(rev. 01/01/2012)

Health & Welfare Plan Summary Plan Description (SPD)

This section presents basic information about all the health and welfare benefits maintained by the EMC Corporation and your rights to benefits as a plan participant. Please refer to the applicable description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage agreement for complete details on specific items such as benefit coverage, definitions, coordination of benefits, exclusions and limitations.

This section and the separate benefit sections under this site together constitute the Summary Plan Description (SPD) for your welfare benefits, which is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974.

The Summary Plan Description is based on a number of legal documents that may include policies, contracts, agreements, plans and trust agreements. Although the SPD is intended to be accurate, any differences between it and the legal documents will be governed by the legal documents.

Administrative & Legal Information

Plan Type	Administration	Plan Year End	Insurers or TPA
Medical, Dental, Vision, Prescription, Behavioral Health, Spending Accounts, Life Insurance and Disability	Combination of Insured and Self-insured	December 31	Harvard Pilgrim, Blue Cross Blue Shield, United Health Care, Tufts Health Plan, Medco, OptumHealth Behavioral Solutions (formerly United Behavioral Health), Delta Dental, VSP, and various HMOs.
Code Section 125 Cafeteria Plan	Unfunded	December 31	EMC Corporation
Health Care and Dependent Care Spending Accounts	Self-insured	December 31	EMC Corporation
Basic/Supplemental/ Dependent Life Insurance	Insured	December 31	Metropolitan Life Insurance
Short-Term Disability	Self-insured	December 31	Metropolitan Life Insurance
Long-Term Disability	Insured	December 31	Metropolitan Life Insurance
AD&D; and Business Travel Accident	Insured	December 31	Chartis (formerly AIG Life Insurance Company)
Legal Insurance	Insured	December 31	ARAG
Long-Term Care Insurance (Frozen plan)	Insured	December 31	John Hancock
Personal Voluntary Plans	Insured	December 31	AFLAC

Additional Information About Your Health & Welfare Benefit Plan—

Name:	EMC Corporation Health & Welfare Benefit Plan
Number:	501
Plan Sponsor, Plan Administrator and Agent for Legal Service:	EMC Corporation 176 South St. Hopkinton, MA 01748 508-435-1000 Employer I.D. Number (EIN): 04-2680009

Authority of Plan Administrator—The Plan Administrator has complete discretionary authority with regard to the operation, administration and interpretation of the Plan, and any determination by the Plan Administrator relating to the Plan shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. The Plan Administrator may also delegate any of its responsibilities under the Plan to any other person or entity.

Any insurance carrier from which benefits are purchased has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy.

Sources of Plan Contributions—Contributions for coverage may be made solely by the Plan Sponsor, or solely by participating employees. Some of the coverages require joint contributions from participating employees and the Plan Sponsor.

Medical Vendors (Fully Insured)

The medical benefits provided through the EMC Corporation Health & Welfare Benefit Plan are funded through a combination of insured and employer funded coverages. Following is a list of medical vendors providing fully insured medical benefits under one or more HMO contracts or insurance policies issued to EMC Corporation. These carriers are solely responsible for financing and providing all medical benefits under the HMO contracts and insurance policies. EMC has no liability for any benefits due, or alleged to be due, under any such insurance contracts.

Type of Coverage	Vendor Name	Vendor Address
Medical - HMOs	Anthem Blue Cross of CA	2121 N. California Blvd. 7th Floor Walnut Creek, CA 94596
	Kaiser Permanente (CO)	Waterpark One 2500 South Havana Street 4th Floor Aurora, CO 80014
	Kaiser Permanente (GA)	9 Piedmont Center Atlanta, GA 30305-1736
	Kaiser Permanente (CA)	333 Twin Dolphin Drive Suit 206 Redwood, CA 94065
	Keystone Health Plan Central (PA)	PO Box 898879 Camp Hill, PA 17089
	Triple-S	1441 FD Roosevelt Avenue San Juan, Puerto Rico 00929

Sources of Plan Contributions—Contributions for coverage may be made solely by the Plan Sponsor, or solely by participating employees. Some of the coverages require joint contributions from participating employees and the Plan Sponsor.

When you enroll in health coverage, your contributions generally are made on a pre-tax basis. This means that your share of the cost of your coverage generally is deducted from your salary before federal, Social Security, and state income taxes are withheld. As a result, your taxable income is reduced, thereby saving you money. However, it's important to note that paying for coverage or making contributions on a pre-tax basis could slightly reduce future Social Security benefits.

Medical Vendors (Self Insured)

Following is a list of medical vendors who provide administrative services to the self-insured portion of the plan. These vendors provide claims payment and other administrative services under an administrative services contract with EMC, but they do not assume any financial risk or obligation with respect to claims or the plan.

