 50 and 55, then every three years; tetanus-diphtheria booster every ten years. Annual pap smear and mammogram under Well Woman Care.* After age 50, bone mineral density scans. Flu vaccine as needed and pneumovax as prescribed by your Doctor/Physician. Hepatitis A &amp; B Series.</td>
</tr>
<tr>
<td>65 years and over</td>
<td>One physical exam every Calendar Year, including occult blood analysis; EKG, bone mineral density scans, PSA and DRE for men; sigmoidoscopy or colonoscopy every three years; tetanus-diphtheria booster every ten years; flu vaccine as needed, pneumovax as prescribed by your Doctor/Physician. Annual pap smear and mammogram under Well Woman Care.* Hepatitis A &amp; B Series.</td>
</tr>
</tbody>
</table>

*Medically Necessary exams performed earlier or more frequently if required by Doctor/Physician would be considered under other benefits of the Plan.

**Using In-Network Services**

For In-Network care, the Plan pays one hundred percent (100%) of Covered Expenses for office visits less any Copay. Other In-Network professional services are reimbursed at the Coinsurance amount of Covered Expenses after satisfying the Deductible (for individual or for family). After your share of Covered Expenses reaches the applicable Calendar Year Out-of-Pocket Maximum, the Plan pays one hundred percent (100%) of Covered Expenses for the rest of the Calendar Year, excluding applicable Copays and Mental Health/Substance Abuse Treatment expenses. See the Summary of Benefits for the applicable amount of Deductibles, Copays, Coinsurance, and Out-of-Pocket-Maximums.

Using Network Care Providers, you generally pay only the per-visit Copay amount at the time services are rendered (subject to being Medically Necessary and other Plan exclusions). Your Network Care Provider takes care of paperwork and claims. Using In-Network services takes away some uncertainties and concerns about health care services:

- Your Copay is known in advance.
- You cannot be balance billed by Network Care Provider unless you sign a statement from the Doctor/Physician stating that you will be responsible for certain charges not paid by the Plan.
- The network carefully qualifies and selects participating Doctors/Physicians and Hospitals.
- Effectiveness of care and patient satisfaction is monitored by the Claims Administrator.
Using Out-of-Network Services

When you receive services from a Non-Network Care Provider, a lower level of benefits is provided for most Covered Expenses. Benefits are payable only after you meet the per person Deductible (or applicable family deductible). Then, the Plan generally pays a Coinsurance amount of the R&C Expenses. After your share (or your family’s share) of R&C Expenses reaches the applicable Out-of-Pocket Maximum in a Calendar Year, the Plan pays one hundred percent (100%) of R&C Expenses for the rest of the Calendar Year, excluding applicable Copays and Mental Health/Substance Abuse Treatment expenses. See the Summary of Benefits for the applicable amount of Deductible, Copay, Coinsurance, and Out-of-Pocket Maximum.

Using the Out-of-Area Option

The Out-of-Area option pays a Coinsurance amount of R&C Expenses after you pay the Deductible (for individual or family). After your share of R&C Expenses reaches the applicable Out of Pocket Maximum in a Calendar Year, the Plan pays one hundred percent (100%) of R&C Expenses for the rest of the Calendar Year, excluding applicable Copays and Mental Health/Substance Abuse Treatment expenses. See the Summary of Benefits for the applicable amount of Deductibles, Copays, Coinsurance, and Out-of-Pocket Maximums.

Maximum Annual Out-of-Pocket Expense Limit

The maximum annual out-of-pocket expense limit is the greatest amount of costs for Covered Expenses payable by a Participant in a Calendar Year for Each Participant and Eligible Dependent, including Deductibles. Once you reach the out-of-pocket maximum, the Plan will reimburse one hundred percent (100%) of your Covered Expenses, except for applicable Copays. If the out-of-pocket expenses for any combination of you and your Eligible Dependents reach the out-of-pocket maximum applicable for two or more covered family members, the Plan will reimburse one hundred percent (100%) of your Covered Expenses after applicable Copays.

Note: This benefit does not apply to (i) charges in excess of R&C Expenses; (ii) charges a Participant or Eligible Dependent must pay because of failure to comply with the Plan’s pre-certification requirements for certain Covered Expenses including, Hospital admissions, surgeries, and mental health/substance abuse treatments; (iii) prescription drug repayments; and (iv) any expense not covered by the Plan.

General Medical Expenses

The following are examples of Covered Expenses provided outside of a Hospital or Convalescent Facility (except for surgery charges) that must be Medically Necessary unless specified:

- Services of Doctors/Physicians and Nurses;
- Cost and administration of oxygen and anesthesia;
• Diagnostic laboratory procedures and x-rays;
• Radiation therapy or chemotherapy;
• Local professional ground or air ambulance service, when Medically Necessary and directed by the attending Doctor/Physician or under conditions of an Emergency or a transfer;
• Services provided by a licensed midwife;
• Rental (or purchase, if more cost effective) of durable medical equipment (excluding lifts for vans), such as wheelchairs, crutches, or other durable equipment Medically Necessary for therapeutic use, but not their replacement or repair unless functionally necessary;
• Cost of initial artificial limbs or other prosthetic appliances and cost of replacements when functionally necessary;
• The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances that are required for support of an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness;
• Up to five hundred dollars ($500) for one wig or hairpiece (synthetic, human hair or blends) per Calendar Year when prescribed by a Doctor/Physician for hair loss (regardless of whether it is Medically Necessary) due to Injury (such as severe burns), covered disease or treatment of a covered disease. The vendor where you purchase the wig or hairpiece is not subject to network guidelines;
• Transplant of a body organ or tissue into a covered individual to replace a diseased or injured organ or tissue. Transplants include all medically appropriate, non-experimental procedures performed in the U.S. When Centers of Excellence are utilized, expenses are covered at one hundred percent (100%) and include a travel and lodging allowance for the patient and a companion;
• Expenses associated with a covered person’s donation of an organ or tissue when the recipient of the organ or tissue is covered by the Plan;
• Dental services connected with an accidental Injury to natural sound teeth;
• Services for performing and interpreting mammograms once at age forty (40), then annually (or earlier or more often if Medically Necessary and ordered by a Doctor/Physician) with limitations as follows:
  • Out-of-Network charges subject to a two hundred fifty dollar ($250) Calendar Year combined maximum benefit for Well Woman Care and Adult Preventive Care;
  • Out-of-Area charges subject to a five hundred dollar ($500) Calendar Year combined maximum benefit for Well Woman Care and Adult Preventive Care;
• Charges for one pap smear per Calendar Year beginning at age thirteen (13) with limitations as follows:
  • Out-of-Network charges are subject to a two hundred fifty dollar ($250) Calendar Year combined maximum benefit for Well Women Care and Adult Preventive Care;
• Out-of-Area charges are subject to a five hundred dollar ($500) Calendar Year combined maximum benefit for Well Women Care and Adult Preventive Care;
• Maternity care for covered persons is paid as any other Illness. A Routine Pregnancy is covered under the maternity benefit. NOTE: Medical complications of pregnancy with diagnostic codes other than for Routine Pregnancy, requiring additional tests or services within the gestational period, will be paid as any other Illness and will be subject to additional Copays.
• Sterilization procedures, whether Medically Necessary or not;
• Expenses incurred for diagnosis and treatment of ophthalmologic disease or Injury to the eyes, excluding routine eye exams and treatment to correct refractive disorders. However, benefits are offered through the VSP plan;
• Initial eyeglasses or contact lenses (but not both) following cataract surgery;
• Treatment for glaucoma, as well as testing (not screening) once glaucoma is apparent;
• Electronic heart pacemaker;
• Expenses of a Christian Science practitioner for actual visits for healing purposes, provided the practitioner is listed as such in the Christian Science Journal at the time of the visits, subject to same limits as if such expenses were charged by a Doctor/Physician;
• Expenses incurred for diagnosis or non-surgical treatment of hearing loss or impairment due to a congenital defect or Injury are covered as any other Illness. For all other causes, up to three hundred dollars ($300) of expenses for examination, purchase, and fitting of a hearing aid (but not parts, repairs, or batteries) once in any twenty four (24) month period;
• Expenses for an acupuncture procedure that is performed for therapeutic purposes by a licensed practitioner, practicing within the scope of his/her license;
• Short-Term Rehabilitative Therapy services – physical therapy, speech therapy/developmental delays, occupational therapy, chiropractic therapy, and acupuncture – are subject to Plan limits. Treatment beyond 25 visits is subject to additional review and must be approved by the Plan Administrator in order for continued visits to be covered. Therapy should follow a specific treatment plan that details the treatment, specifies frequency, duration, provides ongoing reviews and is renewed only if continued therapy is appropriate;
• Up to a total of thirty-five (35) visits per Calendar Year for chiropractic services performed In-Network, Out-of-Network, or Out-of-Area (treatment for maintenance purposes is not covered);
• Speech therapy by a registered speech therapist to restore speech after an accident or Illness, or to correct a speech impairment caused by a congenital defect, developmental delay or by surgery;
• Diagnosis and treatment of foot care;
• Eligible surgical charges, including fees for surgery performed by a licensed Doctor/Physician or surgeon in or out of the Hospital;
• Assistant surgeon charges, as long as Medically Necessary for a covered surgical or obstetrical service; the assistant’s duties cannot routinely be available from a Hospital intern, resident, or full-time salaried Doctor/Physician;
• Private duty nursing up to seventy (70) shifts per Plan Year (one shift is equal to eight hours of private duty nursing services);
• Infertility assessment and treatment (except in vitro, artificial insemination, and embryo transfer procedures are excluded); and
• Cosmetic surgery, reconstructive surgery, and orthodontic services performed for correction of an accidental Injury or Illness or severe congenital abnormalities, including post-mastectomy reconstructive breast surgery; surgery to repair an accidental Injury must be performed in the Calendar Year of the accident or in the next Calendar Year.

Note: The Women’s Health and Cancer Rights Act of 1998 requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Specifically, health plans must cover:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Benefits required under the Women’s Health and Cancer Rights Act will be provided in consultation between the patient and attending Doctor/Physician. These benefits are subject to the Plan’s regular Copays and Deductibles.

