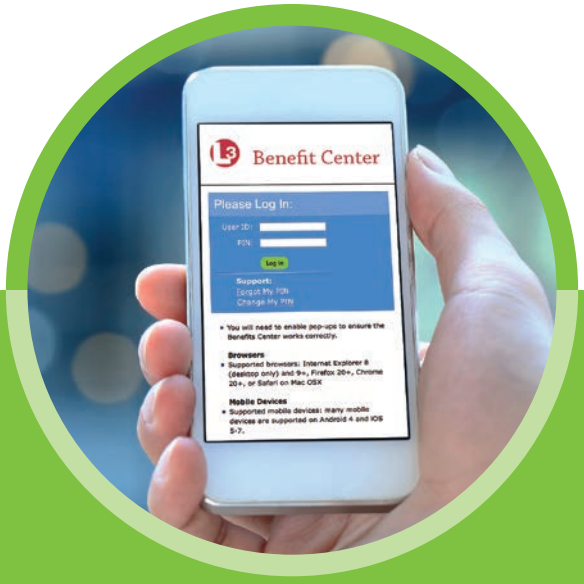
2016 BENEFIT PLANNER

HEALTHY FOCUS



THE L-3 BENEFIT CENTER

The Benefit Center is L-3's dedicated benefits enrollment and information resource:

- **WEB:** Log on to **https://L-3.benefitcenter.com** from any computer or mobile device with internet access. You do not need to be behind L-3's security firewall.
- **PHONE:** Call a Benefit Service Representative at **1-866-919-2424** between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

If you are an international employee, you can reach the Benefit Center at 1-412-505-6904.

SHOP SMART WITH WELLMATCH

WellMatch makes shopping for medical care easier than ever for Aetna HSA and Aetna HealthFund HRA Medical Plan participants. The convenient online tool allows you to search for network providers and medical services based on price, quality and location. Simply enter the type of physician or procedure you're interested in (e.g., colonoscopy or MRI) and receive a list of local providers, along with what they charge for that procedure, their quality rankings and their travel distance. WellMatch shows you how much you can expect to pay out-of-pocket by taking into account the funds available from your HRA (if applicable), your deductible and your out-of-pocket maximum.

Visit **www.WellMatchHealth.com** and follow the steps to register as a new user to get started.

WellMatch℠

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ABOUT THIS BENEFIT PLANNER

This *Benefit Planner* identifies the issues you may want to consider as you make your benefit elections and presents the highlights of benefit plan options available throughout L-3 Communications Corporation ("L-3"). **Please note that not all benefit plans are offered at all business units.** To find out the specific options available at your location, please refer to your *Personalized Enrollment Worksheet,* which you will receive from the L-3 Benefit Center prior to enrollment.

We encourage you to read each benefit overview carefully so you understand the coverage offered. If you previously received Summary Plan Descriptions describing your benefits, this *Benefit Planner* takes precedence over those Summary Plan Descriptions to the extent that any provisions of the *Benefit Planner* are inconsistent with the provisions of the Summary Plan Descriptions. You will receive updated Summary Plan Descriptions that are effective January 1, 2016, in the near future. Until then, if you have questions about your coverage, please contact the L-3 Benefit Center toll-free at 1-866-919-2424.

This brochure highlights certain provisions of the welfare benefit plans and programs available to eligible L-3 employees (and dependents and/or beneficiaries) effective January 1, 2016. L-3 reserves the right to terminate, suspend, withdraw, amend or modify these plans at any time without prior notice to participants to the extent permitted by law and in accordance with applicable collective bargaining agreements. In addition, the tax treatment of these benefits is subject to change without notice, as determined by federal, state or local tax authorities.

If you have any questions about the information provided here, call the Benefit Center, L-3's dedicated benefits information resource, toll-free at 1-866-919-2424. Benefit Service Representatives are available between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

WARNING:

If you do not certify your dependents' continued eligibility for L-3's health plans by October 30 with the Benefit Center, your dependents will not have coverage in 2016!

If you plan to cover your eligible dependents under a health plan in 2016, you must certify each dependent's eligibility for coverage during the enrollment period, even if he/she has coverage in 2015. Coverage will terminate as of December 31, 2015, for any dependent whose eligibility has not been certified.

Your contributions for coverage depend on the Plan you elect and whether you choose to extend coverage to your family. See your *Personalized Enrollment Worksheet* for details.

ENROLLING FOR COVERAGE

All L-3 employees will use the L-3 Benefit Center to enroll for 2016 benefits. The Benefit Center provides online and telephone enrollment capability:

- **Web (computer, tablet or mobile):** Log on to the enrollment website: **https://L-3.benefitcenter.com.**
- **Phone:** Call a Benefit Service Representative: **1-866-919-2424.**

Benefit Service Representatives are available between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday, to answer your benefit questions and/or help you enroll.

Before enrolling, be sure to carefully review your *Personalized Enrollment Worksheet.* It shows the options available to you, the required contribution for each option, dependent data and personal information such as your address. **Review this information carefully.** You may update personal data directly on the enrollment website or by calling the Benefit Center.

Confirmation Statements. After the enrollment period ends, a *Confirmation Statement* that reflects your most recent set of elections will be mailed to your home. Please review your *Confirmation Statement* carefully as soon as you receive it, making sure that it accurately reflects the plans you elected and the dependents you enrolled. Contact the Benefit Center immediately if the *Confirmation Statement* you receive in the mail doesn't match the one you printed when you completed your elections. Please note the following:

- If a newly enrolled dependent's eligibility is still being verified or the Benefit Center has not yet received the required documentation, the *Confirmation Statement* will show "(pending)" next to the dependent's name. This means coverage is not yet in place and will become effective only after the Benefit Center has received and verified the documentation.
- If you did not confirm your previously covered dependent's eligibility for coverage during annual enrollment, your *Confirmation Statement* will show "employee only" coverage for 2016. **Your dependents will not have coverage unless you certify their eligibility with the Benefit Center.**

Attention Military Veterans: TRICARE Supplement Plan Available

The TRICARE Supplement Plan is available to TRICARE-eligible domestic employees. Benefits depend on whether you have TRICARE Standard or Extra or TRICARE Prime. Using your TRICARE coverage along with the TRICARE Supplement available through L-3 may be the most cost-effective option for you. L-3 does not sponsor this Plan, so different eligibility rules may apply. See page 51 for more information.

If you plan to cover your eligible dependents (see page 54) under a health plan in 2016, you must certify each dependent's eligibility for coverage during the enrollment period, even if he/she has coverage in 2015. Coverage will terminate as of December 31, 2015, for any dependent whose eligibility has not been confirmed.

Who Must Enroll

You must enroll if you want to do any of the following:

- cover dependents in 2016
- enroll yourself and/or your dependents in a medical, dental or vision option for the first time
- switch your medical coverage to the Aetna HSA Medical Plan
- switch your medical or dental coverage from one option to another
- elect a new medical or dental option because your current option is being discontinued
- waive medical, dental or vision coverage and you did not waive for 2015 (remember, if you waive your own coverage, you are also waiving coverage for your dependents)
- contribute to a 2016 Health Care FSA, a Dependent Day Care FSA, or a Dental and Vision Flexible Spending Account (for HSA participants only).

You also must go through the enrollment process if you are enrolling for the first time.

IMPORTANT NOTE ABOUT ELECTING THE AETNA HSA MEDICAL PLAN: If you plan to elect the Aetna HSA Medical Plan, please keep these rules in mind for making HSA contributions as you make your election:

- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other medical plan that is not an HSA-compatible health plan (such as a spouse's POS/EPO plan).
- You cannot be enrolled in Medicare or TRICARE. Please note that if you are receiving Social Security benefits, you are enrolled in Medicare. Also, if you are not collecting Social Security benefits but have registered for Medicare, you are considered to be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- You cannot be on active military duty. In general, if you are a veteran, IRS rules state that you are not eligible to make contributions to your HSA for three months after each use of VA medical or prescription drug services unless related to a service-connected disability.
- You cannot elect an L-3 Health Care Flexible Spending Account or be covered by your spouse's Health Care FSA.

Please note that you must enroll a newborn child through the Benefit Center within 60 days after the child is born.

When You Must Enroll

The 2016 enrollment period begins at 12 a.m., Eastern Time on Monday, October 12 and ends at midnight on Friday, October 30, 2015. If you wish to make any changes in your benefit plan participation for 2016, or wish to cover a dependent in 2016, you have until October 30 to do so.

If you are a new hire during 2016 and are enrolling for the first time, you must enroll within 31 days of your eligibility date (or the date that appears on your *Personalized Enrollment Worksheet,* whichever is later).