Type of Coverage	Vendor Name	Vendor Address
Dental	Delta Dental Plan of Massachusetts (Delta USA)	465 Medford Street Boston, MA 02129
Medical: **PPO (Preferred Provider Organization), Indemnity Plan, HMO and HSA (Health Savings Account)**	Blue Cross Blue Shield of Massachusetts	P.O. Box 9131 N. Quincy, MA 02171-9131
Medical - HMO	Fallon Health Plan	10 Chestnut Street Worcester, MA 01608
Medical – HMO	Harvard Pilgrim Health Care	3 Allied Drive Dedham, MA 02026
Medical – HMO	Tufts Health Plan	333 Wyman Street Waltham, MA 02254
Medical – HMO, PPO	United Health Care	P.O. Box 740800 Atlanta, GA 30374
Prescription Drug Coverage	Medco	85 Wells Avenue, Suite 214 Newton, MA 02459
Flexible Spending Accounts	ADP	PO Box 1853 Alpharetta, GA 30023
Behavioral Health Benefits	OptumHealth Behavioral Solutions (formerly United Behavioral Health)	Optum Health Claims PO Box 30755 Salt Lake City, UT 84130-0755
Vision	Vision Service Plan	One Gatehall Drive Parsippany, NJ 07054

Sources of Plan Contributions— Contributions for coverage may be made solely by the Plan Sponsor, or solely by participating employees. Some of the coverages require joint contributions from participating employees and the Plan Sponsor.

When you enroll in health coverage, your contributions generally are made on a pre-tax basis. This means that your share of the cost of your coverage generally is deducted from your salary before federal, Social Security, and state income taxes are withheld. As a result, your taxable income is reduced, thereby saving you money. However, it's important to note that paying for coverage or making contributions on a pre-tax basis could slightly reduce future Social Security benefits.

Life Insurance, Disability and Other Benefit Plan Vendors

Learn about life, disability, long-term care, and legal insurance vendors who provide fully insured benefits under contracts or insurance policies issued to EMC Corporation. These carriers are solely responsible for financing and providing all benefits under the contracts. EMC has no liability for any benefits due, or alleged to be due, under any such insurance contracts.

Type of Coverage	Vendor Name	Vendor Address
Life Insurance – Basic Group Term, Supplemental Life and Dependent Life	Metropolitan Life Insurance (MetLife)	MetLife 177 South Commons Drive Aurora, IL 60504
Life Insurance – Accidental Death & Dismemberment and Business Travel Accident	Chartis (formerly AIG Life Insurance Company)	Chartis 145 Water Street New York, NY
Disability – Short-Term and Long-Term	Metropolitan Life Insurance (MetLife)	MetLife 177 South Commons Drive Aurora, IL 60504
Long-Term Care – (Frozen plan. No new enrollment on or after January 1, 2012)	John Hancock	John Hancock Financial Services, Inc. Group Insurance Division, X-3 P.O. Box 111 Boston, MA 02117-0111
Group Legal Plan	ARAG	ARAG Insurance Company 400 Locast Street, Suite 480 Des Moines, IA 50309
Personal Voluntary Plans	AFLAC	604 Washington Street A-10 Gainesville, GA 30501

Sources of Plan Contributions—Contributions for coverage may be made solely by the Plan Sponsor, or solely by participating employees. Some of the coverages require joint contributions from participating employees and the Plan Sponsor.

Eligibility Requirements

You are eligible for EMC's health and welfare benefits if you are scheduled to work at least 20 hours per week*. Eligible employees do not include:

- Any employee regularly scheduled to work less than 20 hours per week, except for participation in the Employee Assistance Program (EAP)
- Any casual or temporary employee, regardless of the work schedule or number of hours worked
- Any employee whose employment is subject to the terms of a collective bargaining agreement, unless the agreement explicitly provides for inclusion in the plans
- Any employee who is a nonresident alien who receives no U.S. source of income
- Any employee classified as an independent contractor, regardless of any later reclassification, whether or not retroactive
- Student interns, co-operative students or similar student employees, regardless of the student's work schedule or number of hours worked
- Any individual considered to be an employee solely by reason of the leased employee rules under Code Section 414(n)

* If you are scheduled to work 20-29 hours per week, the employee premium deduction for medical, dental, and vision coverage is two times that of employees normally scheduled to work at least 30 hours per week.

Qualified Dependents

Dependent Eligibility—When you enroll in the plan, you may elect to cover eligible dependents

- to the extent dependent coverage is available, and
- subject to any limitations, exclusions or requirements of the plan and any related insurance contract.