**Hospital and Convalescent Facility Expenses**

The following list includes procedures which are Medically Necessary Covered Expenses:

• Semiprivate room and board (if the Hospital is constructed without semiprivate rooms, the Plan will cover the room and board cost of the Hospital’s private room);
• Use of operating, delivery, and treatment rooms;
• General nursing care;
• Anesthesia and dressings;
• Administration of blood, blood plasma, and oxygen, and the cost of blood, if the blood is not replaced;
• The cost of drawing, banking, and administering one’s own blood, when recommended by the attending Doctor/Physician in connection with planned surgery and performed no more than thirty (30) days in advance of the surgery;
• Diagnostic X-rays, laboratory, or pathological exams;
• Radiation therapy;
• Use of an approved birthing center;
• Nursery charges for a newborn, as long as hospitalization is required for the mother;
  - Note: Per the Newborns’ and Mothers’ Health Protection Act of 1996, group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth, for the mother or newborn child, to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods;
• Eligible Outpatient Surgical Facility charges; and
• Charges made by a Convalescent Facility if they are furnished to a person while confined to convalesce from a disease or Injury, up to one hundred and twenty (120) days per Calendar Year, if the following apply:
  - The Hospital confinement is for at least three (3) days, and admission to the Convalescent Facility follows within fourteen (14) days of the Hospital confinement;
  - The Doctor/Physician determines that care in a 24-hour-a-day nursing Convalescent Facility is essential to the patient’s recovery, and the Doctor/Physician continues treatment during the Convalescent Facility confinement; and
  - The Convalescent Facility is under the full-time supervision of a Doctor/Physician or a Registered Nurse, or offers the services of a Doctor/Physician.
• Charges may include cost of room and board (but not room and board in a private room over the Private Room Limit); use of special treatment rooms; x-ray and lab work; physical, occupational or speech therapy; oxygen and other gas therapy; and medical supplies. Charges for treatment of drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation and any other mental disorder are NOT covered by this section.

Participants should ensure that Precertification requirements have been satisfied. Please refer to that section for requirements.

Organ Transplants

Through Aetna’s Institute of Excellence™ (IOE) programs, Participants and enrolled Eligible Dependents may access health care facilities that are nationally recognized for expertise in certain highly specialized and expensive procedures.
The Plan will pay:

- One hundred percent (100%) of expenses for specific complex organ and tissue transplants, such as heart, liver, lung, kidney, pancreas, and bone marrow, performed at participating Hospitals in the U.S.; and
- Travel and lodging expenses up to ten thousand dollars ($10,000) for the covered patient and a companion, subject to a fifty dollar ($50) a day lodging and meal limit per individual (one hundred dollars ($100) per family). Meals are only reimbursable if provided in a hospital or similar institution.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as Out-of-Network services and supplies, even if the facility is a network facility or IOE for other types of services.

Organ means: solid organ; stem cell; bone marrow; and tissue. See Precertification section to ensure that you have satisfied the requirements.

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your Eligible Dependents may require an organ transplant:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- 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;
- Any other single organ transplant, unless otherwise excluded under the 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;
• 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).

The Plan covers:

• 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 supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
• Charges for activating the donor search process with national registries.
• Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
• Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are 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 covered transplant expenses during each phase are:

1. 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;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

Limitations
Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- 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;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Home Health Care

The Plan covers Home Health Care expenses provided under a certified Home Health Care Program subject to the Plan provisions. The Doctor/Physician must certify, in writing, that proper treatment of the Illness or Injury would require Hospitalization if services and supplies were not available under the Home Health Care Program. Any services and supplies must be provided by an authorized Home Health Care Agency.

Covered Home Health Care expenses include the following:

- Medical supplies, drugs, and medication ordered by a Doctor/Physician;
- Laboratory services furnished by a Home Health Care Agency; and
• Up to one hundred and fifty (150) visits in any Calendar Year for:
  - Part-time or intermittent nursing care by or under the supervision of a
    registered Nurse;
  - Part-time or intermittent home health aide services; and
  - Physical therapy, occupational therapy, and speech therapy.

A home health visit for up to four (4) hours by any member of a Home Health Care team will be considered one Home Health Care visit.

The benefits for medical social services are a separate benefit that are paid in addition to the 150-visit-per-calendar-year limit by a Home Health Care team. Covered Expenses for a licensed social worker performed under the direction of a Doctor/Physician include, but are not limited to, the following:

• Assessment of the social, psychological and family problems related to or arising out of the Illness and treatment;

• Appropriate action and utilization of community resources to assist in resolving the problems; and

• Participation in the development of the overall plan of treatment.

Expenses are not covered for:

• Benefits and services otherwise provided by the Aetna Choice™ POS II option or the Aetna Out-of-Area option;

• Services or supplies not included in the Home Health Care treatment plan;

• Services of a person who ordinarily resides in the same house as the covered person or is a member of the family of the covered person or the family of the covered person’s Spouse;

• Services and supplies not related to medical care or treatment;

• Services received when the covered person is not under the continuing care of a Doctor/Physician;

• Home Health Care expenses incurred for visits in excess of one hundred and fifty (150) visits per Calendar Year (except as indicated previously for Medical Social Services); and

• Custodial care.

Participants should ensure that Precertification requirements are satisfied. See Precertification section for requirements.
Hospice Program

The Plan covers a Hospice Program (as defined in the Words to Know section). Eligible services and supplies include those for you and your enrolled Eligible Dependents participating in an approved Hospice Program.

Covered Hospice Care expenses include the following:

- Room and board in an approved hospice facility;
- Other Hospice Care services required for pain relief, including medicines, medical supplies, drugs, and short-term rental of durable equipment;
- Nursing care or home health care provided by a Nurse or a home health aide;
- Counseling visits for the patient, provided a Doctor/Physician determines the terminal Illness is the direct cause of the need for counseling. Counseling must be provided by a licensed psychologist, psychiatrist, clinical practitioner, or social worker (Precertification of this Hospice Care benefit by MHNet is not required);
- Physical, respiratory, and speech therapy, if ordered by the attending Doctor/Physician and the Hospice Program;
- Dietary and nutritional assistance when provided by a licensed nutritionist or dietician; and
- Other services provided through the Hospice Program if the attending Doctor/Physician determines the services are Medically Necessary.

See Precertification section to ensure that you meet the requirements.

Emergency Medical Condition

Emergency room charges for an Emergency Medical Condition are covered at the Negotiated Charge for a Network Care Provider and at the billed rate for Non-Network Care Providers, subject to a Copay. The Emergency Room Copay is waived if you or your Eligible Dependent are admitted to the Hospital, but the Inpatient Hospital stay will be subject to the applicable Deductible, Copay, and Coinsurance amounts. Hospital charges for admissions that result from an Emergency Medical Condition at a Non-Network hospital are covered subject to applicable In-Network Deductible, Copayment, and Coinsurance. Non-Network Care Providers’ charges for such Hospital admissions are subject to applicable In-Network Deductible and Coinsurance and may be subject to R&C Expense limits. **Precertification is required within forty-eight (48) hours of the Hospital admission. See Precertification Section for requirements.**

Minor Illnesses such as colds, flu, earaches, sprains, cuts, and back pain generally are not considered Emergency conditions. To ensure payment of the highest level of benefits, contact Aetna before seeking any emergency treatment for minor Illnesses. Use of the
emergency room for a minor Illness is not covered under the Plan.

In the event of a minor Illness, call Aetna Member Services at 1-888-466-8857 or access aetna.com to obtain providers or Urgent Care providers in the area.

**Emergency Medical Conditions and Urgent Care While Outside the U.S. on Personal Travel**

For treatment of Illness or Injury while traveling outside of the U.S. for personal reasons, the Plan will cover the billed charges of the Covered Expenses subject to the applicable In-Network Deductibles, Copays, and Coinsurances. The Participant will pay for the services and submit a claim to Aetna for reimbursement. If the attending provider prescribes medication, the pharmacy expense will be reimbursed at the Out-of-Network rate. Transplants performed outside of the U.S. are not covered.

**XI. WHAT’S NOT COVERED BY THE PLAN**

The following are examples of medical expenses that are not covered under the Plan:

- Expenses incurred prior to the effective date of a Participant’s coverage, or after the date of termination of coverage;

- Expenses that exceed the R&C Expense limits for the treatment or services provided;

- Expenses listed as not covered elsewhere in this SPD;

- Anything not ordered by a Doctor/Physician or not Medically Necessary or appropriate, as determined by your Claims Administrator or other appropriate fiduciary in its sole and absolute discretion and authority, including, without limitation, any service, supply, treatment or procedure not approved for reimbursement by the Claims Administrator or which is not in accordance with generally accepted principles of medical practice in the United States at the time furnished;

- Services or supplies that are, as determined by your Claims Administrator to be, Experimental or Investigational (as defined in the Words to Know).

  This exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if your Claims Administrator determines that: the disease can be expected to cause death within one (1) year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination your Claims Administrator will take into account the results of a review by a panel of independent medical professionals selected by them. This panel will include professionals who treat the type of disease involved. Also, if your Claims Administrator determines that available scientific evidence demonstrates that
the drug is effective or shows promise of being effective for the disease, this exclusion will not apply with respect to drugs that: have been granted treatment Investigational new drug (IND) or Group treatment IND status; or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute.

- Treatment (including services and supplies) that the Participant or Eligible Dependent is not charged for and is not legally required to pay;

- Expenses paid as part of a legal settlement that are not covered by the Plan;

- Any care or treatment provided by the Participant or an immediate family member, including the Participant’s Spouse, or by a child, brother, brother-in-law, sister, sister-in-law, parent or grandparent of a Participant or his Spouse;

- Expenses for care furnished mainly to provide a surrounding that is free from exposure that can worsen a disease or Injury;

- Expenses for or related to mental health and substance abuse are not covered by the medical provider, but may be provided by MHNet;

- Expenses for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field;

- Expenses for services of a resident Doctor/Physician or intern rendered in that capacity;

- Expenses that are made only because there is health coverage;

- Custodial Care, regardless of who prescribes or renders the care;

- Injuries or Illnesses covered by workers’ compensation;

- Medical expenses paid for by a governmental agency;

- Injury or Illness caused by an act of war unless Government funds do not cover the Illness or Injury;

- Preventive medical care or routine physical examination or immunizations, including well-child care, except as provided in the Preventive Care Benefits Schedule;

- Surgery or treatment for cosmetic purposes, except for accidental Injury, Illness, correction of congenital anomalies, or post-mastectomy reconstructive breast surgery;
• Expenses related to donation of an organ or tissue by a covered individual when the recipient is not also a covered Participant or Eligible Dependent;

• Massage therapy services;

• Acupuncture therapy, unless performed by a licensed practitioner, practicing within the scope of their license;

• Diagnosis and treatment of foot care when not Medically Necessary;

• Dental services other than those connected with accidental Injury to sound natural teeth;

• Routine eye examinations and prescriptions or fitting of eyeglasses or contact lenses to correct refractive disorders. However, benefits are offered through the VSP Plan. Prescriptions and fittings for initial lenses following cataract surgery are covered;