Enrolling your dependents for coverage. You can enroll your eligible dependents in health plan coverage if you enroll, as long as you provide proper documentation, including Social Security numbers for each dependent.* When you enroll a new dependent for coverage, you will be required to complete the *L-3 Dependent Eligibility Questionnaire* and provide certain documents to prove that your dependents are eligible. This requirement applies in **ALL** cases in which you may want to enroll a dependent, whether that's at annual enrollment, as a new hire, or when you have a "qualifying event" (see page 55).

Note: No change through December 31, 2016 for currently enrolled same-sex civil union or same-sex domestic partners. L-3 will continue to cover any **currently enrolled** same-sex civil union partner or same-sex domestic partner, and allow you to re-enroll your currently covered same-sex civil union partner or same-sex domestic partner for 2016 (as long as there is no interruption in coverage). Beginning January 1, 2017, L-3 will discontinue coverage for same-sex civil union partners and same-sex domestic partners. At that point all lawfully married spouses, whether same sex or opposite sex, will be eligible for coverage under L-3's health and welfare benefit plans.

Enrolling new children. Please note that you must enroll a newborn child within 60 days after the child is born. Otherwise, you risk having coverage denied for that dependent. This requirement applies in all cases, whether or not you have already enrolled other children. For example, if you have "employee and child(ren)" or "employee and family" coverage, when you have another child you still must enroll the new child within 60 days. Similarly, newly adopted children also must be enrolled within 60 days of becoming your dependent.

HIPAA special enrollment rights. If you decline health plan enrollment for yourself and/or your dependents (including your spouse) because you have other health insurance or group health plan coverage and the other coverage ends, you may enroll yourself and/or your dependents in an L-3 health plan if you request enrollment within 60 days after your other coverage ends. To enroll for coverage, you must provide written proof that your other coverage has ended. Similarly, if you decline L-3 coverage because you have other employer-sponsored coverage (such as through your spouse's employer) and the employer stops contributing toward your or your dependents' other coverage, you may enroll yourself and/or your dependents in an L-3 health plan if you request enrollment within 60 days after employer contributions for your other coverage end. To enroll for coverage, you must provide written proof that employer contributions for your other coverage have ended.

In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) if you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption. See page 55 for more information.

To request special enrollment or obtain more information, contact the Benefit Center.

* If a dependent does not yet have a Social Security number (e.g., a newborn child), you must provide one within 60 days, unless the process is delayed for reasons beyond your control. You are not required to report a Social Security number for a dependent who is not a U.S. citizen (and therefore does not have a Social Security number nor is eligible for Medicare). If the dependent becomes eligible for a Social Security number, you must provide it as soon as it is received.

If You Fail to Enroll

If you are currently enrolled. If you are enrolled for benefits in 2015 but do not enroll for 2016 benefits when you are eligible to do so, it is assumed that you:

- have elected to keep the same coverage you currently have
- do not wish to cover any dependents in 2016
- do not want a 2016 Flexible Spending Account (even if you have one in 2015).

If you wish to cover dependents in 2016, you must log on to the enrollment website (or call a Benefit Service Representative) and verify each dependent's eligibility for coverage. This rule applies even if you have dependent coverage under a health plan in 2015.

If you do not enroll by the enrollment deadline, your next opportunity to elect or change your benefit elections will be during next fall's annual enrollment period, unless you experience a qualifying event.

If your current medical plan option is unavailable. If the medical plan option you elected for 2015 will not be available in 2016 and you do not elect a new one, you will automatically be enrolled in the default plan shown on your *Personalized Enrollment Worksheet* for "employee only" coverage. Your 2016 employee contributions for medical coverage will be those required for your default plan.

If you are eligible for the first time. If you do not enroll when you are first eligible to do so, your coverage will be limited to your business unit's default benefits (which in most cases means you will have **no** medical and/or dental coverage in 2016). See your *Personalized Enrollment Worksheet* to find out your default benefits. Please note that if you enroll late (or waive and later wish to enroll) for certain kinds of coverage, you may be required to submit an Evidence of Insurability Statement that is accepted by the applicable insurance carrier.

If you wish to cover dependents in 2016, you must log on to the enrollment website (or call a Benefit Service Representative) and verify each dependent's eligibility for coverage, even if they have dependent coverage in 2015.

INCENTIVE CREDITS

HEALTHY FOCUS

L-3 offers financial incentives to eligible employees and their spouses who are focused on their health and engage in healthy behaviors. You and your spouse have up to three opportunities to earn incentive credits:

- **Take an online Health Assessment through ActiveHealth between January 1, 2016, and February 29, 2016: earn a $75 incentive credit per person.** To access the Health Assessment, log on to www.myactivehealth.com/L-3com. (If it is your first time visiting the MyActiveHealth site you will need to create an account.) Click "Take Health Assessment"—or click "My Health," then choose "Health Assessment"—and answer a series of questions about your health. The assessment should not take longer than 20 minutes, and all answers are confidential. When you are done, you will see a personalized report; we encourage you to print and review it with your physician. You may save your answers at any time and return later, but you will not receive incentive credits until you have *completed and submitted* the Health Assessment.

  If you completed a Health Assessment in 2015, you need only update your assessment between January 1 and February 29, 2016, to receive the $75 incentive credit in 2016. The simplified assessment update consists of a subset of health questions and should not take more than 10-15 minutes to complete. To access the simplified assessment, log on to the ActiveHealth website, click on "Take Assessment" and select "Update Health Assessment."

  If you're a new hire in 2016 or become a new plan participant as a result of a qualifying event in 2016, you have until December 31, 2016 to complete the Health Assessment.

- **Get an annual physical during 2016: earn a $125 incentive credit per person.** It is important that your doctor's office code your visit as "preventive" to get credit for an annual physical. When you schedule your annual physical, be sure to inform the office that you receive financial credits for getting an annual physical when your visit is coded as preventive.

- **Complete four telephone sessions with ActiveHealth during 2016: earn a $300 incentive credit per person.** **Note:** This incentive is for employees and spouses who qualify and have been invited to participate in the Condition Management Program only. If you've previously opted out of the program or have not responded, you will be given another chance to participate. A "telephone session" is a 15–20 minute phone call in which you and a nurse coach address existing or potential issues related to your chronic condition(s) and set health-related goals. (See page 8 for more information about working with a nurse coach.) Please note that just scheduling an appointment with a nurse coach does not count as a session.

Incentives are available to employees and spouses enrolled in the following L-3 national, self-insured medical plans only: Aetna HSA Medical Plan, Aetna HealthFund HRA I, Aetna HealthFund HRA II, Aetna Choice POS II, Aetna Elect Choice EPO and Aetna Out-of-Area.

If you begin working with an ActiveHealth nurse coach on or after January 1, 2016, and are unable to complete your fourth call before December 31, 2016, you will not be eligible to receive the $300 incentive credit.*

If you are eligible for condition management, you can earn up to $500 ($1,000 if your spouse is also eligible for condition management). If you are **not** eligible for condition management, the maximum incentive reward you can earn is $200 ($400 if both you and your spouse participate).

How Incentives Work

How you receive your incentive credits depends on the medical plan in which you are enrolled:

- **Aetna HSA Medical Plan:** Your incentives are deposited automatically to your HSA account as cash, as soon as administratively feasible after you have earned them. There is no action required on your part. Any incentive credits you earn for taking the Health Assessment, getting a checkup or, if you qualify, engaging with ActiveHealth are deposited into your HSA, and are yours to keep. Your enrolled spouse can earn incentives, too. But remember: it is your responsibility to make sure that your contributions plus your incentive credits don't put you over the annual IRS contribution limit for HSAs (see page 11).
- **Aetna HealthFund HRA Medical Plans:** Your incentive credits are added automatically to your HRA account as additional Benefit Dollars. There is no action required on your part. If the Benefit Dollars are added to your HRA account before you meet the annual deductible, you may use these additional Benefit Dollars to pay for eligible health care expenses. If they are added to your account **after** you meet the annual deductible (i.e., when you are in the Health Coverage portion of the Plan), they will be used to pay your coinsurance (i.e., your share of eligible health care expenses).

If you completed a Health Assessment in 2015, you must log on to the ActiveHealth website between January 1 and February 29, 2016 to update your assessment and receive the $75 incentive credit in 2016. Unlike past years, you cannot start the update process before January 1. The simplified assessment update consists of a subset of health questions and should not take more than 10-15 minutes to complete.

- **Aetna Choice POS II, Aetna Elect Choice EPO or Aetna Out-of-Area Medical Plan:** Your incentive credits will be added automatically to an Incentive Credit Account the Company establishes on your behalf with WageWorks. Then, as soon as administratively possible after you incur eligible out-of-pocket health care expenses, WageWorks will send you a reimbursement check. There is no action required on your part: no forms to complete and no claim forms to file. Please note that you cannot use your WageWorks Card for incentive credits.

