

PDS Tech, Inc.
2012
HEALTH PLAN NOTICES

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MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice from PDS Tech About Your Prescription Drug Coverage and Medicare."

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PDS Tech and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PDS Tech has determined that the prescription drug coverage offered by the PDS Tech Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare – General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the PDS Tech Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the PDS Tech Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your PDS Tech prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PDS Tech changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2012
Name of Entity/Sender:	Julie Surley
Contact--Position/Office:	Human Resources Manager
Address:	1925 W John Carpenter Freeway, Irving, TX 75063
Phone Number:	(800) 270-4737

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Rev. 5/13/11

PDS Tech, Inc.
IMPORTANT NOTICE
HIPAA Comprehensive Notice of Privacy Policy and Procedures

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you on behalf of:

PDS Tech Comprehensive Employee Welfare Benefit Plan

The Plan's Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

Rev. 10/13/11

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by ABC Company that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. *However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.*

Other Uses and Disclosures of Your PHI Not Requiring Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as ABC Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll

department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization:

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to have an Opportunity to Object:

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
 - *Effective February 17, 2010, you can restrict disclosure of PHI for payment or health care operations if you pay the health care provider the full out-of-pocket cost.*

- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

A new federal law, the American Reinvestment and Recovery Act of 2009 (ARRA) has made numerous changes to the rules governing PHI that is maintained by the Plan and its service providers (business associates). Effective September 23, 2009, any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. The notice will be provided to you if the breach poses a significant risk of financial, reputational or other harm to you.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information or to Submit a Complaint.

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official.

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Julie Surley
Human Resources Manager
(800) 270-4737

The Plan's Deputy Privacy Official(s) is/are:

Julie Surley
Human Resources Manager
(800) 270-4737

Organized Health Care Arrangement Designation.

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

PDS Tech Medical Plan
PDS Tech Dental Care Plan
PDS Tech Vision Plan
PDS Tech Long Term Care Plan

Effective Date.

The effective date of this Notice is: 1/1/2012.

Rev. 10/20/10

GENERAL NOTICE OF PRE-EXISTING CONDITION RESTRICTIONS

The PDS Tech imposes a preexisting condition exclusion on adults over the age of 18 (individuals under age 19 are not subject to the pre-existing condition restriction, effective 1/1/2012. This means that if a 19-year-old or older enrollee has a medical condition before coming to the Plan, the enrollee might have to wait a certain period of time before the Plan will provide coverage for that condition.

This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a **six-month period**. Generally, this six-month period ends the day before coverage becomes effective.

However, if the enrollee was in a waiting period for coverage, the six-month period ends on the day before the waiting period begins.

The preexisting condition exclusion does not apply to pregnancy nor to an employee or dependent child under the age of 19 who is enrolled in the plan.

This exclusion may last up to **12 months** (18 months if the enrollee is a late enrollee) from the first day of coverage, or, if the enrollee was in a waiting period, from the first day of the waiting period. However, the enrollee can reduce the length of this exclusion period by the number of days of his or her prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if the enrollee has not experienced a break in coverage of at least 63 days.

To reduce the 12-month (or 18-month) exclusion period by the enrollee's prior creditable coverage, you or the enrollee should give us a copy of any certificates of creditable coverage you or the enrollee have. If you do not have a certificate, but you or the enrollee do have prior health coverage, we will help you or the enrollee obtain one from the enrollee's prior plan or insurance company. There are also other ways that an enrollee may prove prior creditable coverage.

Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

Julie Surley
Human Resources Manager
(800) 270-4737

Rev. 10/20/10

PDS Tech, Inc **NOTICE OF SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;

- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact:
 Julie Surley
 Human Resources Manager
 (800) 270-4737

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

Rev. 10/20/10

GENERAL COBRA NOTICE

1/1/2012

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this Notice of COBRA health care coverage continuation rights because you have recently become covered under one or more group health plans. The plan (or plans) under which you have gained coverage are listed at the end of this Form, and are referred to collectively as "the plan" except where otherwise indicated.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare 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/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For more information about your rights and obligations under the plan and under federal law, you should either review the plan's Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description.

COBRA Continuation Coverage and "Qualifying Events"

Rev. 10/13/11

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 notice. 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 of employees, and eligible children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or
- You become divorced or legally separated from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce* and a divorce* later occurs, then the divorce* will be considered a qualifying event even though you actually lost coverage earlier. ***If you notify the Plan Administrator or its designee within 60 days after the divorce* and can establish that the employee canceled the coverage earlier in anticipation of the divorce,* then COBRA coverage may be available for a period after the divorce (but not for the period between the date your coverage ended, and the date of divorce).**** But you ***must*** provide timely notice of the divorce* to the Plan Administrator or its designee or you will not be able to obtain COBRA coverage after the divorce.* See the rules in the box below, under the heading entitled, "Notice Requirements," regarding the obligation to provide notice, and the procedures for doing so.