• Radial keratotomy or other eye surgery mainly to correct refractive errors;

• Infertility treatment other than for diagnosis and treatment of underlying cause, including in-vitro fertilization, artificial insemination, or embryo transfer procedures;

• Elective abortions and birth control devices, except oral contraceptives or devices that are prescribed by a Doctor/Physician;

• Charges relating to treatment of sexual dysfunction or inadequacies that do not have a physiological or organic basis;

• Expenses for the reversal of previous sterilization procedures;

• Speech therapy that is not Medically Necessary;

• Fees for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling;

• Fees for completion or filing of claim forms;

• Fees for providing information requested by the Claims Administrator such as for further documentation of a treatment;

• Fees for broken or missed appointments;

• Personal items or services, such as television sets and telephones, used during a Hospital stay;

• Charges for treatment to alter physical characteristics to those of the opposite sex,
or for any treatment of gender identity disorders;

- Charges for treatment of weight loss other than for Morbid Obesity when an underlying severe medical condition is not present. Severe medical conditions include, but are not limited to: diabetes, hypertension, and cardiovascular disease. In disputed cases, the Claims Administrator reserves the right to make the final decision;

- Charges for cochlear implants, hearing aid batteries, as well as special education for a person whose ability to hear is lost or impaired, including lessons in sign language;

- Charges for Injury or Illness resulting from participation in, or in consequence of having participated in, the commission of an assault or a felony;

- Charges that are reported to the Claims Administrator more than twelve (12) months after the date the charges were incurred;

- Charges for vitamins and nutritional supplements. Note: Nutritional supplements may be covered if they are prescribed by a Doctor/Physician, and it is determined they are Medically Necessary;

- Charges for non-surgical treatment of Temporomandibular Joint (TMJ) Syndrome; and

- Transplants performed outside of the U.S.

- Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your Illness or Injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat Illnesses, Injuries or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

XII. PRECERTIFICATION

Precertification for Hospital Admissions

Inpatient Hospital admissions must be Precertified within forty-eight (48) hours of the Hospital admission. The provider is responsible for Precertification of In-Network Inpatient Hospital admissions and you are responsible for Precertification of Out-of-Network or Out-of-Area Inpatient Hospital admissions. To Precertify benefits, call Aetna Member Services at 1-888-466-8857 and ask for the Precertification Department. If you do not Precertify Out-of-Network/Out-of-Area Inpatient Hospital admissions within forty-eight (48) hours of the Hospital admission, Covered Expenses will be reduced to fifty percent (50%) provided that Aetna determines the admission to be Medically Necessary. If Precertification is requested and denied, but treatment is received, there will be no benefit paid. The expenses not payable under the Plan will not count toward satisfying the Deductible or the annual Out-of-Pocket Maximum.

A Precertification specialist will review the admission and your Doctor/Physician’s treatment plan to determine if Medically Necessary. When appropriate, the specialist will suggest equally effective and less costly alternatives. You also will be told if any part of your Doctor/Physician’s treatment plan is outside usual standards and not covered by the Plan.

The Claims Administrator has complete fiduciary discretion and authority to establish and apply its own medical review standards and criteria for determining Medically Necessary or appropriate treatment, and may certify or deny Precertification of any services, treatment, or supplies based on objective standards consistently applied.

The Claims Administrator’s decisions only affect the level of reimbursement under the Plan. Any decisions concerning actual treatment are made solely between the patient and the Doctor/Physician.
Precertification for Convalescent Facility Admissions, Home Health Care, Hospice Care, or Durable Medical Equipment

A confinement in a Convalescent Facility, a Hospice Program, Home Health Care Program, and purchase or rental of certain durable medical equipment must be Precertified.

If Precertification has been requested and denied, or if Precertification has not been requested and is not Medically Necessary as determined by Aetna, no benefits will be paid. If Precertification has not been requested, but the services are Medically Necessary as determined by Aetna, Covered Expenses will be reduced to fifty percent (50%). The expenses not payable under the Plan will not count toward satisfying the Deductible or the annual Out-of-Pocket Maximum.

Precertification for Mental Health Care and Substance Abuse

If the admission is for treatment of Mental Health/Substance Abuse, please refer to the Precertification requirements in the Mental Health/Substance Abuse section.

XIII. PRESCRIPTION DRUGS

Prescription Drug Expenses

Eligible prescription drugs are covered for you and your Eligible Dependents under the Aetna options as follows:

- Pharmacy Copays, and Coinsurance do not count toward the Deductible or annual Out-of-Pocket Maximum; and

- Copays or Coinsurance must always be paid, even if the Plan’s Out-of-Pocket Maximum has already been reached.

Retail purchases

- Prescriptions (up to a 30-day supply) may be filled at a network retail pharmacy for a Copay of ten percent (10%) of a discounted In-Network price for generic prescriptions and twenty five percent (25%) for brand-name prescriptions. The cost of the drug will be limited to a five dollar ($5) minimum (or cost of drug if less than $5) and a two hundred dollar ($200) maximum out-of-pocket cost per prescription fill.

- Benefits are reduced for purchases from Out-of-Network retail pharmacies. Prescriptions obtained from Out-of-Network pharmacies are covered at seventy percent (70%). Your Out-of-Pocket expense is thirty percent (30%) of the cost of the prescription.
Mail order purchases

Prescriptions for maintenance drugs (up to a 90-day supply) may be filled through the Aetna mail order pharmacy service for a Copay of ten dollars ($10) for generic drugs and thirty dollars ($30) for brand-name drugs each time a prescription is filled.

Your cost for prescriptions through retail or mail order will be higher if a brand-name drug is requested when a generic equivalent could be dispensed. Unless the prescribing Doctor/Physician denotes that a prescription should be “dispensed as written” with a brand-name drug, the Plan will cover the cost of generic equivalent drugs (if a generic is available). You or the patient must pay any additional cost at the time the prescription is filled. The cost will be the brand-name Copay (as described below) plus the price difference between the brand-name drug and the generic drug.

If you need to purchase a prescription before you receive your medical ID card in the mail, you can print a temporary ID card by registering on Aetna Navigator at aetna.com.

Using Network Retail Pharmacies

To fill a prescription at a local network pharmacy, take the following to the pharmacy:

- The original prescription; and
- Your medical ID card.

If you elected to contribute to a Health Care Spending Account (HCSA), payment can be made using the Auto Debit feature. Just show your Aetna ID card and as long you have sufficient funds in your HCSA, your Copay is drawn directly from your HCSA and you pay nothing out-of-pocket at the point of purchase.

To find out whether a pharmacy is a network pharmacy, call the pharmacy. In addition, lists of local network retail pharmacies are available by calling Aetna at 1-888-466-8857 or checking the Aetna Navigator website at aetna.com.

Using Out-of-Network Retail Pharmacies

To fill a prescription at an Out-of-Network retail pharmacy, take the original prescription to the pharmacy. You will have to pay for the prescription and file for reimbursement.

Using the Mail Order Prescription Service

The mail order service is intended to save you money on the cost of maintenance medications (drugs taken for chronic conditions or over a long period of time). Certain drugs are not carried through the mail order program. If you have questions regarding your drug, contact Aetna Rx Home Delivery.

When a Doctor/Physician prescribes medication to be taken for more than thirty (30)
days, ask the Doctor/Physician to write two prescriptions: one for an initial supply to be filled at your local participating retail pharmacy, and another for an extended supply to be mailed to Aetna's mail order carrier, Aetna Rx Home Delivery. For example, the extended supply might be written as a 90-day supply with three refills. If the prescription is for a controlled substance, your doctor must put a diagnosis on the prescription to receive a 90-day supply. *If a diagnosis is not on the prescription, Aetna Rx Home Delivery will only ship a 30-day supply and you will be charged the full mail order Copay.*

**For first-time prescription fills, print the Aetna Rx Home Delivery Brochure and the Aetna Rx Home Delivery Order form. These forms are available on the Ericsson North America Homepage, under HR SSC Dallas/E-Flex Benefits/Medical and on the Ericsson Online Benefits Tool.**

**Using Aetna Specialty Pharmacy**

Patients with chronic medical conditions often need medications that are not readily available at a local pharmacy. These medications may require special storage and handling, and sometimes they have side effects that must be carefully monitored.

Aetna Specialty Pharmacy provides medications, such as self-injectable drugs, and clinical support for patients with chronic medical conditions such as:

- Asthma
- Blood disorders
- Cancer
- Chronic renal failure
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Infertility
- Multiple Sclerosis
- Osteoporosis
- Pulmonary disease
- Rheumatoid arthritis
- Psoriasis
- Transplants

The goal of Aetna Specialty Pharmacy is to work with you and your physician to ensure that you:

- Are on the right medication therapy;
- Have the medications and supplies you need; and
- Know how to administer your medications.

These drugs are covered at the In-Network level of benefits only when dispensed through a network retail pharmacy or Aetna’s Specialty Pharmacy. You may refer to [www.aetna.com](http://www.aetna.com) to review the list anytime. Each prescription is limited to a maximum 30 day supply.

You can reach Aetna Specialty Pharmacy 24-hours-a-day, 7 days a week at 1-866-782-2779.
Drug Expenses That Are Not Covered

Some medications or items are not covered by the Plan, including the following:

- Medications that can be purchased without a prescription (except insulin);
- Drugs prescribed for unapproved purposes;
- Medications dispensed for cosmetic purposes;
- Rogaine;
- Retin-A for cosmetic purposes for individuals thirty seven (37) and older;
- Therapeutic devices or appliances;
- Charges for administration or injection of any drug;
- Any prescription or refill dispensed more than one (1) year from the original prescription (other than for a controlled substance, in which case a thirty (30) day limit applies);
- Diet pills or drugs;
- Immunological, Experimental, or Investigational drugs;
- Growth hormones unless Precertified; and
- More than eight Viagra tablets per month.

XIV. MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

Mental health care and substance abuse treatment has been carved out to MHNet with respect to Participants and Eligible Dependents covered by the Aetna options of the Plan. This means that MHNet manages the mental health/substance abuse benefits for all Participants and Eligible Dependents in the Plan who are covered by the Aetna options.

Ericsson Services recognizes that health care includes more than physical well-being. It also involves preserving a healthy state of mind and treating psychological problems, mental and nervous disorders, and dependence on or abuse of drugs and alcohol.

Ericsson Services offers benefits to assist you and your Eligible Dependents in receiving mental health care and substance abuse treatment through the Employee Assistance
The Employee Assistance Program (EAP)

The EAP provides confidential counseling and psychological assessment, free of charge, to all active Eligible Employees and Eligible Dependents, whether or not they are enrolled in the medical plan. EAP services are not available to LTD participants.