If you complete a Health Assessment, your incentive credits are available sometime after March 1, 2016. If you get an annual physical or complete a four-call engagement with ActiveHealth (if eligible), your incentive credits are available as soon as administratively possible after you complete the task. Please note that **incentive credits cannot be used to reimburse claims processed before the date the reward is credited** to your HSA, HRA or Incentive Credit Account (whichever applies). For example, if you go to the doctor on January 24 and then have an annual physical (for a $125 incentive credit) on February 17, you will not be reimbursed for your January 24 office visit. You will, however, be reimbursed for any office visits or other eligible out-of-pocket expenses for claims paid after the date the incentive credit is added to your account.

* Time between telephone coaching sessions must exceed a two-week time period. In order to achieve the four-call requirement to earn the incentive, you will need a minimum of eight weeks to complete them.

Incentive balances roll over from year to year. Here's how it works for each type of account:

- **HSA:** Any incentive credits deposited to your HSA become part of your account balance and are yours to use for eligible expenses at any time in the future.*
- **HRA:** Any Benefit Dollars remaining in your HRA on December 31, 2015 are available in the 2016 Plan Year.* **Credits are never paid out in cash,** nor do they become payable when you terminate employment with L-3. If you have unspent credits when your employment ends, you forfeit them. However, if you elect COBRA, unspent credits remain available to you for as long as your COBRA coverage continues.
- **WageWorks Incentive Credit Account:** Any incentive credits remaining in your WageWorks Incentive Credit Account on December 31, 2015, are available in the 2016 Plan Year.* **Credits are never paid out in cash,** nor do they become payable when you terminate employment with L-3. If you have unspent credits when your employment ends, you forfeit them. However, if you elect COBRA, unspent credits remain available to you for as long as your COBRA coverage continues.

Using an FSA with your Incentive Credit Account. If you're in the Aetna Choice POS II, Aetna Elect Choice EPO or Aetna Out-of-Area Medical Plan, your Incentive Credit Account is set up to automatically pay for your eligible out-of-pocket expenses first, before your Health Care Flexible Spending Account (HCFSA). However, using the WageWorks website, you can shut off this automatic process (in advance only) by logging on to your account at www.wageworks.com and turning off "streamlining." Once you do, the Incentive Credit Account will no longer release funds and you can use your HCFSA to pay for out-of-pocket expenses. However, please note that you must reactivate the streamlining feature in order for incentive credits to be released going forward. Incentive credits can only be used to pay for claims processed after the feature is once again activated.

The Incentives Program described here is a Company-wide program and is independent of any local business unit wellness programs. Please contact your local Human Resources Department for more information about local programs.

* If you are enrolled in the Aetna Choice POS II or Aetna Elect Choice EPO Medical Plan in 2015 and you enroll in either Aetna HealthFund HRA for 2016, your remaining 2015 incentive credits will roll over automatically to your 2016 HRA account as additional Benefit Dollars in April 2016. No action is required on your part. However, if you are enrolled in either Aetna HealthFund HRA Medical Plan in 2015 and choose to enroll in a different medical plan for 2016, any incentive credits remaining in your HRA as of December 31, 2015, will not be transferred. If you choose to enroll in the Aetna HSA Medical Plan for 2016, any incentive credits remaining in your HRA or WageWorks Incentive Credit Account as of December 31, 2015, will not be transferred.

If you don't use all of your Incentive Credits in a calendar year, that's not a problem. They roll over from year to year.

ACTIVEHEALTH MANAGEMENT

To help support a Company-wide "culture of health," L-3 utilizes ActiveHealth Management as our health and condition management partner.* ActiveHealth, an independent company that specializes in chronic condition and overall health management, offers tools and resources to help you take an active role in managing your own health. All services are free to you and your spouse and information is always kept strictly confidential.

MyActiveHealth.com: Online Health Tools and Resources

MyActiveHealth.com is an online health management tool designed to make managing your health easier and more convenient. In addition to completing a Health Assessment (see page 5), you can use MyActiveHealth to store and retrieve medical information such as test results and immunizations; set reminders for scheduling doctor visits and renewing prescriptions; access your medical files online from home, work or the doctor's office; keep health information for each family member organized; track your progress in improving your health numbers; and much more. To get started, visit **www.myactivehealth.com/L-3com.** (If it is your first time, you will need to register and create an account.)

Condition Management Program

ActiveHealth has a team of nurse coaches who work with eligible participants to better understand and manage chronic conditions. If you or your spouse has been identified (through claims data or the results of your Health Assessment) as having, or being at risk for, a chronic condition, you may choose to participate in the Condition Management Program. Your nurse coach will work with you one-on-one to explore ways to best manage your condition and overall health. Phone calls with your nurse coach give you the opportunity to:

- better understand your doctor's recommendations
- formulate questions for your next doctor's visit
- review your medications
- learn more about your condition
- understand how to recognize warning signs that may require medical attention.

Your nurse coach will help you set health goals and discuss how adjusting lifestyle factors such as diet, weight and exercise can help you meet those goals.

Nurse coaches are not meant to take the place of your doctor or other health care provider; rather, they provide support between doctor visits and can help you find ways to improve the quality of your life. Your nurse coach will help you see "the big picture" and track the details of your treatment at the same time. This can be especially useful if you see several physicians and have multiple prescriptions for your conditions. Plus, if you work with a nurse coach for at least four phone calls you'll receive a $300 incentive credit (see page 5).

EVERYTHING IS CONFIDENTIAL

All information you provide to ActiveHealth is confidential whether in a Health Assessment, on MyActiveHealth.com or through interactions with your nurse coach. ActiveHealth will never share personal health information with L-3 or anyone else.

* ActiveHealth provides health and condition management services to participants enrolled in these national, self-insured medical plans only: Aetna HSA Medical Plan, Aetna HealthFund HRA I, Aetna HealthFund HRA II, Aetna Choice POS II, Aetna Elect Choice EPO and Aetna Out-of-Area.

YOUR MEDICAL COVERAGE OPTIONS

If you want Company-sponsored medical coverage you must elect it by enrolling with the L-3 Benefit Center. At some L-3 business units, employees may choose between one or more of the national self-insured medical plans described in this *Benefit Planner*, and a local Health Maintenance Organization. Employees eligible for our national self-insured medical plans (Aetna HSA Medical Plan, Aetna HealthFund HRA I, Aetna HealthFund HRA II, Aetna Choice POS II and Aetna Elect Choice EPO) can visit the Benefit Center's Decision Center, as described below.

High deductible health plans. L-3 offers three high deductible health plan (HDHP) options: the Aetna HSA Medical Plan, the Aetna HealthFund HRA I Medical Plan and the Aetna HealthFund HRA II Medical Plan. These plans generally feature lower monthly contributions in exchange for higher potential cost-sharing when expenses are incurred. Even with the higher potential cost-sharing, though, you may be better off electing an HDHP because the contribution savings would more than cover the HDHP's deductible or coinsurance requirements. The Decision Center's Health Plan Evaluator tool (as described at right) can help you determine which plan makes the most economic sense for you.

Out-of-Area Plan. If your home ZIP code is outside the provider networks in L-3's self-insured national medical plans, you will be offered the Aetna Out-of-Area Plan. Look for more information about the Aetna Out-of-Area Plan on the Benefit Center website.

Foreign-based employees. Employees on a U.S. payroll who are on extended assignment (generally six months or more) outside the United States generally have only one medical plan option available: the Aetna International Medical Plan. See page 28 for more information.

Local plans. Some L-3 business units also offer local Health Maintenance Organizations (HMOs) or other local plans. If the local plan is an HMO, you may be required to select a Primary Care Physician from the HMO's provider directory. An HMO generally does not pay benefits for care that is not provided or actively managed by your PCP.

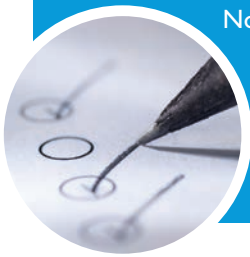
To find out if local plans are available at your location, please refer to your *Personalized Enrollment Worksheet*. Look for more information about local plans on the Benefit Center website.

Visit the Decision Center Before You Choose Your Medical Plan

Before you make your 2016 medical plan election, be sure to visit the Decision Center, which features these easy-to-use interactive tools:

- A **Health Plan Evaluator** that helps you choose the most cost-effective health plan option. This tool shows your personalized bottom-line cost for each plan available to you, factoring in your L-3 Aetna claim history as well as each plan's monthly cost of coverage, deductibles, copays/coinsurance, Benefit Dollars, incentive credits and other relevant figures. It can help you understand not only the true cost of health care, but your own personal costs.
- A **Comparison Module** that offers a customized side-by-side view of medical plan details based on your family profile and cost. It can help you focus on how each plan covers the services that are most applicable to your own experience.
- A **Savings Account Estimator** that helps you determine the appropriate amount to contribute to a Health Care FSA or HSA. It takes into account medical plan design, your estimated expenses, your basic tax profile and other factors to generate a personalized tax savings estimate.