For purposes of EMC health plan coverage (medical, dental, vision), eligible dependents are:

- Your lawful spouse;
- Your domestic partner, subject to the terms of EMC's Domestic Partner Policy (please review information regarding Imputed Income;
- Any child of yours, your lawful spouse or your domestic partner who has not attained age 26. In addition to a son or daughter, a child includes:
    - A legally adopted child;
    - A foster child;
    - A stepchild;
    - A child for whom you have legal guardianship;
    - A child born to one of your dependent children, as long as your grandchild is living with you, your grandchild is primarily supported by you and your dependent child is enrolled in EMC health plan coverage.
    -
- Any disabled child of yours, your lawful spouse or your domestic partner who has attained age 26:
    - Who is primarily supported by you and incapable of self-sustaining employment by reason or mental or physical disability.
    - Proof of the child's condition and dependence must be submitted to the insurer within 30 days after the date the child ceases to qualify as an eligible dependent above. The insurer may, from time to time, require proof of the continuation of such condition and dependence.

  A child is disabled if he or she is considered physically or mentally disabled under the provisions of the applicable EMC health plan coverage for purposes of continuing the child's coverage after attaining age 26.

For purposes of EMC spouse and dependent life insurance coverage, eligible dependents are:

- Your lawful spouse;
- Your domestic partner, subject to the terms of EMC's Domestic Partner Policy (please review information regarding Imputed Income;
- Any child of yours, your lawful spouse or your domestic partner who has not attained age 26. In addition to a son or daughter, a child includes:
    - A legally adopted child;
    - A stepchild;

Benefit coverage for a dependent child will continue until the last day of the month in which his 26th birthday occurs.

No one may be considered as a dependent of more than one EMC employee. Anyone who is enrolled in an EMC health plan (medical/dental/vision) as an EMC employee will not be considered as an eligible dependent of another EMC employee.

If you elect to enroll an individual in your health coverage (such as your domestic partner, same-sex spouse, ex-spouse or adult child up to age 26 -- if and to the extent permitted by the Plan) and the individual is not considered your spouse, child or other dependent for federal tax purposes, then the fair market value of the health coverage provided to that individual must be includible in your taxable gross income. This means that any contribution you make toward that individual's coverage will either be deducted by the Plan Sponsor from your after-tax compensation, or paid by pre-tax salary reduction and included in your gross income as additional wages for federal tax purposes, which is referred to as imputed income. Any employer contribution toward that individual's coverage, will also be includible in your gross income as imputed income. If you have any questions, please contact the EMC Benefits

Service Center. For additional information, please refer to IRS Notice 2004-79, Mass DOR Tax Information Release 07-16 (December 21, 2007) and IRS Notice 2010-38.

Filing a Claim

You or your beneficiary must file a claim, in writing and within the time period prescribed in the specific plan, or within a reasonable period if none is specified, to the Claims Administrator for the plan under which you are claiming benefits. If your claim for benefits is denied, in whole or in part, you may appeal the denial using the procedures outlined here. For purposes of a health benefit claim under the Plan, a claim denial includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time). Please note these procedures are different for health benefits, disability benefits, and life benefits under ERISA.

Health Benefits Claims

This section outlines the procedures for health benefit claims and appeals under the following plans:

- Medical Plan
- Dental Plan
- Vision Plan
- Health Care Flexible Spending Account
- Limited Health Care Flexible Spending Account
- Behavioral Health Benefits
- Prescription Benefits
- Long Term Care

Initial Claim Response—After receiving your claim, the Claims Administrator will provide notice of its decision within the following timeframes. These are maximum timeframes for all health plans. Some Claims Administrators may have shorter timeframes for responding to claims.

- **Post-service claims.** The Claims Administrator will provide written or electronic notice of a claim denial within 30 days of receipt of your claim. This period may be extended up to an additional 15 days for matters beyond the control of the Claims Administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the reasons for the delay and when the Claims Administrator expects to make a decision. If you are notified of the need to provide additional information, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days, the Claims Administrator will notify you of its decision within 15 days after the requested information is received. If you do not supply the requested information within the 45-day period, your claim will be denied.

- **Pre-service claims.** The Claims Administrator will provide written or electronic notice of a claim approval or denial within 15 days of receipt of your claim. This period may be extended up to an additional 15 days for matters beyond the control of the Claims Administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the reasons for the delay and when the Claims Administrator expects to make a decision.

  If your pre-service claim was filed improperly, you may be notified no later than five days after the pre-service claim is received. Notice of an improperly filed pre-service claim may be provided orally or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim. In order to receive notice of an improperly filed pre-service claim, you or your authorized representative must have provided a communication regarding the claim to the Claims Administrator. This communication must include the patient's name, a specific medical condition or symptom, and a request for approval for a specific treatment, service, or product.