Services through the EAP

Care for mental health/substance abuse problems generally starts with a call to the EAP. The EAP’s professional counselors evaluate your needs by phone or through an office visit and direct you to the appropriate type of care. The EAP provides up to six (6) visits per issue per year for either short-term counseling or assessment and referral.

If Outpatient or Inpatient care is needed, the EAP can obtain advance approval of the care from the MHMP and provide referral to care providers; this ensures that the patient qualifies for the maximum benefits available.

To schedule a counseling session or receive emergency crisis counseling, call MHNet at 1-800-492-4357. The EAP is available by telephone twenty-four (24) hours a day, seven (7) days a week.

The Mental Health Management Program (MHMP)

The MHMP provides confidential Inpatient and Outpatient treatment. Benefits are paid based on the following:

- The type of care received;
- Whether the care is Precertified; and
- Whether an MHNet Network Care Provider is used.

MHNet coordinates a nationwide group of Network Care Providers specializing in mental health/substance abuse treatment. This network is different from the Aetna Choice™ POS II network. For the highest available benefits to be paid, services must be Precertified and provided by a MHNet Network Care Provider.

Care through the MHMP

MHMP health care professionals work with your Doctor/Physician or therapist to assess your needs, plan an appropriate course of care, and monitor the progress of your care for effectiveness and cost efficiency.

In almost all cases, care providers and the MHMP quickly agree on an appropriate course of care. If agreement cannot be reached, you will be told which parts of the planned treatment the Plan will cover and which are outside normal practice.
Outpatient Care

Covered Expenses include the services of a psychologist, psychiatrist, licensed professional counselor, or licensed social worker, when the patient is not admitted to a Hospital. Partial day Hospital programs are considered Inpatient Care (see below).

Inpatient Care

Subject to the Precertification requirements, Covered Expenses include confinements in a Hospital or residential care facility for the following:

- Detoxification for substance abuse when loss of life or permanent impairment is threatened;
- Psychiatric care of mental health and emotional disorders; and
- Partial-day Hospital programs for psychological counseling, specialized substance abuse rehabilitation, and psychiatric treatment for patients with serious mental and emotional disorders who require regular therapy, but who do not require Inpatient care.

Precertification of Outpatient and Inpatient Expenses and Amount of Benefits

In case of an admission for an Emergency Medical Condition, the admitting facility should immediately contact MHNet (see telephone number below) for approval. This emergency approval service is available twenty-four (24) hours a day, seven (7) days a week.

To request advance approval of benefits for any Inpatient or Outpatient treatment, call MHNet at the following number twenty-four (24) hours per day, seven (7) days per week.

MHNet: 1-800-492-4357

Covered Expenses will be reduced as shown in the following chart, if they are not Precertified (approved in advance) by MHNet or if MHNet’s Network Care Providers* are not used. Mental health care/substance abuse treatment is NOT subject to the Plan Deductible or annual Out-of-Pocket Maximum.

With approval, and if a Network Care Provider is used, benefits for mental health care/substance abuse treatment are paid the same as other medical expenses. MHNet serves to help you and your enrolled Eligible Dependents receive quality care, while making sure that both you and Ericsson Services receive good value for the dollars spent.

MHNet has complete fiduciary discretion and authority to establish and apply its own medical review standards and criteria for determining Medically Necessary or appropriate treatment, and may approve or reject any proposed plan of treatment or care based solely on their standards and criteria.
Their decisions only affect the level of reimbursement under the Plan. Any decisions concerning actual treatment are made solely between the patient and the Doctor/Physician.

**Summary of Benefits for Mental Health/Substance Abuse Treatment**

<table>
<thead>
<tr>
<th>Mental Health/Substance Abuse Benefits</th>
<th>MHNet Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health &amp; Substance Abuse Treatment</strong></td>
<td>If not Precertified, Inpatient Care and Outpatient Care benefits will be paid at the Out-of-Network Benefit Percentage (see grid below). For the highest available benefits to be paid, services must be Precertified and provided by a MHNet Network Care Provider. This network is through MHNet and is different from the Aetna Choice™ POS II network.</td>
<td><strong>Inpatient Care</strong></td>
</tr>
<tr>
<td><strong>Managed by MHNet</strong></td>
<td></td>
<td><strong>Outpatient Care</strong></td>
</tr>
</tbody>
</table>

*80% for the Out-of-Area option

**Expenses That Are Not Covered**

Expenses for some Mental Health Care/Substance Abuse Treatment are not covered by the Plan, including the following:

- Behavior modification;
- Biofeedback;
- Care while confined to a federal, state, county, or local institution;
- Marriage, job, industrial, education, religious, or sex counseling;
- Services ordered by the court;
- Charges for Custodial Care;
- Treatment for mental retardation or learning disabilities;
- Treatment for certain personality or mental disorders, including conduct disorders and eating disorders, unless considered Medically Necessary by MHNet;
- Services that are required because the patient refused to follow the Medically
Necessary treatment plan; and

- Services that are required by any third party, such as for insurance.

Claims for reimbursement of Mental Health Care/Substance Abuse Treatment expenses should not be filed with Aetna. For details, see “Claims Procedures.”

XV. DENTAL PLAN OVERVIEW

How the Dental Plan Works

Below is a summary of dental benefits under the Aetna Dental PPO. All Out-of-Network Charges Are Subject to R&C Expense limits.

<table>
<thead>
<tr>
<th>PPO</th>
<th>ANNUAL DEDUCTIBLE*</th>
<th>PLAN COINSURANCE</th>
<th>BENEFIT MAXIMUMS PER PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Preventive</td>
<td>$0/$0</td>
<td>100%</td>
<td>$2,000/Calendar Year</td>
</tr>
<tr>
<td>- Basic</td>
<td>$25/$50*</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>- Major</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>- Orthodontia</td>
<td>$0/$0</td>
<td>50%</td>
<td>$2,000/lifetime for Orthodontia</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$0/$0</td>
<td>100% of R&amp;C</td>
<td>$1,750/Calendar Year</td>
</tr>
<tr>
<td>- Preventive</td>
<td></td>
<td>80% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- Major</td>
<td>$25/$50*</td>
<td>50% of R&amp;C</td>
<td>$1,750/Lifetime For Orthodontia</td>
</tr>
<tr>
<td>- Orthodontia</td>
<td>$0/$0</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
</tbody>
</table>

* Separate from Medical Plan Deductible; combined Deductible for any combination of basic and/or major services In-Network or Out-of-Network.

You can access the Aetna Dental PPO network at www.aetna.com.

These benefits are explained in detail in the section, “Eligible Expenses Covered by the Plan.”

The Annual Deductible

An annual Deductible (shown in the chart above) must be satisfied before the Plan pays In-Network or Out-of-Network benefits for Basic and Major dental services. Preventive services and Orthodontia do not require a Deductible. The percentage level of Coinsurance depends on whether or not the provider participates in Aetna’s network.
Amounts paid for services not covered by the Plan are not credited toward the Deductible.

**Benefit Maximums**

Total benefits for Preventive, Basic, and Major dental services combined are limited to two thousand dollars ($2,000) for each covered person per Calendar Year for services rendered by a Network Care Provider and one thousand seven hundred fifty dollars ($1,750) for services performed by a Non-Network Care Provider. Each covered person also has a separate Orthodontia Lifetime Maximum benefit of two thousand dollars ($2,000) for In-Network and one thousand seven hundred fifty dollars ($1,750) for Out-of-Network.

**Reasonable and Customary Expenses**

The Plan’s Coinsurance for Covered Expenses is limited to the R&C Expenses for the dental services and supplies received from a Non-Network Care Provider. The Participant is responsible for paying the full amount of any charges in excess of the R&C Expense.

**Eligible Expenses Covered by the Plan**

The Plan covers the following services if they are Medically Necessary, customarily used nationwide, and deemed by the profession and Aetna to be appropriate. The services must meet broadly accepted national standards of dental practice.

**Preventive Services**

The Plan pays one hundred percent (100%) for In-Network services and one hundred percent (100%) of R&C Expenses for Out-of-Network services for the allowable charges for covered Preventive services without a Deductible. These services are intended to reduce or eliminate the need for more costly dental work and are generally the most common types of dental care. Below are some of the Preventive services the Plan covers:

- Oral exams twice each Calendar Year for each covered person;
- Cleaning teeth (prophylaxis) twice each Calendar Year for each covered person;
- Diagnostic bitewing X-rays twice each Calendar Year for each covered person;
- One application of sealants on permanent molars for covered persons under age nineteen (19). Limited to one treatment every three (3) Calendar Years;
- Full-mouth or Panoramic X rays once every three (3) Calendar Years;
  - Vertical Bitewing X-rays one set every three (3) Calendar Years;
- Fluoride treatments for covered persons under age twenty-five (25) once every Calendar Year;
• Emergency treatment only to relieve or reduce severity of pain, but not to treat the condition; and

• Space maintainers for covered persons.

**Basic Services**

Of course, dental problems can arise even with the best preventive care. So the Plan pays a portion of the allowable charges for covered Basic services, after the annual Deductible is satisfied. The percentage paid by the Plan depends on whether the provider is In-Network (eighty five percent (85%) paid by the Plan) or Out-of-Network (eighty percent (80%) of Reasonable and Customary expenses paid by the Plan). Below are some of the Basic services the Plan covers:

• Extractions (both simple and surgical) and oral surgery that is dental in nature. Extractions include local anesthesia and routine post-operative care;

• Amalgam, silicate, acrylic, synthetic porcelain, composite, or gold fillings;

• X rays necessary in conjunction with basic services;

• Periodontal cleanings twice per calendar year following periodontal treatment;

• General anesthetics administered in connection with oral surgery upon demonstration of Medical Necessity;

• Endodontics, including pulp infection and root canal therapy;

• Crowns, inlays, and onlays including crowns as abutments;

• Repair and recementing of crowns, bridges, inlays, and onlays; and

• Antibiotic drug injections. (Other drugs prescribed by a dentist are generally covered under the medical plan’s prescription drug benefits).

Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)

Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)

Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)

Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
Major Services

Major services usually involve significant dental treatment or services. The Plan pays fifty percent (50%) for In-Network services and fifty percent (50%) of R&C Expenses for Out-of-Network services for the allowable charges for these services, but the Deductible must be satisfied before benefits are paid. Below are some of the major services the Plan covers:

- Initial installation of fixed bridgework;

- Initial installation of full or partial dentures and adjustments within six (6) months of installation;

- Non-surgical treatment of Temporomandibular Joint (TMJ) Syndrome;

- Initial installation of dental implants, when dentures or fixed bridgework do not provide an adequate replacement; and

  Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years

  Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years

  Soft tissue graft procedures

- Replacement of or addition to bridgework or dentures when needed because:
  
  - additional teeth are extracted;
  
  - existing denture or bridge cannot be repaired; or
  
  - existing denture is an immediate temporary one. Replacement by permanent denture must take place within twelve (12) months from the date the immediate temporary one was first installed;

  - Removable dentures are normally replaced by another set of removable dentures. However, if fixed bridgework provides an adequate replacement, then fixed bridgework will be covered by the Plan.