The Decision Center is designed to make it easier for you to make an informed choice about your medical plan option. The best way to gauge how helpful it can be is to try it out yourself. To get started, look for the Decision Center link on the Benefit Center's home page.



Not all plans described in this *Benefit Planner* are available at all business units. The plans available at your location are shown on your *Personalized Enrollment Worksheet.*

AETNA HSA MEDICAL PLAN

The Aetna HSA Medical Plan is a high deductible health plan, as described on page 9. This Plan offers lower payroll contributions, along with the opportunity to benefit from a Health Savings Account (HSA). The Plan gives you direct access to a network of doctors and hospitals that charge eligible participants lower fees. You can see any provider in the network at any time; you are not required to designate a Primary Care Physician or get a referral. When you need care, you have the choice of going In- or Out-of-Network. Benefits are higher In-Network.

This Plan has two parts:

- **Health Coverage.** The HSA-compatible medical plan, administered by Aetna, has the same Aetna network of providers as our other Aetna-administered plans. The Plan requires an annual deductible before it pays benefits and provides the protection of an annual out-of-pocket maximum. Annual checkups and other preventive care are covered at 100%, with no deductible required. Other eligible expenses are covered at 85% after the deductible when you use In-Network providers. You can choose to pay your share of the cost with your HSA, as described below, or with money out of your own pocket.
- **The Health Savings Account (HSA).** When you enroll in the HSA plan, you gain access to a special, tax-advantaged savings account known as a Health Savings Account. The HSA allows you to make pre-tax contributions which you can use for qualified out-of-pocket medical expenses, including deductibles and coinsurance. The HSA can be a very effective tool to build savings and invest for your future medical expenses (including retiree medical expenses).

  The way your HSA is opened depends on how you enroll:

  - **If you enroll on the Benefit Center website,** Fidelity will automatically open a Health Savings Account on your behalf (as long as you have a valid street address on file with the Benefit Center; see page 11). Please note that you must acknowledge that you have reviewed the HSA "Terms and Conditions" to complete your enrollment in the Aetna HSA Medical Plan.

- **If you enroll over the phone,** a Health Savings Account will **not** be opened automatically. You must do it yourself, by logging on to your Fidelity NetBenefits homepage. From the homepage, click *Open* next to Health Savings Account. (If you do not have access to NetBenefits, contact a Fidelity Representative at 1-800-354-7125 for an application.) You also must have a valid street address on file with the Benefit Center, as described on page 11.

  Your account is funded from three potential sources: your contributions, any amounts you earn under the L-3 Incentive Credit Program, and any interest or investment income your HSA earns. You pay no taxes on your HSA contributions, interest/investment earnings or the HSA funds you receive as reimbursements, provided you use your account only for qualified health expenses. That is, HSA money is untaxed when it goes in, when it grows, and when it comes out. What's more, you own your HSA and take it with you if you switch jobs or retire.

Getting Started and Keeping Track of Your HSA

When you make your annual enrollment elections, you may also elect to make pre-tax contributions to the HSA. Once you do you'll receive a welcome package from Fidelity, which will contain instructions on how to properly set up and use your account. You may contribute up to the following annual limits:

- Single Coverage: $3,350
- Family Coverage: $6,750
- Catch-Up (age 55 or older): $1,000 additional

Once your Fidelity HSA is established, you'll be able to manage it and track your balance on your Fidelity NetBenefits homepage, along with your 401(k) and Employee Stock Purchase Plan accounts. Because the HSA is your account, you can stop or change your contribution elections at any time by visiting your Fidelity NetBenefits homepage or by calling 1-800-354-7125.

Note: Fidelity cannot set up an HSA account for you if the address you have in the Benefit Center is a PO Box, according to U.S. Government requirements. A valid **street address** must be on file with the Benefit Center in order to establish a Health Savings Account with Fidelity. If you do not have a valid street address on file (i.e., you have PO box address but not a street address):

- Fidelity will contact you to request that you change to a valid street address at the Benefit Center, which you must do prior to making any HSA deposit.
- The Benefit Center will enroll you in the Aetna HSA Medical Plan, regardless of whether or not you have provided the street address as needed for the Fidelity HSA. However, you cannot make an HSA contribution—even if you have elected to do so—or receive any incentive credits you may have earned until your account is in good order.

Incentive Credits and Your HSA. Any incentive credits you earn for taking the Health Assessment, getting a checkup or, if you qualify, engaging with ActiveHealth are deposited as cash into your HSA. Your enrolled spouse can earn incentives, too. But remember: it is your responsibility to make sure that your contributions plus your incentive credits don't put you over the annual IRS limit.

Investment opportunity. When you first open your Fidelity HSA your contributions are deposited into what's known as a "cash core position," which is similar to a money market account and earns interest. Once you reach a minimum balance of $2,500 you can invest in a wide variety of options, including more than 5,000 mutual funds, individual stocks and bonds, Treasuries, CDs, and more. Any earnings on your investments are automatically reinvested and grow tax free. (As with all investments, there may be investment fees depending on your investment decisions. Ask about these or other fees if you decide to invest your account balance.)

Transferring assets from another HSA. You may transfer funds from another HSA (such as an HSA you established with a previous employer) to your Fidelity HSA through a transfer of assets transaction so long as the account type and registration are the same. The tax advantages will stay in effect—and transfers are not included when calculating your maximum annual HSA contribution amount. To get started with a transfer of assets, visit your Fidelity NetBenefits homepage or call 1-800-354-7125.

Using Your HSA

When you need care, it's your choice whether to use your HSA to pay for medical expenses or to pay out of your pocket. There are multiple ways to use your HSA for payment or reimbursement of qualified medical expenses, including:

- **Fidelity HSA debit card.** You'll receive a Fidelity HSA debit card to use at the point of sale for qualified medical expenses. Many providers will also accept your Fidelity HSA debit card for payment of an invoice you received in the mail. You can request debit cards for your spouse and eligible dependents, too.

You cannot have a regular Health Care Flexible Spending Account if you have an HSA. That's why there's a special dental-and-vision-care-only FSA just for HSA users, as described on page 44. Also refer to page 48 for details on what happens with your HCFSA and your HSA if you do not exhaust your HCFSA by December 31, 2015.

- **Fidelity BillPay® for Health Savings Accounts.** This online bill paying service enables you to make payments to health care providers, companies, and individuals from your computer. You can also set up an automatic payment schedule, reimburse yourself for out-of-pocket qualified medical expenses, and keep track of all payments and activity.
- **Fidelity HSA checkbook.** Use your Fidelity HSA checkbook to pay for qualified medical expenses at the point of sale or to make a payment for an invoice you received in the mail. You can even write a check to reimburse yourself for qualified medical expenses.
- **Save it for later.** To take advantage of the long-term growth potential of your HSA, you may choose to pay for a qualified medical expense out of pocket rather than use the funds in your HSA. If you do pay out of pocket, you may reimburse yourself from your HSA at any time in the future without penalty.

If you pay for an eligible health care expense upfront and would like to reimburse yourself from your HSA, the process is not automatic. You will need to actively request reimbursement, and if you don't have enough in your account to cover the expense, you'll need to wait until your account balance reaches that amount. To ensure you're reimbursed, log on to your Fidelity NetBenefits homepage to view your HSA balance. Once there is enough to cover the expense you've paid upfront, you can withdraw that amount. Or, you can leave the money in your account to grow over time.

Reimbursements for your eligible medical expenses are not automatic. To request a withdrawal—or to make sure you have enough in your HSA to cover the expense—visit your Fidelity NetBenefits homepage or call 1-800-354-7125.

Tax penalties apply to non-qualified withdrawals. If you use your HSA to pay for ineligible expenses or for a medical expense that was incurred before your HSA was established, you will be taxed and may be subject to an additional 20% penalty. Please make sure you save your receipts and other records to show that you used your HSA money to pay for or reimburse yourself only for eligible expenses. Remember, you are responsible for the tax consequences associated with contributions to and withdrawals from your HSA.

SAMPLE HSA ELIGIBLE MEDICAL EXPENSES

- Health plan deductibles and coinsurance
- Most medical care and services
- Dental and vision care services
- Prescription drugs and insulin
- Medicare premiums (if age 65 or older)

Note: These expenses must not already be covered by your medical plan, and health insurance premiums generally do not qualify. For more information about HSAs and qualified medical expenses, refer to IRS Publications 969 and 502 at www.irs.gov or consult a tax professional.