  If more information is needed to process your pre-service claim, the notice will describe the information needed. Once you are notified of the need to provide additional information, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days, the Claims Administrator will notify you of its decision within 15 days after the requested information is received. If you do not supply the requested information within the 45-day period, your claim will be denied.

- **Urgent care claims.** The Claims Administrator will provide notice of claim approval or denial as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of your claim. To expedite the processing of an urgent care claim, the Claims Administrator's notice may be oral, but a written or electronic confirmation will follow within three days.

  If your urgent care claim was filed improperly, you may be notified no later than 24 hours after the urgent care claim is received. Notice of an improperly filed urgent care claim may be provided orally or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim. In order to receive notice of an improperly filed urgent care claim, you or your authorized representative must have provided a communication regarding the claim to the Claims Administrator. This communication must include the patient's name, a specific medical condition or symptom, and a request for approval for a specific treatment, service, or product.

  If additional information is needed to process your urgent care claim, the Claims Administrator will notify you within 24 hours after receipt of your claim. You will have not less than 48 hours to provide that information. The Claims Administrator will then have 48 hours from the earlier of: the plan's receipt of the requested information or the end of the additional 48 hour period. If you do not provide the additional information within 48 hours of when it is requested, the claim will be denied.

- **Concurrent care claims.** If you request an extension of ongoing treatment in an urgent care situation, the Claims Administrator will notify you as soon as possible given the medical circumstances, but no later than 24 hours of your request, provided your request is made at least 24 hours before the end of approved treatment. If your request for extended treatment is not made within 24 hours before the end of the previously approved treatment period, the request will follow the urgent care timeframes.

  If you request an extension of non-urgent care, your request will be considered a new claim and will be decided according to post-service or pre-service timeframes, whichever applies.

  If an ongoing course of treatment will be reduced or terminated, the Claims Administrator will notify you sufficiently in advance to give you an opportunity to appeal before the decision takes effect.

You will receive written or electronic notification of the determination of your claim. If your claim is denied, the notice will include:

- The specific reason or reasons for the denial;
- References to the specific plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect (complete) a claim and an explanation of why such material or information is necessary;
- A description of the plan's appeals procedures and applicable time limits;
- A statement regarding your rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- If the determination is based on medical necessity or experimental treatment (or similar exclusion or limit), a statement regarding your rights to obtain, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination.

Appeal Process—If your claim for health benefits is denied, in whole or in part, you or your authorized representative may appeal the denial within at least 180 days of the receipt of the written or electronic notice of denial. You may, however, first want to contact the Claims Administrator's Member Services Department to see if you can resolve the issue to your satisfaction.

If you choose to appeal your claim, your appeal should be in writing and should explain why you believe the claim should be paid. Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn't include that information with your original claim. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

A qualified individual who was not involved in the previous claim determination (and is not that person's subordinate) will decide your appeal. If your appeal involves a medical judgment, including whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the review will be done in consultation with a healthcare professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate. As part of the appeal resolution process, you consent to this referral and the sharing of pertinent medical claim information. If a medical or vocational expert is contacted in connection with an appeal, you will have the right to learn the identity of such individual.

With respect to the assignment of any appeal of a claim denial to a claims adjudicator or medical expert, neither the Plan Sponsor nor any Claims Administrator shall make any decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert based upon the likelihood that the individual acting as the review processor will support a denial of benefits.

The Claims Administrator will provide you (free of charge) with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

After receiving your appeal, the Claims Administrator will provide notice of its decision within the following timeframes. These are maximum timeframes for all health plans. Some Claims Administrators have shorter response times for responding to appeals.

- **Post-service appeals.** The Claims Administrator will provide notice of the appeal decision within 60 days following receipt of your appeal.

- **Pre-service appeals.** The Claims Administrator will provide notice of the appeal within 30 days following receipt of your appeal.

- **Urgent care appeals.** You or your authorized representative should contact the Claims Administrator as soon as possible. You can request an expedited appeal process orally or in writing. In this case, all necessary information, including the Plan's benefits determination on review, shall be relayed to you or your representative by telephone, fax or other similarly expeditious method. The Claims Administrator will provide notice of the appeal decision as soon as possible, taking into account the seriousness of your condition, but no later than 72 hours after receipt of your appeal.

You will receive written or electronic notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- The specific reason or reasons for the adverse determination;
- References to the specific Plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all records, documents and other information relevant to your benefit claim;
- description of any voluntary appeal procedures offered by the plan;
- A statement regarding your rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- If the determination is based on medical necessity or experimental treatment (or similar exclusion or limit), a statement regarding your rights to obtain, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination.