Orthodontic Services

The Plan pays fifty percent (50%) for In-Network services and fifty percent (50%) of R&C Expenses for Out-of-Network services for orthodontic charges, including preliminary treatment and monthly maintenance. No Deductible applies. Orthodontic
expenses do not count toward the per person annual maximum for other dental services, but they are limited to a Lifetime Maximum of two thousand dollars ($2,000) for In-Network and one thousand seven hundred fifty dollars ($1,750) for Out-of-Network for each covered person (including amounts paid under Ericsson Services prior dental plans). Below are some of the Orthodontic services the Plan covers:

- Orthodontic diagnostic procedures, including cephalometric X rays; and
- Braces for adults and Children;

What’s Not Covered

The Plan will pay for the least expensive dental treatment method that is effective. The Plan will not pay for treatment received before coverage under the Plan becomes effective. Also, if treatment that began prior to coverage is not completed until after coverage is effective, the Plan is not required to pay for such treatment, but will consider whether it is eligible for payment.

The following are examples of dental expenses that are not covered under the Plan:

- Expenses that exceed the R&C Expense limits for the dental treatment or service provided. Does not apply to Network Care Providers;
- Expenses that apply toward the Deductible or Coinsurance;
- Expenses incurred before coverage by the Plan is in effect or after coverage ends;
- Services performed solely for cosmetic reasons;
- Replacement of lost or stolen prosthetic devices;
- Charges for adjustment of dentures or bridges within six (6) months of installation when performed by the same dentist who installed them;
- Services or supplies which, in Aetna’s sole discretion and authority, do not meet accepted dental standards or are not Medically Necessary;
- Experimental or Investigational procedures (as determined by Aetna);
- Myofunctional therapy (muscle training therapy or training to correct or control harmful habits);
- Periodontal splinting;
- Drugs prescribed by a dentist (these may be covered under the medical plan);
- Any appliances, restorations, and procedures designed to alter vertical dimension;
• Any expenses that the covered person is not charged for or required to pay;

• Fees for broken appointments, or for completion or filing of claim forms;

• Fees for providing information requested by the insurance company for further documentation of a treatment;

• Educational or training programs, dietary instructions, or plaque control programs;

• Services that are covered under worker’s compensation or a similar law;

• Expenses paid or eligible for payment under any other law, plan, or program (except Medicaid) of any federal, state, or local government of any country;

• Services covered by any other health plan sponsored by Ericsson Services;

• Services not furnished by a licensed dentist, Doctor/Physician, or dental hygienist;

• Treatment of dental diseases or injuries resulting from declared or undeclared war unless Government funds do not cover the Illness or Injury, insurrection, participation in a riot or felony, or service in the armed forces of any government;

• Charges which are reported to Aetna more than twelve (12) months after the date the charges were incurred; and

• Surgical treatment of Temporomandibular Joint (TMJ) Syndrome.

Predetermination of Benefits

If charges for planned dental work are expected to be two hundred dollars ($200) or more, you can request a predetermination of benefits from Aetna before the work begins. This will allow you and your dentist to find out in advance if the expense is covered, the benefit amount that applies, and if a less expensive alternative is acceptable.

To request a predetermination, complete the Employee section of a dental claim form. The claim form is available on the North America Homepage, under the HR SSC Dallas, E-Flex Benefits/Dental Plan. Request the dentist to complete his section of the form, indicating that the form is for Predetermination of Benefits. Aetna will determine which procedures are eligible for payment, which could be treated by alternate methods and provide an estimate of what benefits will be payable.
XVI. VISION CARE OVERVIEW

How the Vision Care Plan Works

The Plan pays a vision care benefit for expenses such as vision exams, eyeglasses, and contacts. Benefits are provided once every year for the exam, lenses or contacts. Note: contacts are covered in lieu of lenses. When contacts are obtained, the Participant and Eligible Dependents are not eligible for lenses and frames for one (1) Calendar Year.

How In-Network Benefits Work

Services are provided by Vision Service Plan (VSP), a nationwide network of vision care providers. If a VSP member doctor is used to provide services, Covered Expenses are paid in full after an annual Copay of ten dollars ($10) per person. In other words, each year the Participant pays the first ten dollars ($10) of Covered Expenses for each covered person, and the Plan pays the remaining Covered Expenses up to certain limits. There is no Out-of-Pocket Maximum or Copay.

For example, when a regular vision exam is performed, a ten dollars ($10) Copay is paid to the doctor (if it hasn’t already been paid for that year). VSP takes care of the remaining Covered Expenses. If additional tests or special procedures are needed, the Participant must pay the extra cost. And if frames or lenses are chosen that cost more than the Plan allowance, the Participant must pay the difference. A list of expenses that are not covered in full by the Plan can be found in the section “What’s Not Covered” below.

A directory of VSP network providers for each area is available on VSP’s website at www.vsp.com. You can call VSP’s Member Services at 1-800-877-7195.

How to Use the VSP Network

When making an appointment with a VSP participating provider, identify yourself as a VSP member. The participating provider will contact VSP to verify eligibility and Plan coverage.

At the appointment, the VSP network doctor will ask the Participant to pay the ten dollars ($10) Copay, if applicable. VSP pays the provider the balance of charges directly, as shown in the “Schedule of Benefits” section. It is not necessary to file a claim.

For elective contacts, eyeglass frames or lenses with any special features not covered by the Plan, the Participant must pay the provider the difference between what the Plan covers and the actual expense. VSP will then reimburse the provider up to the scheduled benefit amount.

How Out-of-Network Benefits Work

If desired, services may be received from an Out-of-Network doctor or optical supply
store. In this case, the Participant must pay for the services first, then submit an itemized bill to VSP. **No reimbursement will be provided for claims more than six (6) months old.** Depending on the submitted charges, a Copay may apply to Out-of-Network benefits. It is important to remember that the Plan will pay no more than the amounts shown in the “Schedule of Benefits” section if an Out-of-Network provider is used. The Participant will be responsible for the expenses over these Plan maximums.

**Expenses Covered By The Plan**

Schedule of Benefits – effective as of January 1, 2010

<table>
<thead>
<tr>
<th>Type of Expense</th>
<th>Benefit per covered person</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay</td>
<td>$10/year for each covered person</td>
<td>$10/year for each covered person</td>
</tr>
<tr>
<td>Standard Eye Exam</td>
<td>100% once per Calendar Year</td>
<td>$45 once per Calendar Year</td>
</tr>
<tr>
<td>Lens:</td>
<td><em>Pays once per Calendar Year for one type of lens. Lenses for glasses and contacts are not paid in the same Calendar Year.</em></td>
<td><em>Pays once per Calendar Year for one type of lens. Lenses for glasses and contacts are not paid in the same Calendar Year.</em></td>
</tr>
<tr>
<td>Single Lined Bifocal Lined Trifocal Lenticular</td>
<td>100%</td>
<td>Up to $45 Up to $65 Up to $85 Up to $125</td>
</tr>
<tr>
<td>Necessary Contacts:</td>
<td>100% with prior approval</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Elective Contacts:</td>
<td>Up to $105</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Frames</td>
<td>100% up to the frame allowance of $105 once every other Calendar Year plus 20% off any out-of-pocket costs (When contacts are obtained, frames will not be available for one (1) Calendar Year)</td>
<td>Up to $47 once every other Calendar Year (When contacts are obtained, frames will not be available for one (1) Calendar Year)</td>
</tr>
</tbody>
</table>
About Contacts

A standard eye examination is covered in full; however, the fitting and follow-up for
contacts is not covered under the standard eye exam benefit. The Plan does allow a 15%
discount off the usual and customary fees and you may utilize a portion of the contact
lens allowance towards those costs.

Current soft contact lens wearers may qualify for a special contact lens program that
includes a contact lens evaluation and initial six month supply of replacement lenses.
Contact your doctor or vsp.com for more information on this program.

The Plan pays a different benefit for contacts depending on whether they are necessary or
elective.

Necessary lenses include contacts approved by the Plan following cataract surgery, when
glasses cannot correct vision to 20/70 or better, to correct for significant anisometropia
(unequal vision in each eye), and keratoconus (cone shaped cornea).

Elective contacts are those chosen for any other reason as long as a prescription is
needed.

The distinction between necessary and elective contacts applies to hard, soft, gas
permeable, disposable, and any other type of lenses.

What’s Not Covered

Limitations for Vision Care Benefits

Because the Plan is designed to cover Medically Necessary visual rather than cosmetic
needs, the extra cost for any of the following services must be paid by the Participant:

- Blended or progressive lenses;
- Oversize or ultra-lightweight lenses;
- Frames that cost more than the VSP allowance;
- Elective contacts that cost more than the VSP allowance;
- Scratchproof, UV-protected, or other coated lenses;
- Tinted lenses (other than pink #1 or pink #2); or
- Materials or services that are not Medically Necessary for vision health.

In addition, the Plan does not cover eyeglasses and contacts in the same Calendar Year.
Exclusions from Coverage

No reimbursement will be received from the Plan for any professional services or materials connected with:

- Glasses and contacts within the same Calendar Year;
- Orthoptics, vision training, or subnormal vision aids;
- A second pair of eyeglasses instead of bifocals;
- Lenses and frames which are lost or broken;
- Non-prescription lenses (plain lenses);
- Medical or surgical treatment of the eyes (these treatments may be covered as medical benefits under the Plan);
- Services or materials provided as a result of any worker’s compensation law or similar legislation;
- Any eye examination required by an employer as a condition of employment; or
- Any services or materials provided by or paid for by any other vision or health care plan.

XVII. FILING OF CLAIMS

The Plan is designed to process claims as quickly as possible. To ensure timely payment, claims for medical benefits should be submitted promptly to Aetna, claims for Mental Health/Substance Abuse Treatment should be submitted to MHNet, and claims for Out-of-Network prescription drug expenses should be submitted to Aetna Pharmacy Management.

The process of filing claims depends on the nature of the expense as noted in the following sections. Generally, no claim is required for reimbursement of In-Network expenses. The Network Care Provider will take care of the paperwork for you. However, if the Plan provides secondary coverage, claim forms may need to be submitted (along with the Explanation of Benefits from the primary coverage) in order to receive reimbursement. Benefits payable as a result of a claim will be paid to you unless you complete the Assignment of Benefits section of the claim form, indicating that benefits are to be paid directly to your health care provider.