Prescription Drug Coverage

Prescription drugs (such as antibiotics your doctor may prescribe on a one-time basis) are covered like any other eligible medical expense, with one exception: preventive medications. The Plan covers certain preventive medications at the In-Network coinsurance level (85%) without your needing to meet your annual deductible first. Preventive medications are used to prevent a disease or condition, complications from a disease, or reoccurrence of a condition. They are generally prescribed for people who may be at risk for certain diseases or conditions but who are not yet showing signs, and they do not include drugs or medicines for treatment of an existing illness or condition. A full list of covered medications is available on Aetna's website or by calling Aetna Member Services at 1-800-345-5839. Your medication must be on Aetna's list to be covered. Please note that this list of preventive drugs is different and separate from the list of chronic and preventive medications used in connection with L-3's Aetna HealthFund HRA Plans.

Please note there are special requirements for filling maintenance medication prescriptions, as described on page 33. Also, special rules apply to specialty drugs (powerful, expensive drugs used to treat certain serious medical conditions), as described on page 34.

IMPORTANT NOTE: You Must Be Qualified to Contribute to a Health Savings Account

The eligibility requirements to open and contribute to a Health Savings Account (HSA) described on page 2, as well as the annual individual and family contribution limits shown on page 11, are mandated by the Internal Revenue Service (IRS), not by L-3. Individuals who enroll in an HSA but are later determined to be ineligible for that account, or who contribute more than the applicable annual limit, are subject to financial penalties from the IRS. It is your responsibility to ensure that you meet all HSA eligibility requirements and contribution limits. Neither Fidelity, Aetna nor the Benefit Center will be responsible for monitoring your HSA participation to ensure that you don't violate IRS rules.

The information about HSAs in this *Benefit Planner* is intended to provide a general description of HSAs to help you understand the personal tax consequences associated with your contributions to and receipt of incentive credits in your HSA. It is not intended to provide you with personal tax or financial planning advice. The rules relating to HSAs are complicated and can be impacted by factors unrelated to your Plan participation (such as your enrollment in Medicare and your participation in other medical coverage through a spouse's plan). It is recommended that you review your individual situation with your personal tax advisor or financial planner and/or Fidelity. You are responsible for the tax consequences associated with the contributions to and withdrawals from your HSA. L-3 will not be held responsible for any use/misuse of the information about HSAs provided in this document when making personal tax or financial planning decisions, including decisions made in connection with the preparation of your personal income tax return.

You can learn more about your HSA by visiting your Fidelity NetBenefits homepage or by calling 1-800-354-7125 to speak with a Fidelity representative.

AETNA HSA MEDICAL PLAN
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NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
How You Access Care	Go to any network provider.	Go to any licensed/certified provider.
Basis for Reimbursement	In most cases, In-Network reimbursements are based on the **negotiated charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Reimbursements for preventive care are also based on the negotiated charge.	In most cases, Out-of-Network reimbursements are based on the **reasonable and customary charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Reimbursements for preventive care are also based on the reasonable and customary charge.
Annual Deductible		
• Employee only	$1,500	
• Employee and spouse	$2,250	
• Employee and child(ren)	$2,250	
• Employee and family	$3,000	
	The annual deductible applies to all eligible expenses, In-Network and Out-of-Network care combined, except for In-Network preventive care. Your annual deductible depends on the coverage level you choose.	
Incentive Credits	You and your spouse have three opportunities to increase your HSA balance (see page 5): • Take an online Health Assessment through ActiveHealth between January 1, 2016, and February 29, 2016: $75 per person (new hires have until December 31; see page 5) • Get an annual physical during 2016: $125 per person • Complete a four-call engagement with ActiveHealth during 2016: $300 per person (if identified as eligible for condition management).	
Coinsurance	15%	35%
	Once you meet the annual deductible, you pay these percentages and Health Coverage pays the rest for additional eligible health care expenses.	
Annual Out-of-pocket Maximum	The annual out-of-pocket maximums below include the annual deductible.	
• Employee only	$3,500	$5,000
• Employee and spouse	$5,250	$7,500
• Employee and child(ren)	$5,250	$7,500
• Employee and family	$6,550	$10,000
	Coinsurance amounts you pay for eligible In-Network expenses apply toward the Out-of-Network annual out-of-pocket maximum, and vice versa. **Please note the following do not apply to the annual out-of-pocket maximum:** • any amounts above reasonable and customary charges • the difference between the cost of a brand-name and a generic drug when a generic is available but you choose the brand-name.	
Lifetime Maximum Benefit	Unlimited	
Preventive Care		
• Annual physical examination	No cost (no deductible); Plan pays 100%	35% after deductible
• Routine pediatric care (to age 19)	No cost (no deductible); Plan pays 100%	35% after deductible
• Routine gynecological exam	No cost (no deductible); Plan pays 100%	35% after deductible
• Routine mammograms	No cost (no deductible); Plan pays 100%	35% after deductible

continued

You cannot have a regular Health Care Flexible Spending Account if you have an HSA. That's why there's a special dental-and-vision-care-only FSA just for HSA users, as described on page 44. Also refer to page 48 for details on what happens with your HCFSA and your HSA if you do not exhaust your HCFSA by December 31, 2015.

AETNA HSA MEDICAL PLAN
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NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
Outpatient Care		
• Physician office visit	15% after deductible	35% after deductible
• Specialist office visit	15% after deductible	35% after deductible
• Chiropractic care	15% after deductible	35% after deductible
	Combined maximum of 20 visits/year In-Network and Out-of-Network	
• Outpatient surgery	15% after deductible	35% after deductible
• X-ray and lab tests	15% after deductible (billed by separate facility)	35% after deductible
Inpatient Hospital Care		
• Physician and surgical services	15% after deductible	35% after deductible*
• Semi-private room and board	15% after deductible	35% after deductible*
Emergency Care		
• Emergency room visit	15% after deductible (no coverage for non-emergency use of emergency room)	
• Ambulance service	15% after deductible	15% after deductible for emergency; 35% after deductible for non-emergency
• Walk-in clinic	15% after deductible	35% after deductible
• Urgent care facility visit	15% after deductible	35% after deductible
Maternity Care		
• Prenatal office visits	No cost (no deductible); Plan pays 100%	35% after deductible*
• All other physician's services	15% after deductible	35% after deductible*
• Hospital services		
• Mother	15% after deductible	35% after deductible*
• Child	15% after deductible	35% after deductible*
Mental Health/Substance Abuse Treatment*		
• Inpatient	15% after deductible	35% after deductible
• Outpatient (therapist's visits)	15% after deductible	35% after deductible
Other Covered Services		
• Physical, occupational or speech therapy	15% after deductible	35% after deductible
	Combined maximum of 90 visits/year In-Network and Out-of-Network	
• Outpatient (private duty) nursing care	15% after deductible	35% after deductible
	Combined maximum of 180 visits/year In-Network and Out-of-Network	
• Convalescent (skilled nursing) facility	15% after deductible	35% after deductible*
	Combined maximum of 120 days/year In-Network and Out-of-Network	
• Home health care	15% after deductible	35% after deductible*
	Combined maximum of 180 visits/year In-Network and Out-of-Network	
• Hospice care	15% after deductible	35% after deductible*
Prescription Drugs**	Administered by Aetna Pharmacy Management	
Retail (up to a 30-day supply)	15% after deductible	15% after deductible
Mail-order (up to a 90-day supply)***	15% after deductible	No coverage
Dependent Age	Dependent children enrolled in the plan are covered to age 26	

* It is strongly recommended that you or your provider call Aetna Member Services before you or your enrolled dependents receive this type of medical care

** There is special coverage of preventive/chronic and OTC medications, as described on page 33

*** Mail-order is mandatory for maintenance medications; see page 32 for more information about using the mail-order pharmacy

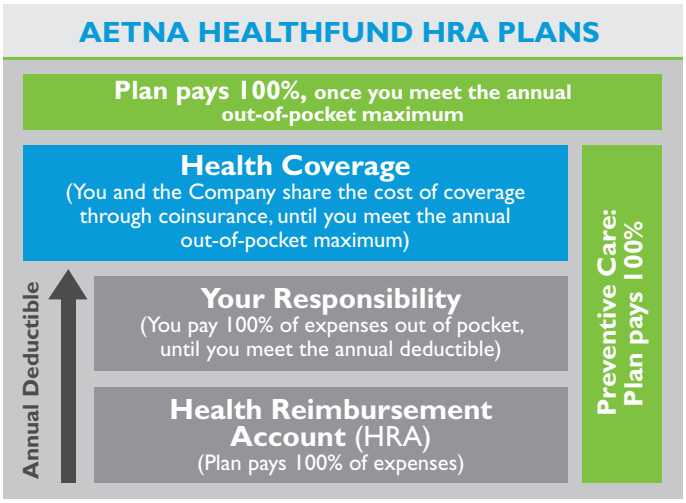
AETNA HEALTHFUND HRA MEDICAL PLANS

The Aetna HealthFund HRA Medical Plans are high deductible medical plans, as described on page 9. These Plans put you—the consumer of health care services and supplies—in charge of how you spend your health care dollars. The Plans give you direct access to a network of doctors and hospitals that charge lower fees for services they provide to eligible participants. You can see any physician/specialist in the network at any time; you are not required to designate a Primary Care Physician or get a referral.