The Plan Administrator has the right to interpret the provisions of the plan and the administrator's decisions are final and conclusive.

External Review for Health Benefit Claims
If the health benefit plan you are enrolled in provides for an external review procedure -- to the extent required by applicable state or federal law, including PPACA -- then please refer to the applicable description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage agreement for a description of the external review procedures and the scope of claims eligible for external review.

Terms You Should Know—

Concurrent care	Claims to extend an ongoing course of treatment that was previously approved for a specific period of time or number of treatments. For example, if a hospital admission was initially approved for three days, and your doctor requests that it be extended to five days, that would be a concurrent care claim. Concurrent care claims also include claims where the plan reduces or terminates coverage for previously approved treatments.
Post-service	Claims for payment of benefits after medical care has been received. For example, a claim that is submitted after you go to the doctor's office would be a post-service claim. Health Care FSA reimbursements would also be considered post-service claims.
Pre-service	Claims that require notification or pre-approval before receiving care. For example,

	some plans require that you obtain pre-approval before receiving non-urgent behavioral health or hospital care.
Relevant	For purposes of this claims procedure, a document, record or other information will be considered relevant to a claim if it: • Was relied upon by the Claims Administrator in making its initial decision on the claim • Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the Claims Administrator in reaching its decision on the claim • Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination
Urgent care	Claims that require notification or pre-approval before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that cannot be managed without the requested treatment. (The determination of whether a claim involves urgent care will be made by an individual acting on behalf of the plan, applying the judgment of a "prudent layperson" who possesses an average knowledge of health and medicine. However, the claim will automatically be treated as urgent care if a physician who knows your medical condition determines that the claim involves urgent care.)

Disability Benefits Claims

This section outlines the procedures for disability benefit claims and appeals under the following plans:

- Short-Term Disability Plan
- Long-Term Disability

Initial Claim Response—Once you have filed your written claim, the Claims Administrator will notify you of the claim denial within 45 days of the receipt of your claim. This period may be extended by 30 days for matters beyond the control of the Claims Administrator. A written notice of the extension, the reason for the extension and when the Claims Administrator expects to decide your claim, will be furnished to you within the original 45-day period. This period may be extended for an additional 30 days beyond the original extension. A written notice of the additional extension, the reason for the additional extension and when the Claims Administrator expects to decide your claim, will be furnished to you within the first 30-day extension if an additional extension of time is needed. The written notice of any extension will describe the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim and any additional information needed from you to resolve these issues.

You will receive written or electronic notification of the determination of your claim. If your claim is denied, in whole or in part, the notice will include:

- The specific reason or reasons for the denial;
- References to the specific plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect (complete) a claim and an explanation of why such material or information is necessary;
- A description of the plan's appeals procedures and applicable time limits;
- A statement regarding your rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- If the determination is based on medical necessity or experimental treatment (or similar exclusion or limit), a statement regarding your rights to obtain, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination.

Appeal Process—If your claim for benefits is denied, in whole or in part, you or your representative may appeal your denied claim in writing to the Claims Administrator within at least 180 days of the receipt of the written or electronic notice of denial. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn't include that information with your original claim.

Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. A qualified individual who was not involved in the previous claim determination (and is not that person's subordinate) will decide your appeal. This review will not afford any deference to the initial benefit determination.

If your appeal involves a medical judgment-including whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate-the review will be done in consultation with a healthcare professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate. As part of the appeal resolution process, you consent to this referral and the sharing of pertinent medical claim information. If a medical or vocational expert is contacted in connection with an appeal, you will have the right to learn the identity of such individual.

The Claims Administrator will make a determination on your claim appeal within 45 days of the receipt of your appeal request. When special circumstances require more time (up to 45 additional days) for a fair decision on your appeal, you will be notified in writing during the original 45-day period of the reason for the delay and the timeframe for making the decision.

You will receive written or electronic notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- The specific reason or reasons for the adverse determination;
- References to the specific plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all records, documents and other information relevant to your benefit claim;
- A description of any voluntary appeal procedures offered by the plan;
- A statement regarding your rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- If the determination is based on medical necessity or experimental treatment (or similar exclusion or limit), a statement regarding your rights to obtain, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination.

The Plan Administrator has the right to interpret the provisions of the plan and the administrator's decisions are final and conclusive.

Life Insurance and Other Benefit Plan Claims

This section outlines the procedures for benefit claims and appeals under the following plans:

- Life Insurance Plan
- Accidental Death & Dismemberment Plan (AD&D)
- Business Travel Accident Plan (BTA)
- Legal Insurance Plan

Please note that the Dependent Care Flexible Spending Account is not covered by ERISA, so it is not subject to these procedures.