Medical Claims Under the Aetna Options

Claim forms are available on the Ericsson North America Homepage under HR SSC
Dallas/E-Flex Benefits/Medical or on the Ericsson Online Benefits Tool.

To be considered by the Plan, claims must be submitted within twelve (12) months of the date the expense is incurred.

For medical claims (except claims for Mental Health/Substance Abuse Treatment), send a completed claim form to Aetna at the following address:

Aetna
P.O. Box 981106
El Paso, TX 79998-11066
1-888-466-8857

Mental Health/Substance Abuse Treatment Claims Under MHNet

To be considered by the Plan, claims must be submitted within twelve (12) months of the date the expense is incurred.

A claim form and instruction sheet to file for services from a Non-Network Care Provider are available on the Ericsson North America Homepage under HR SSC Dallas/E-Flex Benefits/Medical Plans or on the Ericsson Online Benefits Tool.

Send the claim to the following address:

MHNet
Attn: Ericsson Services Claims
P.O. Box 7802
London, KY 40742

For questions about these claims, call 1-800-492-4357.

Prescription Drug Claims Under the Aetna Options

Network Retail Pharmacies

Claim forms are not normally needed when you purchase prescriptions through a network pharmacy. The pharmacy will advise you the amount to be paid at the time you pick up your prescription or if you elected the Health Care Spending Account (HCSA), payment can be made using the Auto Debit feature. Just show your Aetna ID card and as long you have sufficient funds in your HCSA, your Copay is drawn directly from your HCSA and you pay nothing out-of-pocket at the point of purchase.

If you need to file a pharmacy claim for a prescription that you filled prior to being in the Aetna system, follow the instructions below.

Non-Network Retail Pharmacies

You or your Eligible Dependent must submit a claim form, along with receipts, for
benefits to be paid.

To be considered by the Plan, claims must be submitted within twelve (12) months of the date the expense is incurred.

Send a completed claim form to the following address:

    Aetna Pharmacy Management
    Attn: Claim Processing
    P.O. Box 14024
    Lexington, KY 40512-4024

Mail Order Pharmacy Service

You must complete the Aetna Rx Home Delivery New Participant Order Form and Patient Profile and submit with an original prescription from your doctor indicating a 90-day supply of the medication. If you elected the Health Care Spending Account (HCSA), payment can be made using the Auto Debit feature. As long you have sufficient funds in your HCSA, the Copay is drawn directly from your HCSA. You will need to provide credit card information on the New Participant Order Form so that in the event there are insufficient funds in your HCSA, the payment will be charged to your credit card. If you did not elect the HCSA, you will need to include a check, money order, or credit card information for the prescription cost.

For questions about mail order prescription claims, call:

    Aetna Rx Home Delivery 1-800-227-5720

Aetna Specialty Pharmacy Service

Medications can be ordered from Aetna Specialty Pharmacy as follows:

- Your physician can fax the prescription.
- You or your physician can mail the prescription to:

    Aetna Specialty Pharmacy
    503 Sunport Lane
    Orlando, FL 32809

- Your physician can call Aetna Specialty Pharmacy at 1-866-782-2779.

Your medications will usually be shipped within 24-48 hours. A welcome packet in your first delivery will tell you about the services offered by Aetna Specialty Pharmacy, explain how to order refills, and provide important contact information.

Claim Tips

These reminders will help with claim filing and speed up the payment process:
Always include your full name and health plan member ID number on any claim form;

Complete separate claim forms for each Eligible Dependent and clearly indicate on each form and statement the name and Social Security number of the person who was the patient. If three Eligible Dependents are listed on one statement, then a separate claim form and copy of the statement should be submitted for each Eligible Dependent;

Answer all applicable questions on the claim form;

Attach original copies of itemized statements or receipts that show the nature of the medical expenses;

Prescription drug bills must show the name of the patient, the name of the drug, the dose, the NDC code of the drug dispensed, the quantity dispensed, the date the medication was dispensed, the prescription number, the name of the pharmacy, and the NABP or address of the pharmacy; and

Keep copies for your personal records.

Proof of Claim
The Claims Administrator may request additional information about any medical claim. For instance, to determine what benefits are payable, x-rays and other appropriate diagnostic and evaluative materials may be requested.

If these materials are unavailable, and verification of Covered Expenses cannot reasonably be made by Claims Administrator based on the available information, benefits may be reduced or denied.

Dental Claims Under Aetna Dental
Claim forms are available on the Ericsson North American Homepage under HR SSC Dallas/E-Flex Benefits/Dental Plan. Benefits will be paid to the Participant unless the Assignment of Benefits section of the claim form is completed, indicating that benefits are to be paid directly to the dentist.

To be considered by the Plan, claims must be submitted within twelve (12) months of the date the expense is incurred.

Send completed claim forms to:

Aetna Dental
P.O. Box 14094
Lexington, KY 40512-4094

For questions about dental claims, call 1-800-466-8857.
Dental Claim Tips

These reminders will help with claim filing and speed up the payment process:

- Always include the full name and social security number of the Participant on any claim form;

- Complete separate claim forms for each enrolled Eligible Dependent. If more than one enrolled Eligible Dependent is listed on one statement, then a separate claim form and copy of the statement should be submitted for each enrolled Eligible Dependent;

- Answer all applicable questions on the claim form;

- Attach itemized statements that show the nature of the dental expenses; and

- Keep copies for personal records.

Proof of Dental Claims

Aetna may request additional information about any dental claim. For instance, to determine what benefits are payable, X rays and other appropriate diagnostic and evaluative materials may be requested.

If these materials are unavailable, and verification of covered dental expenses cannot reasonably be made by Aetna based on the available information, benefits may be reduced or denied.

Submitting Dental Claims

The Plan is designed to process claims as quickly as possible. To ensure timely payment, claims for dental benefits should be submitted promptly to Aetna, but in no event later than twelve (12) months from the date of the treatment.

Vision Claims Under VSP

At the appointment, the VSP network doctor will ask the patient to pay the ten dollar ($10) Copay, if applicable. VSP pays the provider the balance of charges directly, as shown in the “Schedule of Benefits” section. It is not necessary to file a claim.

If desired, services may be received from a Non-Network Doctor/Physician or optical supply store. In this case, the Participant must pay for the services first, then submit an itemized bill to VSP. The itemized bill must display the following information:

- Patient’s name;

- Employee’s name and mailing address;
• Employee’s Social Security number;
• Employee’s Employer;
• Doctor/Physician’s name, address, and tax I.D. number;
• Date services were provided;
• Services and materials received; and
• Type of lenses received (single vision, bifocal, trifocal, contacts), if any.

Mail the bill to VSP at the following address:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

VSP will then reimburse the expenses according to the schedule of benefits shown in the Schedule of Benefits in the Vision Care Plan Overview. No reimbursement will be provided for claims more than six (6) months old. It is important to remember that the Plan will pay no more than the amounts shown in the “Schedule of Benefits” section if an Non-Network provider is used. The Participant will be responsible for the expenses over these plan maximums.

Written Inquiries

When submitting a written inquiry, it must be submitted directly to Aetna, MHNet, Aetna Pharmacy Management or Aetna Rx Home Delivery or VSP. The following information must be given at the time of each written inquiry:

• Name and address of Employee and patient;
• Employee’s health plan member ID number or Social Security number;
• Date service or treatment was received;
• Provider’s name; and
• Reason the claim should be reconsidered.

XVIII. CLAIMS PROCEDURES

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan also will recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a
claim involving Urgent Care, a health care professional with knowledge of your condition may always act as your authorized representative.

**Pre-Service Claims**

**Urgent Care Claims.** If a person or his duly authorized representative files a pre-service claim which is an “Urgent Care claim” as defined below, the Claims Administrator shall notify the claimant of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim unless the claimant fails to provide sufficient information for the Claims Administrator to make a determination. A “pre-service claim” means any claim for medical benefits under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

An “Urgent Care claim” is any claim for medical care or treatment with respect to which the application of 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 Doctor/Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the information received by the Plan is insufficient for the Plan to make a determination, the Claims Administrator shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. In such case, the claimant shall be given a reasonable additional amount of time, but not less than forty-eight (48) hours to provide the specified information. The Claims Administrator shall notify the claimant of the Plan’s 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 period afforded the claimant to provide the specified additional information.

The Claims Administrator may notify the claimant of its decision orally, in writing or electronically within the applicable forty-eight (48) hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to the claimant not later than three (3) days after the oral notification.

**Non-Urgent Care Claims.** A person or his duly authorized representative may file a written claim with the Claims Administrator for a determination of benefits for a “pre-service claim” that is not an “Urgent Care claim.”
The Claims Administrator will notify the claimant of its decision. Notification of a claim denial will be given within a reasonable time, but not later than fifteen (15) days after the pre-service claim is received by the Claims Administrator.

Failure to Follow Pre-Service Claims Procedures. If a person or his duly authorized representative submits the claimant’s name, specific medical condition, and specific treatment, service or product to a person or unit customarily responsible for handling benefits matters, but fails to follow the Plan’s procedures for pre-service claims, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant, as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file an Urgent Care claim) following the failure. Notification may be oral unless written notification is requested by the claimant.

Concurrent Care Claims

A person or his duly authorized representative may file a claim with the Claims Administrator for a determination of benefits for “concurrent care.” “Concurrent care” means any ongoing course of treatment approved by the Plan to be provided over a period of time or number of treatments.

Non-Urgent Care Claim. If there is any reduction or termination by the Plan of concurrent care (other than by Plan amendment or termination) before the end of such approved period of time or number of treatments which does not involve an Urgent Care claim, the Claims Administrator will notify the claimant of such reduction or termination within a reasonable period of time not less than fifteen (15) days before any such reduction or termination.

Urgent Care Claim. If a claimant makes a request to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care claim, the Claims Administrator shall make a claim determination as soon as possible, taking into account the medical exigencies, but not later than twenty-four (24) hours after receipt of the claim by the Plan provided that any such claim must be made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

The Claims Administrator may notify the claimant of its decision orally within the twenty-four (24) hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to the claimant not later than three (3) days after the oral notification.

Post-Service Claims

If any person believes that he is being denied any benefits under the Plan for a “post-service claim,” such person or his duly authorized representative may file a written claim with the Claims Administrator. “Post-service claim” means any claim for benefits under the Plan which is not a “pre-service claim” as defined above, i.e., for which no advance approval is required.
Notification of a claim denial will be given within a reasonable time, but not later than thirty (30) days after the claim is received by the Claims Administrator.