* or legal separation

Your covered **eligible children** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an "eligible child."

Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been **timely 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,
- enrollment of the employee in any part of Medicare,

the employer (if the employer is not the Plan Administrator) must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Julie Surley
Human Resources Manager
(800) 270-4737

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- The ***name of the plan or plans*** under which you lost or are losing coverage,
- The ***name and address of the employee*** covered under the plan,
- The ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- The ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, "*Duration of COBRA Coverage.*" That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

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

Once the Plan Administrator or its designee receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage for their spouses, and

parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. ***If you or your spouse or eligible children do not elect continuation coverage within the 60-day election period described above, you will lose your right to elect continuation coverage.***

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to **36 months**.

When the qualifying event 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 three ways in which the period of COBRA continuation coverage can be extended...

1. Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator or its designee in writing and 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 the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage. The plan requires you to follow the procedures specified in the box above, under the heading entitled "Notice Procedures." In addition, your notice must include:

- The name of the disabled qualified beneficiary,
- The date that the qualified beneficiary became disabled, and
- The date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

2. Second qualifying event extension of 18-month period of continuation coverage.

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of **36 months (including the initial period of COBRA coverage)**.

This extension is available to ***the spouse*** and ***eligible children*** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- Dies,
- Enrolls in any part of Medicare, or
- Gets divorced *or legally separated*.

The extension is also available to an **eligible child** when that child stops being eligible under the plan as an eligible child.

In all of these cases, you must make sure that the Plan Administrator or its designee is notified in writing of the second qualifying event within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last. The plan requires you to follow the procedures specified in the box above, under the heading entitled "Notice Procedures." Your notice must also **name the second qualifying event and the date it happened.** If the second qualifying event is a divorce or legal separation, your notice must include **a copy of the divorce decree or legal separation agreement.**

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. Medicare Extension for Spouse and Eligible Children.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is **36 months** from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Other Rules and Requirements

Same Rights as Active Employees to Add New Dependents.

A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, "Children Born or Placed for Adoption with the Covered Employee During COBRA Period," for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change (adding or dropping dependents, for example).*** See the rules in the box above, under the heading entitled, "Notice Procedures," for an explanation regarding how your notice should be made.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period.

A child born to, adopted by or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, "Notice Procedures," for an explanation regarding how your notice should be made.

Alternate Recipients Under Qualified Medical Child Support Orders.

A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the

covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, "Notice Procedures," for an explanation regarding how your notice should be made.

If You Have Questions

Questions concerning your plan or your COBRA continuation rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). 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 or its designee 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 its designee.

Plan and Plan Contact Information

Julie Surley
Human Resources Manager
(800) 270-4737

Rev. 12/6/10

NOTICE OF GRANDFATHERED STATUS

Aetna believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Julie Surley Human Resources Manager (800) 270-4737

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

**NOTICE THAT PDS TECH, INC GRANTED
WAIVER FROM ANNUAL LIMIT REQUIREMENT**

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least \$1.25 million.

Your health coverage, offered by Aetna Life Insurance Company, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

Aetna SRC Premier	10,000	5,000
Most this plan will pay overall per coverage year	\$10,000	\$5,000
Most this plan will pay per coverage year for:		
Outpatient charges	\$1,000	\$500
Hospital services other than daily room charge	\$1,000	\$500
Most this plan will pay per month for prescriptions	\$35	\$35

This means that your health coverage might not pay for all of the health care you expenses you incur.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least \$1.25 million this year.

Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2013.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact Julie Surley
Human Resources Manager (800) 270-4737.

Rev. 6/17/11

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

PDS Tech is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The PDS Tech plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at Julie Surley Human Resources Manager (800) 270-4737.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER OF FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443

ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-792-4884	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP

<p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
LOUISIANA – Medicaid	
<p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207</p>	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
<p>Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557</p>	<p>Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583</p>
MASSACHUSETTS – Medicaid and CHIP	
<p>Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120</p>	
MINNESOTA – Medicaid	NEW YORK – Medicaid
<p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-6944</p>	<p>Website: http://www.nc.gov Phone: 919-855-4100</p>
NORTH DAKOTA – Medicaid	UTAH – Medicaid
<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>	<p>Website: http://health.utah.gov/upp Phone: 1-866-435-7414</p>
OKLAHOMA – Medicaid	VERMONT – Medicaid
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://www.greenmountaincare.org/ Telephone: 1-800-250-8427</p>
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP

Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human
Services
Centers for Medicare and Medicaid
Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565