Initial Claim Response—Once you have filed your claim, the Claims Administrator will notify you of the claim denial within a reasonable period of time, no later than 90 days after receipt of your claim. If special circumstances warrant more time (up to 90 additional days), you will be notified in writing before the end of the initial 90-day period of the reason for the delay and the timeframe for making the claim determination.

If your claim for benefits is denied, you or your authorized representative will receive a written or electronic notice of the denial. The notice will include:

- The specific reason or reasons for the denial;
- References to the specific plan provisions on which the benefit determination was based;

- A description of any additional material or information necessary for you to perfect (complete) a claim and an explanation of why such material or information is necessary; and
- A description of the plan's appeals procedures and applicable time limits.

Appeal Process—If your claim is denied, in whole or in part, you may appeal and have your claim reviewed. You have at least 60 days to make an appeal from the time you are notified of the denial. Your request for an appeal must be made in writing to the Claims Administrator. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn't include that information with your original claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision.

The Claims Administrator must act on your claim appeal within a reasonable period of time, no later than 60 days after receiving it. In special cases-for example, if a hearing is held-the Claims Administrator is allowed an extension of an additional 60 days. You will be notified in writing before the end of the original 60-day period of the reason for the delay and the timeframe for making the decision.

If the claim on appeal is denied in whole or in part, you will receive a written notification of the denial. The notice will include:

- The specific reason or reasons for the adverse determination;
- References to the specific plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request; and
- A description of any voluntary appeal procedures offered by the plan.

The Plan Administrator has the right to interpret the provisions of the plan and the administrator's decisions are final and conclusive.

Legal Actions—You have the right to pursue legal remedies against the plan and its administrators under ERISA if you are dissatisfied with the application of plan provisions in your situation. If you do not appeal within the specified timeframe, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court). The plan's internal appeal process will not be deemed exhausted (thereby permitting you to seek immediate external or judicial review) based on a de minimis violation of the claims and appeal rules that was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan or insurer's control;
- In the context of an ongoing, good faith exchange of information between the claimant and the plan or insurer; and
- Not reflective of a pattern or practice of non-compliance by the plan or insurer.

Loss of Benefits

The Plan contains some restrictions on the type and amount of benefits payable as well as the circumstances under which benefits are paid. Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, rescission or suspension of any benefits are described in the separate benefit booklets. You should review the applicable booklet(s) in order to acquaint yourself with these provisions. You may lose coverage under the Plan if the Plan Sponsor terminates the Plan or amends it to reduce or eliminate your coverage. Your coverage under this Plan generally terminates when you terminate employment with the Plan Sponsor or otherwise cease to be an eligible employee.

Note: If you or any of your dependents lose coverage under a plan, contact the person who administers the plan to determine what arrangements, if any, may be made to continue your group coverage or to convert to any available individual coverage. Certain rights to continue health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) are outlined under Continuation of Health Benefits Under COBRA.

Plan Amendment and Termination

The Plan Sponsor (EMC), in its sole discretion, may at any time modify, amend or terminate the provisions, terms and conditions of a plan without the consent of any participant or any beneficiary under a plan. Any modification, amendment or termination of a plan will be by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate, and filed with the Plan Administrator. Any claims or expenses incurred before the date of any Plan amendment or termination will be paid in accordance with the Plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims. No vested rights of any nature are provided by the Plan.

Your Rights Under ERISA

As a welfare benefits plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to receive information about the plan and benefits; and continue group health plan coverage:

Receive Information about the Plan and Benefits—

- You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- You are entitled to obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage—

- You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under health care plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review these summary plan descriptions and the documents governing the health care plans on rules governing your COBRA coverage.
- You are entitled to reduce or eliminate any exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries— In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing Your Rights— If you have a claim for benefits that is denied or ignored, in whole or in part, you have a right to know why it was denied or ignored, to obtain copies (without charge) of documents relating to the decision, and to appeal any denial within certain timeframes.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the plan

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

Assistance with Your Questions— If you have any questions about a benefit plan, contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed below. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline at the Employee Benefits Security Administration.

The nearest office of the Pension and Welfare Benefits Administration is:

Boston Regional Office
One Bowdoin Square
7th Floor
Boston, MA 02114
Telephone: 617-424-4950

COBRA Continuation Coverage

Introduction—This section pertains to you if you are covered under an EMC Health Plan (the Plan). It contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review this entire **Summary Plan Description** of which this is a part.

The Plan Administrator has delegated to the ADP COBRA Benefits Service Center responsibility for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?—COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses/domestic partners of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage. You will be notified at the time you are offered COBRA continuation coverage of the amount and the date payment is due.