Extensions in the Case of Initial Determinations of Post-Service Claims and Non-Urgent Pre-Service Claims

For post-service claims and non-urgent pre-service claims, the claim review period may be extended once for up to fifteen (15) days, provided that the Claims Administrator determined both (i) that such extension is needed and beyond the Claims Administrator’s control and (ii) notifies the claimant of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision prior to the expiration of (a) the initial permissible response period of forty-five (45) days, (b) the initial permissible response period of fifteen (15) days for pre-service claims, or (c) the initial permissible response period of thirty (30) days for post-service claims. 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 shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. The benefit determination period shall be put on hold from the date of the notice of extension until the earlier of (i) the date the claimant responds to the request for additional information, or (ii) the last day of the forty-five (45) day period. Once the claimant has provided the additional information or, if earlier, the forty-five (45) day period has ended, the benefit determination period shall recommence. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

The claimant and the Claims Administrator may extend any claim filing deadline by mutual written consent.

Notification Requirements for All Claims

If any claim is wholly or partially denied, the notification will be set forth in a manner calculated to be understood by the claimant and must contain: (i) the specific reason or reasons for the adverse determination, (ii) the specific reference to Plan provisions on which the determination is based, (iii) a description of any additional material or information necessary for the person to perfect his claim and an explanation of why such material or information is necessary, (iv) information as to the steps to be taken if the claimant wishes to submit a request for review, including applicable time limits and the claimant’s right to bring a civil action under section 502(a) of ERISA. For medical claims, if the benefit determination was adverse, the notification must also contain any internal rule, guideline, protocol or other similar criterion (collectively “Protocols”) that were relied upon in making the adverse determination and that a copy of such Protocols will be available to the claimant, free of charge, upon his request. For medical claims only, if the benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, the notification must also contain either (A) an explanation of the scientific or clinical judgment for the determination, applying the
terms of the Plan, as applicable, to the claimant’s medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request. For all urgent claims for medical benefits, the notification must also contain a description of the expedited review process applicable to such claims.

**Time Period for Review**

**Medical.** Within one hundred and eighty (180) days after the date that the claimant receives notice of a claim denial for medical benefits under the Plan, the claimant or his duly authorized representative may file a request that the Claims Administrator review his denied claim.

For concurrent claims, the claimant or his duly authorized representative may file a written request with the Claims Administrator for a review of his denied claim on or before the date his benefits are reduced or terminated. Such request must be filed within a reasonable time but not later than five (5) days before a concurrent claim benefit is reduced or terminated.

The claimant may request an expedited review of his Urgent Care claim by contacting the Claims Administrator orally or in writing if his Urgent Care claim has been wholly or partially denied. If the claimant requests an expedited review, all necessary information, including the Plan’s benefit determination on review, shall be transmitted expeditiously between the Plan and the claimant.

**Review Standards**

The Plan provides for two levels of appeal for all benefits. In order for a claimant to pursue his rights as explained in the “Rights After Appeal” section below, he must first exhaust his appeal rights under the Plan.

The claimant and/or his authorized representative may inspect or request, free of charge, relevant documents and submit written comments, documents, records, and other information to the Claims Administrator for review of his medical claim. The review of the claimant’s appeal shall be reviewed without affording deference to the initial adverse benefit determination and will not be conducted by the individual who made the initial review, nor a subordinate of such individual, but shall be conducted by such individual(s) designated or appointed by the Claims Administrator, as the case may be. If the claim is denied upon review and notice of such denial upon review is provided to the claimant as provided in these procedures, the claimant may pursue his rights as set forth in the “Rights After Appeal” section described below.

**Procedures Applicable to Appeal.** If a decision is based in whole or part on a medical judgment, the appropriate person(s) determining the appeal shall consult with a healthcare professional (not consulted in the initial claim that is being appealed nor a subordinate of such healthcare professional) who has appropriate training and experience in the field of medicine involved in the medical judgment and shall provide the claimant with such information regarding such health care professionals as the Claims Administrator, as the case may be, determines is appropriate. The claimant shall be
provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Claims Administrator relied upon the expert’s advice.

Notification of Decision on Review

The Claims Administrator will notify the claimant of its decision. If an expedited method such as oral notification is used, it must be followed up with a transmission of the Claims Administrator’s decision. Notifications will be set forth in a manner calculated to be understood by the claimant and will contain: (i) the specific reason or reasons for the denial, (ii) specific references to Plan provisions on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits, (iv) a statement describing any voluntary appeals offered by the Plan, including information concerning the procedures of the voluntary appeal that would allow the claimant to make an informed decision about whether to appeal and such other information which the Claims Administrator determines is appropriate regarding alternative dispute resolution options, (v) a statement of the claimant’s right to bring an action under section 502(a) of ERISA, (vi) a description of the Protocols, if any, used to make the decision and that a copy of the Protocols will be available free of charge upon request, (vii) a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon request by the claimant, and (viii) the statement:

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 United States Department of Labor Office and State insurance regulatory agency.

Response Dates on Appeal

For an urgent, pre-service claim, the decision on review will be made as soon as possible, taking into account the medical exigencies, but not later than thirty-six (36) hours after receipt of the claimant’s request for review. If the claimant is dissatisfied with the appeal decision on a claim involving Urgent Care, the claimant may file a second level appeal. The claimant will be notified of the decision not later than thirty-six (36) hours after the appeal is received.

For a non-urgent, pre-service claim, the decision on review will be made within fifteen (15) days after the appeal is received by the Claims Administrator. If the claimant is dissatisfied with the appeal decision on a non-urgent, pre-service claim, the claimant may file a second level appeal within sixty (60) days of receipt of the level one appeal decision. The claimant will be notified of the decision not later than fifteen (15) days after the appeal is received.

For a post-service claim, the decision on review will be made within thirty (30) days after the request for review is received by the Claims Administrator. If the claimant is
dissatisfied with the appeal decision on a post-service claim, the claimant may file a second level appeal within sixty (60) days of receipt of the level one appeal decision. The claimant will be notified of the decision not later than thirty (30) days after the appeal is received.

For concurrent claims, the decision on review will be made before the concurrent claim benefit is reduced or terminated.

**Written or Electronic Notifications**

All notifications regarding claim decisions shall be either written or electronic, except as discussed in the section on Urgent Care. Electronic notification shall comply with standards imposed by the Claims Administrator consistent with applicable guidance. This written or electronic notification can be included as part of the expedited method used as provided above (for example, if facsimile transmission is used).

**Rights After Appeal**

If the Participant is dissatisfied with the Claims Administrator’s review of the decision, the Participant has the right to file suit in a federal court, which suit must be filed within twelve (12) calendar months immediately following the date of such Claims Administrator’s decision. No action may be brought for benefits provided by the Plan or to enforce any right hereunder until after a claim has been submitted to and determined by the Claims Administrator and all appeal rights under the Plan have been exhausted. Thereafter, the only action which may be brought is one to enforce the decision of the Claims Administrator, as the case may be. The Participant’s beneficiary should follow the same claims procedure in the event of the Participant’s death.

**XIX. COORDINATION OF BENEFITS**

The Plan has been designed to help meet the cost of treatment for disease or Injury. It is not intended that the Plan pay more in benefits than the regular amount payable when coverage is available from another group Plan. The Plan takes into account any benefits provided by other insurance, government programs, and group plans so that total benefits paid will not be more than the benefit amount payable by the Plan alone. Benefits will be coordinated with the following:

- Group insurance plans;
- Medicare and other government programs; and
- Coverage under medical payment provisions of no-fault automobile insurance contracts.

You are required to notify the Claim Administrator of coverage from any other plan and to provide any information necessary to apply these Coordination of Benefits provisions.
How Coordination of Benefits Works

If you or your enrolled Eligible Dependent is covered under more than one plan, one plan is considered primary – and pays benefits first – while the other is considered secondary. The Plan usually pays benefits for a Participant. However, when coverage is available from another group health care plan or other source, the order of payment may vary, so a common set of guidelines is used to determine which plan pays first.

Coordination of Benefits Rules

When a claim is made, the primary plan pays benefits first, without regard to any other plan. The secondary plan adjusts its benefits so that the total benefits available will not be greater than the benefit amount payable under its provisions.

When all the plans have compatible coordination provisions, benefits are coordinated as follows:

- The plan covering the patient directly, rather than as an Employee’s Eligible Dependent, is primary and the other is secondary;
- If a child is covered under both parents’ plans, the plan covering the parent whose birthday falls earlier in the year is primary and the parent whose birthday falls later in the year is secondary (the parent’s year of birth is not considered);
- In the case of an Employee who is terminated, laid-off, or retires and continues coverage under the Plan, any other plan covering the person as an active Employee (or as that person’s Eligible Dependent) pays benefits first. The plan covering that person as a terminated, laid-off, or retired Employee (or as that person’s Eligible Dependent) pays benefits second. 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 is ignored; and
- If the order of benefit determination cannot be established by either of the above, then the plan covering the patient longest is primary.

Special coordination rules apply if all the plans do not have compatible coordination provisions, as follows:

- A plan without a coordination provision is always the primary plan;
- A plan purporting to be always secondary (or to offer no coverage at all when other coverage is available) is always primary; and
- No-fault automobile insurance and HMOs not sponsored by Ericsson Services are always primary.

If a claim is submitted for an Eligible Dependent whose parents are divorced or separated, the order of coverage is as follows:
**Primary:** The plan of the parent who has custody, if the child is an Eligible Dependent under that parent’s plan;

**Secondary:** If the parent with custody has remarried, the plan of the stepparent residing with the child is secondary, if the child is an Eligible Dependent under that stepparent’s plan; and

**Tertiary:** The plan of the parent without custody, if the child is an Eligible Dependent under that parent’s plan.

However, if a court decree has otherwise established financial responsibility for the child’s medical, dental, or other health care expenses, the plan of the parent with this responsibility will be primary.

**Coordination with Medicare.** If the Participant is an Employee of Ericsson Services and is also covered by Medicare, the Plan is typically primary and Medicare is secondary. However, if the Participant is covered under the Plan as a result of COBRA, Medicare is typically primary and the Plan is secondary.

Medicare is also primary if 1) entitled due to disability, employment has been terminated, and the Participant is not covered by another family member who is actively employed, or 2) the Participant has end-stage renal disease (“ESRD”), and the Plan has been primary for thirty (30) months. In computing the Plan’s payments, all benefits to which the Employee or Eligible Dependent would be entitled under Medicare will be included in determining Medicare’s deemed payment, whether or not the Employee or Eligible Dependent has registered for Part A or enrolled in Part B of Medicare.