Each HRA Plan has three components:

- **Health Reimbursement Account (HRA).** The Plan establishes an individual account for you, known as an HRA. **The Company funds** this account with Benefit Dollars that you use to pay for eligible medical expenses. You may use this account to cover eligible In-Network or Out-of-Network expenses. Amounts remaining in your HRA at year-end roll over to the next year and are added to that year's HRA allocation to cover future medical costs.
- **Your Responsibility.** If you spend all of the Benefit Dollars in your HRA, **you pay 100%** of your health care expenses out of pocket until you meet the annual deductible. Once you satisfy the annual deductible, the Health Coverage portion of the Plan begins.
- **Health Coverage.** Once you satisfy the annual deductible, **you and the Company share the cost** of your eligible medical expenses through coinsurance. Coverage depends on the Plan you elect and whether you use In-Network or Out-of-Network providers for your care. Preventive care is covered at 100% and is not subject to the deductible provided you go In-Network. If you reach the annual out-of-pocket maximum, the Plan will pay 100% of eligible expenses for the rest of the Plan Year.

In summary, when you incur eligible expenses, you pay them by first using the Company-provided Benefit Dollars deposited in your HRA, then by using money out of your own pocket (Your Responsibility), until you reach the annual deductible. Once you meet the annual deductible, Health Coverage begins and you pay coinsurance.



Two HRA Plans to choose from. There are two Aetna HealthFund HRA Medical Plans:

- **HRA I:** You pay less out of pocket when you receive care because you have a larger HRA allocation (see page 17) and lower coinsurance (10% In-Network/30% Out-of-Network) to pay, but you pay more upfront through payroll deductions.
- **HRA II:** You pay more out of pocket when you receive care because you have a smaller HRA allocation (see page 17) and higher coinsurance (20% In-Network/40% Out-of-Network) to pay, but you pay less upfront through payroll deductions.

FREE PREVENTIVE CARE IN-NETWORK

When you stay In-Network for eligible preventive care, it is covered in full and is not deducted from your Health Reimbursement Account, nor does it apply to the annual deductible. You may, if you like, go Out-of-Network for preventive care and use your Health Reimbursement Account to pay for it, but that depletes your HRA and prevents you from using it for other expenses.

The HRA and Annual Deductible

For the first Plan Year in which you are enrolled in the HRA Plan you elect, it will take both the Benefit Dollars in your HRA and money out of your pocket (Your Responsibility) to meet the annual deductible, as shown in the chart below. If you have Benefit Dollars left over in your HRA at year-end, they will roll over automatically to your HRA for the next Plan Year and will be added to that year's allocation. The more Benefit Dollars you have in your HRA, the less you must pay out of your own pocket (Your Responsibility). In future years, the rollover feature could even mean you are able to cover the deductible entirely with the Benefit Dollars in your HRA.

Coverage Level	HRA Allocation Each Plan Year	+	Your Responsibility (Paid out of your pocket)	=	Annual Deductible
HRA I					
Employee only	$800	+	$1,200	=	$2,000
Employee and spouse	$1,100	+	$1,900	=	$3,000
Employee and child(ren)	$1,300	+	$1,700	=	$3,000
Employee and family	$1,600	+	$2,400	=	$4,000
HRA II					
Employee only	$300	+	$1,700	=	$2,000
Employee and spouse	$350	+	$2,650	=	$3,000
Employee and child(ren)	$550	+	$2,450	=	$3,000
Employee and family	$600	+	$3,400	=	$4,000

If you are a new hire or enroll mid-year due to a qualifying event. If you enroll during the year, your HRA allocation will be pro-rated on a monthly basis. Your annual deductible will not be pro-rated.

If you leave the Company. When you terminate employment, you forfeit amounts remaining in your HRA, unless you elect COBRA coverage.

Prescription Drug Coverage

Prescription drugs (such as antibiotics your doctor may prescribe on a one-time basis) are covered like any other eligible medical expense. There are two exceptions:

- **Preventive and chronic medications:** If you have certain conditions such as hypertension, high cholesterol, diabetes, asthma or osteoporosis, the HRA Plans cover **certain** maintenance medications without your needing to meet your annual deductible first. The In-Network coinsurance (10% of the cost of the drug under HRA I; 20% under HRA II) is all that is applied to your HRA and to the deductible. A full list of covered medications is available on Aetna's website (http://www.aetna.com/assets_aetnaCom/documents/chronic-and-preventive-medicine-list.pdf) or by calling Aetna Member Services at 1-800-345-5839. Your medication must be on Aetna's list to be covered.
- **Over-the-counter medications:** The Plan covers OTC store-brand and brand-name Axid, Claritin, Nexium 24HR, Nicoderm, Nicorette, Pepcid, Prevacid, Prilosec and Zantac without your needing to meet your annual deductible first. You are responsible for the In-Network coinsurance only, depending on the option you choose. See page 33 for more information about how to use the OTC drug program.

Please note there are special requirements for filling maintenance medication prescriptions, as described on page 33. Also, special rules apply to specialty drugs (powerful, expensive drugs used to treat certain serious medical conditions), as described on page 34.

WellMatch's convenient online tool can help you make the most of your Health Reimbursement Account and keep your out-of-pocket expenses to a minimum. Search for network providers and medical services based on price, quality and location, and know the cost of a procedure before you go. Visit www.WellMatchHealth.com to get started.

THE AETNA HEALTHFUND HRA I
1-800-345-5839 • WWW.AETNA.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE				
	IN-NETWORK				OUT-OF-NETWORK
How You Access Care	Go to any network provider.				Go to any licensed/certified provider.
Basis for Reimbursement	In most cases, In-Network reimbursements are based on the negotiated charge for medically necessary eligible expenses and are subject to the annual deductible and to pre-certification where required. Reimbursements for preventive care are also based on the negotiated charge.				In most cases, Out-of-Network reimbursements are based on the reasonable and customary charge for medically necessary eligible expenses and are subject to the annual deductible and to pre-certification where required. Reimbursements for preventive care are also based on the reasonable and customary charge.
Annual Deductible (HRA + Your Responsibility)	**HRA Annual Allocation**	**+**	**Your Responsibility**	**=**	**Annual Deductible**
• Employee only	$800	+	$1,200	=	$2,000
• Employee and spouse	$1,100	+	$1,900	=	$3,000
• Employee and child(ren)	$1,300	+	$1,700	=	$3,000
• Employee and family	$1,600	+	$2,400	=	$4,000
	The annual deductible applies to all eligible expenses, In-Network and Out-of-Network care combined, except for In-Network preventive care. Your annual deductible depends on the coverage level you choose.				
Incentive Credits	You and your spouse have three opportunities to increase your HRA allocation (see page 5): • Take an online Health Assessment through ActiveHealth between January 1, 2016, and February 29, 2016: $75 per person (new hires have until December 31; see page 5) • Get an annual physical during 2016: $125 per person • Complete a four-call engagement with ActiveHealth during 2016: $300 per person (if identified as eligible for condition management).				
Coinsurance	10%				30%
	If you spend your HRA and meet Your Responsibility, you pay these percentages and Health Coverage pays the rest for additional eligible health care expenses.				
Annual Out-of-pocket Maximum	The annual out-of-pocket maximums below include the annual deductible.				
• Employee only	$3,500				$5,000
• Employee and spouse	$5,250				$7,500
• Employee and child(ren)	$5,250				$7,500
• Employee and family	$7,000				$10,000
	Coinsurance amounts you pay for eligible In-Network expenses apply toward the Out-of-Network annual out-of-pocket maximum, and vice versa. **Please note the following do not apply to the annual out-of-pocket maximum:** • any amounts above reasonable and customary charges • the difference between the cost of a brand-name and a generic drug when a generic is available but you choose the brand-name.				
Lifetime Maximum Benefit	Unlimited				
Preventive Care					
• Annual physical examination	No cost (no deductible); Plan pays 100%				30% after deductible
• Routine pediatric care (to age 19)	No cost (no deductible); Plan pays 100%				30% after deductible
• Routine gynecological exam	No cost (no deductible); Plan pays 100%				30% after deductible
• Routine mammograms	No cost (no deductible); Plan pays 100%				30% after deductible