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

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

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

- The employee dies;
- The employee’s hours of employment are reduced;
- The employee’s employment ends for any reason other than his or her gross misconduct;
- The employee becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or your domestic partnership is terminated.

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

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

When is COBRA Continuation Coverage Available?—The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event (1) within 30 days of any of these events or (2) within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events—For the other qualifying events (divorce or legal separation of the employee and spouse, or termination of domestic partnership, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator by contacting the **EMC Benefits Service Center at 888-EMC-BENE or 888-362-2363** within 60 days after the qualifying event has occurred.

How is COBRA Continuation Coverage Provided?—Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered when appropriate to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage is lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event causing loss of coverage is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event causing loss of coverage is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**

  If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that you provide a copy of the SSA's disability determination to the Plan Administrator prior to the last day of the initial 18-month COBRA continuation coverage period **AND** within 60 days of the latest of the dates listed below:

  - The date the qualified beneficiary was informed (through the Summary Plan Description – SPD - or Initial General Notice of COBRA Rights) of the responsibility and procedures for informing the plan of the disability determination;
  - The date on which the qualifying event occurred;
  - The date coverage was lost; or
  - The date the SSA made their determination (date of the determination notice of award).

This notice should be sent to the **ADP COBRA Benefits Service Center** or other party as indicated in the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage. The notice should be sent to the address on the COBRA Election Notice.

- **Second qualifying event extension of 18-month period of continuation coverage**

  If, while receiving COBRA continuation coverage, your spouse/domestic partner and/or dependent child(ren) experiences another qualifying event which causes a loss of coverage, they can get additional months of COBRA continuation coverage, for a total of up to a maximum of 36 months from the date of the first qualifying event. This extension is available only to the spouse/domestic partner and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a

dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to **ADP COBRA Benefits Service Center** or other party as indicated in the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage. The notice should be sent to the address on the COBRA Election Notice.

Please note: At the time you are being provided with this Initial General Notice of COBRA Rights, the **ADP COBRA Benefits Service Center** is your employer's COBRA administrator. In the future, you should refer to the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage to confirm that ADP Benefits Services still performs this function for your employer and that ADP Benefits Services remains the appropriate place for you to send notice of a Social Security Disability or Second Qualifying event.

Early Termination of COBRA— COBRA provides that your continuation coverage may be terminated before the end of the maximum coverage period for any of the following reasons:

- The Plan Sponsor no longer provides group health coverage to any of its employees;
- Any required premium for continuation coverage is not paid in full on time;
- A qualified beneficiary becomes covered -- after electing COBRA continuation coverage -- under another group health plan (as an employee or otherwise) that does not impose any pre-existing condition limitation for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage;
- A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition limitation does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the Plan Sponsor may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

Continuation coverage under COBRA is provided subject to the qualified beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible.

COBRA continuation coverage may also be terminated for any reason if the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

When and how must payment for COBRA continuation coverage be made?

- **First payment for continuation coverage—** If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the party responsible for COBRA administration under the Plan at the address, phone number or e-mail address provided at the end of this section to confirm the correct amount of your first payment.

- **Periodic payments for continuation coverage—** After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA Rates chart. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

- **Grace period for periodic payments—** Although periodic payments are due each month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for

the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If You Have Questions—If you have questions about your COBRA continuation coverage, you should contact the EMC Benefits Services Center at 888-EMC-BENE, or (if already enrolled as a COBRA participant) contact ADP COBRA Benefits Services at 866-898-0393, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa

Keep Your Plan Informed of Address Changes—In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator, or print out any changes you enter online on the EMC Benefits website.

2012 Monthly COBRA Rates

Monthly COBRA Rates by Insurance Carrier	Individual	Individual Adult plus Child(ren)	Individual Adult plus Spouse/DP	Family: Two Adults plus Child(ren)
Global Benefits				
Aetna Global Benefits	$437.57	$971.99	$1,066.18	$1,457.03
Traditional Medical Plans				
Anthem Blue Cross HMO - CA	$526.77	$953.09	$1,139.46	$1,594.11
Blue Cross Blue Shield PPO (US)	$528,57	$977.87	$1,057.15	$1,427.13
BCBS Health & Savings Plan (HSA)	$321.10	$590.83	$642.18	$881.82
Fallon HMO MA	$507.89	$898.55	$1,015.78	$1,371.30
HMSA Health Plan Plus (Hawaii)*	$453.70	N/A	$907.40	$1,356.31
HMSA PPO – A (Hawaii)*	$486.09	N/A	$972.19	$1,453.50
HPHC HMO – MA	$607.97	$1,124.74	$1,215.93	$1,641.51
Kaiser Permanente HMO–CA	$470.28	$938.19	$1,031.43	$1,406.07
Kaiser Permanente HMO–CO	$529.36	$1,000.94	$1,101.94	$1,515.69
Kaiser Permanente HMO–GA	$586.08	$1,059.77	$1,172.15	$1,729.03
Keystone Central HMO–PA*	$730.70	N/A	$1,493.06	$1,934.87
Tufts Navigator EPO–MA	$587.40	$1,086.70	$1,174.79	$1,585.97