**If the Plan Is Secondary.** When the Plan is secondary (pays benefits last) to your Spouse’s plan, the Plan assures that your benefits from both plans will be at least as much as they would have been if the Plan were your only source of benefits.

Example: You have family coverage under the Aetna Choice™ POS II plan and your Spouse’s plan is primary for your Spouse and Children. Then, assume that your Spouse’s plan paid eighty percent (80%) of an eligible expense that the Aetna Choice™ POS II plan would have paid at ninety percent (90%), less any Copays. As long as you used Network Care Providers and followed the regular Aetna Choice™ POS II procedures, the Plan will pay the ten percent (10%) difference (less any Copays that are your responsibility). If you did not use Network Care Providers or follow network procedures, benefits will be coordinated at the seventy percent (70%) Out-of-Network level, *i.e.*, no additional benefit will be paid.

**XX. RECOVERY OF OVERPAYMENTS**

If for any reason a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount (without reduction for your or your Eligible Dependent’s attorneys’ fees or costs) from the person or agency that received it. The Plan also includes the right to receive recovery in favor of the Plan for medical expenses only.
You must produce the documents and perform all other acts necessary to assist the Claims Administrator in enforcing its right of reimbursement and recovery, and the Plan may condition any payment upon you and your Eligible Dependent signing an appropriate form to this effect. Whether or not such form is signed, by participating in the Plan, you and your Eligible Dependents automatically agree to reimburse the Plan in full, without any deduction for any attorneys’ fees or other costs of recovery you may incur, for all benefits paid by the Plan, from up to one hundred percent (100%) of any recovery, settlement, judgment, or other payment from a third party (whether or not denominated as a recovery for medical expenses and whether or not you or your Eligible Dependent is otherwise made whole) and agreeing to grant the Plan a first dollar priority lien, subrogation right, and reimbursement right on any rights to recovery. Your obligation to reimburse the Plan comes first even if you have not been paid or fully reimbursed for all of your damages or expenses or if the payment that you receive is for damages other than medical expenses. You and your Eligible Dependent will not assign any rights to settlement or recovery to any other party without the express written consent of the Plan. The Plan’s right of subrogation and reimbursement will not be affected, reduced, or eliminated by the “make whole” doctrine, the “common fund” doctrine, comparative/contributory negligence, or any other equitable defenses that may affect the Plan’s right to reimbursement.

The Claims Administrator may enforce the right to recovery of overpayments by withholding future payments and offsetting future obligations (whether or not related to the Injury or Illness in question) against any benefits for which you or your Eligible Dependent may be entitled, whether or not it relates to the benefits with respect to which you or your Eligible Dependent has received a third party recovery or with respect to which the Plan has made an overpayment.

XXI. SUBROGATION AND RIGHT OF RECOVERY PROVISION

Definitions

The term “Responsible Party” means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person’s Injury, Illness, or condition. The term “Responsible Party” includes the liability insurer of such party or any insurance coverage.

The term “Insurance Coverage” refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

A “Covered Person” includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the Plan.
Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person’s Injury, Illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an Injury, Illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness, or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an Injury, Illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person’s fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any Illness, Injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person’s representative or agent; Responsible Party; Responsible Party’s insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.
First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan’s recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person’s damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party’s payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person’s damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person’s intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan’s subrogation or recovery interest or to prejudice the Plan’s ability to enforce the terms of the Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan
reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future Domicile.

XXII. HIPAA

The Ericsson Services Flexible Benefits Plan (the “E-Flex Plan”) maintains a Privacy Practice Notice with respect to the health care components of the Benefits Plan. The Ericsson Services Medical, Dental, and Vision Plan is a health care component of the E-Flex Plan. The Privacy Practice Notice is required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The Privacy Practice Notice provides information to individuals whose protected health information (“PHI”) will be used or maintained by the E-Flex Plan. If you would like a copy of the E-Flex Plan’s Privacy Practice Notice, please contact the Ericsson Privacy Officer or Privacy Representative at the Ericsson Contact Center by calling toll free at 1-866-374-2272, press 8. The E-Flex Plan’s Privacy Practice Notice also is posted on the Ericsson North America Homepage under HR SSC Dallas/E-Flex Benefits/Medical Plans.
XXIII. ERISA RIGHTS

Certain rights and protections are provided to Participants in the Ericsson Services Medical, Dental, and Vision Plan under the Employee Retirement Income Security Act of 1974 (ERISA). These ERISA rights include the following:

Any Participant or enrolled Eligible Dependent may contact the Benefits Department to examine all Plan documents without charge. These may include the annual financial reports, the Plan descriptions, trust agreements, insurance contracts, and all other Plan documents filed with the United States Department of Labor.

Copies of Plan documents and other information may be obtained by writing to the Plan Administrator. A reasonable charge may be assessed for these copies.

Each covered person has the right to receive a written summary of the Plan’s annual financial reports. The Plan Administrator is required by law to provide each Participant with a copy of any summary annual report.

An Employee may not be discharged or discriminated against to prevent his or her obtaining a benefit or exercising his or her ERISA rights.

If a claim for a benefit is denied, in whole or in part, a written explanation from the Plan fiduciary or a delegated representative will be provided. Each Participant has the right to have the Plan fiduciary review and reconsider any denied claim.

In addition to creating rights for Plan Participants, ERISA imposes certain duties on the people responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries,” have a duty to do so prudently and in the best interest of Plan Participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

Aetna, MHNet, Aetna Pharmacy Management, Aetna Rx Home Delivery, and VSP are the named fiduciaries for the Plan with respect to the processing and payment of all benefit claims and with respect to the provisions of full and fair review of all claim denials. Ericsson Services is the named fiduciary with regard to the payment of Employee contributions, precertification of eligibility (except for eligibility based on disability which is handled by Aetna), furnishing of Employee data, and such other responsibilities not allocated to Aetna, MHNet, Aetna Pharmacy Management, Aetna Rx Home Delivery, and VSP.

Under certain circumstances, outside assistance may be necessary to resolve disputes between Participants and Plan officials. For example:

- If materials are requested from the Plan Administrator and are not received within thirty (30) days, suit may be filed in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up
to one hundred ten dollars ($110) a day until the materials are received – unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If a claim for benefits is denied or ignored, in whole or in part, after a final review, suit may be filed in a state or federal court.

- If the fiduciaries misuse the Plan’s money, or if a Participant is discriminated against for pursuing a benefit or exercising his or her ERISA rights, the Participant may seek help from the United States Department of Labor or file suit in federal court.

- If a suit is filed, the court will decide who should pay court costs and legal fees. If the Participant wins the suit, the court may order the person sued to pay the court costs and legal fees. If the Participant loses the suit, the court may order the Participant to pay the costs and fees if, for example, the court decides the suit was frivolous.

For further information about this statement or about ERISA rights, contact the Ericsson Contact Center, or the nearest area office of the Employee Benefits Security Administration, United States Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**XXIV. ADMINISTRATIVE INFORMATION**

**Plan Sponsor and Administrator**

The Plan described in this SPD is sponsored by:

Ericsson Services Inc.
6300 Legacy Drive
Plano, TX 75024

The Committee is the Plan Administrator. In most cases, it is the Plan Administrator’s responsibility to operate the Plan and make final decisions on such issues as eligibility and other responsibilities not delegated to Aetna, MHNet, Aetna Pharmacy Management, Aetna Rx Home Delivery, and VSP. Aetna will make all determinations based on the inability of the Dependent to provide for her or her self-support because of physical or mental incapacity. Fiduciary duties with respect to the processing and payment of all benefit claims and with respect to the provisions of full and fair review of all claim denials have been delegated to Aetna, MHNet, Aetna Pharmacy Management, Aetna Rx Home Delivery, and VSP. However, many day-to-day questions can be answered by the Ericsson Contact Center.
The agents for the service of legal process for the Plan are the Plan Administrator and

Ericsson Inc.
Vice President – Legal Affairs
6300 Legacy Drive
Plano, TX 75024

Plan Type, Number, and Year

Documents and reports for the Plan are filed with the United States Internal Revenue Service and the Department of Labor under two numbers:

Employer Identification Number: 26-4082639
Plan Number: 602

The Plan is considered a welfare plan for government purposes, as a plan established to provide medical benefits. Plan records are kept on a plan-year basis, which is January 1 through December 31. The official Plan name is the Ericsson Services Inc. Medical, Dental, and Vision Plan.

Claims Fiduciary

The named Claims Fiduciary for all claims under the Plan is the respective Claims Administrator.

Plan Funding

The Plan is a self-insured plan and is funded in part by employee contributions and in part by Ericsson Services contributions.

Administrative Standards

The Plan fiduciary will have complete fiduciary discretion and authority to establish and apply its own review standards and criteria for determining acceptable or appropriate treatment and may approve or reject any proposed plan of treatment or other care based on objective standards consistently applied.

The Plan fiduciary’s decisions only affect the level of reimbursement under the Plan. Any decisions concerning actual treatment are made solely between the patient and the provider.
XXV. DISCLOSURE INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how the Plan operates and how it may affect you. In an ever-changing environment, the information we provide can never be complete. We urge you to contact the Ericsson Contact Center or your Claims Administrator at the customer service numbers provided in this SPD if the information in this SPD or other material does not answer your questions.

Ericsson Services and your enrolled Claims Administrator do not provide medical services or make treatment decisions. Ericsson Services pays the claims and administrative fees, and your Claims Administrator administers the health benefit plan in which you are enrolled. That means:

- Your Claims Administrator makes decisions regarding the reimbursement of benefits under the Plan.

- Your Claims Administrator does not decide what care you need or will receive. You and your Doctor/Physician make those decisions.

- Ericsson Services or your Claims Administrator may enter into arrangements where another entity carries out some of the administrative duties under the Plan, but those entities must operate consistently with the Plan.

- Your Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.

- Your Claims Administrator forms a network by contracting with Doctor/Physicians and other providers. Their credentialing processes confirm public information about the Doctor/Physicians and other providers’ licenses and other credentials, but do not assure the quality of the services provided.

- Doctor/Physicians and other providers in each network are independent contractors and are not Employees or agents of Ericsson Services or the Claims Administrators.

- Your Claims Administrator may enter into agreements with your Doctor/Physician or other providers to share in the cost savings that those agreements may generate. The Claims Administrators encourage Doctor/Physicians and other providers in their network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your Doctor/Physician about these arrangements.

- Your Claims Administrators encourage Doctor/Physicians to talk with you about medical care you or your Doctor/Physician thinks might be valuable.
• Your Claims Administrator will use individually identifiable information about you as permitted by law, including in its operations and research.