continued

THE AETNA HEALTHFUND HRA I
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NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
Outpatient Care		
• Physician office visit	10% after deductible	30% after deductible
• Specialist office visit	10% after deductible	30% after deductible
• Chiropractic care	10% after deductible	30% after deductible
	Combined maximum of 20 visits/year In-Network and Out-of-Network	
• Outpatient surgery	10% after deductible	30% after deductible
• X-ray and lab tests	10% after deductible (billed by separate facility)	30% after deductible
Inpatient Hospital Care		
• Physician and surgical services	10% after deductible	30% after deductible*
• Semi-private room and board	10% after deductible	30% after deductible*
Emergency Care		
• Emergency room visit	10% after deductible (no coverage for non-emergency use of emergency room)	
• Ambulance service	10% after deductible	10% after deductible for emergency; 30% after deductible for non-emergency
• Walk-in clinic	10% after deductible	30% after deductible
• Urgent care facility visit	10% after deductible	30% after deductible
Maternity Care		
• Prenatal office visits	No cost (no deductible); Plan pays 100%	30% after deductible*
• All other physician's services	10% after deductible	30% after deductible*
• Hospital services		
• Mother	10% after deductible	30% after deductible*
• Child	10% after deductible	30% after deductible*
Mental Health/Substance Abuse Treatment*		
• Inpatient	10% after deductible	30% after deductible
• Outpatient (therapist's visits)	10% after deductible	30% after deductible
Other Covered Services		
• Physical, occupational or speech therapy	10% after deductible	30% after deductible
	Combined maximum of 90 visits/year In-Network and Out-of-Network	
• Outpatient (private duty) nursing care	10% after deductible	30% after deductible
	Combined maximum of 180 visits/year In-Network and Out-of-Network	
• Convalescent (skilled nursing) facility	10% after deductible	30% after deductible*
	Combined maximum of 120 days/year In-Network and Out-of-Network	
• Home health care	10% after deductible	30% after deductible*
	Combined maximum of 180 visits/year In-Network and Out-of-Network	
• Hospice care	10% after deductible	30% after deductible*
Prescription Drugs**	Administered by Aetna Pharmacy Management	
Retail (up to a 30-day supply)	10% after deductible	10% after deductible
Mail-order (up to a 90-day supply)***	10% after deductible	No coverage
Dependent Age	Dependent children enrolled in the plan are covered to age 26	

* It is strongly recommended that you or your provider call Aetna Member Services before you or your enrolled dependents receive this type of medical care

** There is special coverage of preventive/chronic and OTC medications, as described on page 33

*** Mail-order is mandatory for maintenance medications; see page 32 for more information about using the mail-order pharmacy

THE AETNA HEALTHFUND HRA II
1-800-345-5839 • WWW.AETNA.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE				
	IN-NETWORK				OUT-OF-NETWORK
How You Access Care	Go to any network provider.				Go to any licensed/certified provider.
Basis for Reimbursement	In most cases, In-Network reimbursements are based on the **negotiated charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Reimbursements for preventive care are also based on the negotiated charge.				In most cases, Out-of-Network reimbursements are based on the **reasonable and customary charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Reimbursements for preventive care are also based on the reasonable and customary charge.
Annual Deductible (HRA + Your Responsibility)	**HRA Annual Allocation**	**+**	**Your Responsibility**	**=**	**Annual Deductible**
• Employee only	$300	+	$1,700	=	$2,000
• Employee and spouse	$350	+	$2,650	=	$3,000
• Employee and child(ren)	$550	+	$2,450	=	$3,000
• Employee and family	$600	+	$3,400	=	$4,000
	The annual deductible applies to all eligible expenses, In-Network and Out-of-Network care combined, except for In-Network preventive care. Your annual deductible depends on the coverage level you choose.				
Incentive Credits	You and your spouse have three opportunities to increase your HRA allocation (see page 5): • Take an online Health Assessment through ActiveHealth between January 1, 2016, and February 29, 2016: $75 per person (new hires have until December 31; see page 5) • Get an annual physical during 2016: $125 per person • Complete a four-call engagement with ActiveHealth during 2016: $300 per person (if identified as eligible for condition management).				
Coinsurance	20%				40%
	If you spend your HRA and meet Your Responsibility, you pay these percentages and Health Coverage pays the rest for additional eligible health care expenses.				
Annual Out-of-pocket Maximum	The annual out-of-pocket maximums below include the annual deductible.				
• Employee only	$3,500				$5,000
• Employee and spouse	$5,250				$7,500
• Employee and child(ren)	$5,250				$7,500
• Employee and family	$7,000				$10,000
	Coinsurance amounts you pay for eligible In-Network expenses apply toward the Out-of-Network annual out-of-pocket maximum, and vice versa. **Please note the following do not apply to the annual out-of-pocket maximum:** • any amounts above reasonable and customary charges • the difference between the cost of a brand-name and a generic drug when a generic is available but you choose the brand-name.				
Lifetime Maximum Benefit	Unlimited				
Preventive Care					
• Annual physical examination	No cost (no deductible); Plan pays 100%				40% after deductible
• Routine pediatric care (to age 19)	No cost (no deductible); Plan pays 100%				40% after deductible
• Routine gynecological exam	No cost (no deductible); Plan pays 100%				40% after deductible
• Routine mammograms	No cost (no deductible); Plan pays 100%				40% after deductible

continued

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
Outpatient Care		
• Physician office visit	20% after deductible	40% after deductible
• Specialist office visit	20% after deductible	40% after deductible
• Chiropractic care	20% after deductible	40% after deductible
	Combined maximum of 20 visits/year In-Network and Out-of-Network	
• Outpatient surgery	20% after deductible	40% after deductible
• X-ray and lab tests	20% after deductible (billed by separate facility)	40% after deductible
Inpatient Hospital Care		
• Physician and surgical services	20% after deductible	40% after deductible*
• Semi-private room and board	20% after deductible	40% after deductible*
Emergency Care		
• Emergency room visit	20% after deductible (no coverage for non-emergency use of emergency room)	
• Ambulance service	20% after deductible	20% after deductible for emergency; 40% after deductible for non-emergency
• Walk-in clinic	20% after deductible	40% after deductible
• Urgent care facility visit	20% after deductible	40% after deductible
Maternity Care		
• Prenatal office visits	No cost (no deductible); Plan pays 100%	40% after deductible*
• All other physician's services	20% after deductible	40% after deductible*
• Hospital services		
• Mother	20% after deductible	40% after deductible*
• Child	20% after deductible	40% after deductible*
Mental Health/Substance Abuse Treatment*		
• Inpatient	20% after deductible	40% after deductible
• Outpatient (therapist's visits)	20% after deductible	40% after deductible
Other Covered Services		
• Physical, occupational or speech therapy	20% after deductible	40% after deductible
	Combined maximum of 90 visits/year In-Network and Out-of-Network	
• Outpatient (private duty) nursing care	20% after deductible	40% after deductible
	Combined maximum of 180 visits/year In-Network and Out-of-Network	
• Convalescent (skilled nursing) facility	20% after deductible	40% after deductible*
	Combined maximum of 120 days/year In-Network and Out-of-Network	
• Home health care	20% after deductible	40% after deductible*
	Combined maximum of 180 visits/year In-Network and Out-of-Network	
• Hospice care	20% after deductible	40% after deductible*
Prescription Drugs**	Administered by Aetna Pharmacy Management	
Retail (up to a 30-day supply)	20% after deductible	20% after deductible
Mail-order (up to a 90-day supply)***	20% after deductible	No coverage
Dependent Age	Dependent children enrolled in the plan are covered to age 26	

* It is strongly recommended that you or your provider call Aetna Member Services before you or your enrolled dependents receive this type of medical care

** There is special coverage of preventive/chronic and OTC medications, as described on page 33

*** Mail-order is mandatory for maintenance medications; see page 32 for more information about using the mail-order pharmacy

AETNA CHOICE POS II MEDICAL PLAN

The Aetna Choice POS II Medical Plan gives you direct access to a network of doctors and hospitals that charge lower fees for services they provide to eligible participants. You can see any physician/specialist in the network at any time; you are not required to designate a Primary Care Physician or get a referral. Benefits depend on whether you decide to go In-Network or Out-of-Network for your care.