Monthly COBRA Rates by Insurance Carrier	Individual	Individual Adult plus Child(ren)	Individual Adult plus Spouse/DP	Family: Two Adults plus Child(ren)
Traditional Medical Plans, cont'd				
Triple-S HMO–PR*	$227.58	N/A	$455.18	$532.98
United Healthcare Select EPO (US except MA)	$579.16	$1,071.45	$1,158.31	$1,563.71
Tiered Medical Plans**				
BCBS Choice HMO (for MA-residents only)	$529.42	$979.44	$1,058.84	$1,429.43
Fallon Select Advantage HMO (for MA-residents only)				
HPHC ChoiceNet HMO (for MA-residents only)				
Tiered Medical Plans**				
Tufts Your Choice HMO (for MA-residents only)				
United Healthcare Choice Plus PPO (for residents outside of MA, where available)				
Dental Plan				
Delta Dental	$38.17	$66.79	$76.34	$152.68
Vision Plan				
Vision Service Plan	$6.30	$11.03	$12.62	$18.91

* HMSA PPO-A, HMSA Health Plan Plus, Keystone Central, and Triple-S offer only 3 levels of coverage: Individual, Individual Plus One, and Family. In these plans, if your family is composed of Individual plus more than one child, your rate will be the Family rate.

** If you reside in California, Hawaii, Illinois, Maine, Missouri, Montana, New Hampshire, New York, Pennsylvania, Puerto Rico, Vermont, or Wyoming tiered plans are not available through EMC in 2012 due to these markets not yet being fully developed.

Other Information

Every effort has been made to provide you with an easy-to-understand explanation of your benefits. If any conflict arises between this SPD and the official plan documents, the official plan documents will always govern. You will not gain any new rights because of a misstatement in or omission from these summaries.

Your participation in EMC's benefits program does not guarantee your continued employment with the company. If you resign, are discharged or laid off, you do not have a right to any benefit or interest in any plan except as specifically provided in the plan document.

HIPAA - Special Enrollment Periods—Under the Health Insurance Portability and Accountability Act (HIPAA), if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the health care options offered by the Plan Sponsor, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

CHIP - Special Enrollment Periods— Under the Children's Health Insurance Program Reauthorization Act of 2009, effective April 1, 2009, the following special enrollment periods are also applicable to the health care options offered by the Plan Sponsor. The plan must permit you, or your dependent child, who is eligible for, but not enrolled in, the Plan Sponsor's health care plan to enroll in the plan if:

- You or your dependent child is covered under Medicaid or a state CHIP program and such coverage is terminated due to a loss of eligibility, provided that you request enrollment in the Plan Sponsor's health care plan no later than 60 days after the Medicaid/CHIP coverage terminates; or

- You or your dependent child becomes eligible for Medicaid or a state CHIP program, provided that you request enrollment in the Plan Sponsor's health care plan no later than 60 days after you or your dependent child, as applicable, is determined to be eligible for premium assistance under the Medicaid or state CHIP program.

NMHPA - Maternity Stays—Group health plans and health insurance issuers generally may not, under the New Mother's Health Protection Act (NMHPA), restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Reconstructive Surgery Following Mastectomies—A federal law, the Women's Health & Cancer Rights Act of 1998, was enacted requiring group health plans that provide coverage for mastectomies to provide the following mastectomy-related benefits to plan participants:

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

These benefits will be subject to the same deductibles and coinsurance or co-payment provisions consistent with those established for other benefits under the participant's health plan. Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's attending physician.

If you have any questions, please call the member services phone number on your medical plan ID card.

Qualified Medical Child Support Orders (QMCSOs)— As required by ERISA, the Plan recognizes qualified medical child support orders (QMCSOs). A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group health plan.

The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to

which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

A QMCSO must be provided to the Plan Sponsor to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Sponsor receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

A copy of the Plan's QMCSO procedures are available, free of charge, upon written request.

HIPAA Notice of Privacy Practices
Medicare Part D Notice of Creditable Coverage

Disclaimer: PeopleLink Benefits provides only an overview of your EMC benefits. In case of any discrepancy between this Web site and plan documents, the plan documents will govern. EMC reserves the right to amend or to terminate any benefit plan at any time, with or without notice.