Highlights of How the Choice POS II Medical Plan Works

- Under the Choice POS II Medical Plan, your cost is lowest when you use In-Network medical care and treatment, defined as care or treatment provided by an Aetna Choice POS II network provider.
- Doctor's office visits are covered at 100% after you pay a $30/visit copay for generalists (general practitioners, family practitioners, internists and pediatricians) and a $50/visit copay for specialists.
- Hospitalization and surgery are covered at 85% after you pay a $150 per admission copay, as long as you use network doctors and hospitals and you or your network doctor pre-certifies all non-emergency hospital admissions.
- Other eligible In-Network expenses, such as those for outpatient surgery, private duty nursing, durable medical equipment and home health care, are covered at 85% (subject to Plan limits) after you satisfy the $500/individual ($1,000/family) annual deductible.
- The Plan covers a wide range of In-Network preventive services, including an annual check-up and well-baby care, at 100%, with no copay nor annual deductible.
- There are no claim forms to file for In-Network care.
- It's up to you to decide whether or not to use Choice POS II network providers each time you need medical attention.
- Most covered services received from providers outside the Choice POS II network are reimbursed at a percentage of the reasonable and customary charge after you satisfy the annual deductible.
- You can get your prescriptions filled at participating pharmacies. For maintenance drugs, you must use Aetna Rx Home Delivery (Aetna's mail-order pharmacy) or the Maintenance Choice Program. (See *The L-3 Communications Prescription Drug Plan,* page 31, for more information.)
- Vision expenses are covered two ways: through Vision One, which offers point-of-purchase discounts on a wide array of eye care needs, and through participation in the VSP Vision Care Plan (see page 40). You must enroll in the VSP Vision Care Plan to have vision coverage; participation is not automatic when you enroll in the Choice POS II Plan.

Refer to the Choice POS II Medical Plan SPD booklet for more information about what is—and isn't—covered, how to pre-certify, and other important information.

THE AETNA CHOICE POS II MEDICAL PLAN
1-800-345-5839 • WWW.AETNA.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
How You Access Care	Go to any network provider.	Go to any licensed/certified provider.
Basis for Reimbursement	In most cases, In-Network reimbursements are based on the **negotiated charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** where required. Reimbursements for preventive care are also based on the negotiated charge.	In most cases, Out-of-Network reimbursements are based on the **reasonable and customary charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Reimbursements for preventive care are also based on the reasonable and customary charge.
Incentive Credits	You and your spouse have three opportunities to earn incentive credits (see page 5): • Take an online Health Assessment through ActiveHealth between January 1, 2016, and February 29, 2016: $75 per person (new hires have until December 31; see page 5) • Get an annual physical during 2016: $125 per person • Complete a four-call engagement with ActiveHealth during 2016: $300 per person (if identified as eligible for condition management).	
Annual Deductible		
• Individual	$500	$1,000
• Family	$1,000	$2,000
Annual Out-of-Pocket Maximum		
• Individual	$3,000	$6,000
• Family	$6,000	$12,000
	Amounts you pay toward meeting the In-Network annual out-of-pocket maximum apply toward meeting the Out-of-Network annual out-of-pocket maximum, and vice versa.	
	Please note that the following do not apply to the annual out-of-pocket maximum: • prescription drug copays/coinsurance • amounts above the reasonable and customary charge • amounts you pay because you don't pre-certify the services and supplies required. You are responsible for paying these amounts in full.	
Lifetime Maximum Benefit	Unlimited	
Preventive Care		
• Annual physical examination	No copay; Plan pays 100%	35% after deductible
• Routine pediatric care (to age 19)	No copay; Plan pays 100%	35% after deductible
• Routine gynecological exam	No copay; Plan pays 100%	35% after deductible
• Routine mammograms	No copay; Plan pays 100%	35% after deductible
Outpatient Care		
• Physician office visit	$30	35% after deductible
• Specialist office visit	$50	35% after deductible
• Chiropractic care	$50/visit	35% after deductible
	Combined maximum of 20 visits/year In-Network and Out-of-Network	
• Outpatient surgery	15% after deductible	35% after deductible
• X-ray and lab tests	15% after deductible (billed by separate facility)	35% after deductible
Inpatient Hospital Care		
• Physician and surgical services	15% after deductible	35% after deductible*
• Semi-private room and board	15% after $150/admission copay	35% after deductible*

* Must be pre-certified

continued

THE AETNA CHOICE POS II MEDICAL PLAN
1-800-345-5839 • WWW.AETNA.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
Emergency Care		
• Emergency room visit		
• Facility charge	15% after $200 copay (ER copay waived if admitted; no coverage for non-emergency use of emergency room)	
• Physician services	15% after deductible	
• Ambulance service	15% after deductible	15% after deductible for emergency; 35% after deductible for non-emergency
• Walk-in clinic	$30 (generalist); $50 (specialist)	35% after deductible
• Urgent care facility visit	$50	35% after deductible
Maternity Care		
• Prenatal office visits	No cost; Plan pays 100%	35% after deductible*
• All other physician's services	15% after deductible	35% after deductible*
• Hospital services		
• Mother	15% after $150/admission copay	35% after deductible*
• Child	15% after deductible	35% after deductible*
Mental Health/Substance Abuse Treatment		
• Inpatient	15% after $150/admission copay	35% after deductible*
• Outpatient (therapist's visits)	$30 (provider's office); 15% after deductible (outpatient facility)	35% after deductible**
Other Covered Services		
• Physical, occupational or speech therapy	$30 copay (generalist); $50 copay (specialist); 15% after deductible (therapist)	35% after deductible*
	Combined maximum of 60 visits/year In-Network and Out-of-Network	
• Outpatient (private duty) nursing care	15% after deductible	35% after deductible
	Combined maximum of 70 shifts/year In-Network and Out-of-Network	
• Convalescent (skilled nursing) facility	15% after deductible	35% after deductible*
	Combined maximum of 90 days/year In-Network and Out-of-Network	
• Home health care	15% after deductible	35% after deductible
	Combined maximum of 120 visits/year In-Network and Out-of-Network	
• Hearing exam (one every 24 months)	$30 (generalist); $50 (specialist)	No coverage
• Hospice care	15% after deductible	35% after deductible*
	Combined maximum of 5 bereavement counseling visits/year In-Network and Out-of-Network	
Prescription Drugs	Prescription drug coverage provided under the L-3 Communications Prescription Drug Plan (see page 31)	
Dependent Age	Dependent children enrolled in the plan are covered to age 26	

* Must be pre-certified

** Certain outpatient mental health and substance abuse services and procedures must be pre-certified

AETNA ELECT CHOICE EPO MEDICAL PLAN

The Aetna Elect Choice EPO Medical Plan gives you direct access to a network of doctors and hospitals that charge lower fees for services they provide to eligible participants. You can see any physician/specialist in the network at any time without a referral. Eligible services and supplies received from network providers are covered under the Plan. A limited number of services and supplies received from non-network providers (e.g., emergency care, ambulance service, durable medical equipment and prosthetic devices) are also covered up to the reasonable and customary charge.

Highlights of How the Aetna Elect Choice EPO Medical Plan Works

- The Elect Choice EPO Medical Plan generally pays benefits only for care or treatment provided by an Aetna Elect Choice EPO network provider.
- Doctor's office visits are covered at 100% after you pay a $30/visit copay for generalists (general practitioners, family practitioners, internists and pediatricians) and a $50/visit copay for specialists.
- Hospitalization is covered at 85% after you pay a $150 per admission copay, as long as you use network doctors and hospitals and you pre-certify your care with Aetna.
- Other eligible expenses, such as those for outpatient surgery, private duty nursing, durable medical equipment and home health care, are covered at 85% (subject to Plan limits) after you satisfy the $500/individual ($1,000/family) annual deductible, as long as you pre-certify your care.
- The Plan covers a wide range of preventive services, including an annual check-up and well-baby care, at 100%, with no copay nor annual deductible.
- Care received from non-network providers is not covered under the Plan except in limited situations, as described in your SPD booklet.
- Treatment of mental health and substance abuse problems will be offered through a network of providers managed by Aetna. You must pre-certify your care through Aetna. As long as you go to a network facility and the stay has been pre-certified by Aetna, benefits are paid at 85% after a $150 per admission copay.
- You can get your prescriptions filled at participating pharmacies. For maintenance drugs, you must use Aetna Rx Home Delivery (Aetna's mail-order pharmacy) or the Maintenance Choice Program. (See *The L-3 Communications Prescription Drug Plan,* page 31, for more information.)
- Vision expenses are covered in two ways: through Vision One, which offers point-of-purchase discounts on a wide array of eye care needs, and through participation in the VSP Vision Care Plan (see page 40). You must enroll in the VSP Vision Care Plan to have vision coverage; participation is not automatic when you enroll in the EPO Medical Plan.

Refer to the Aetna Elect Choice EPO Medical Plan SPD booklet for more information about what is—and isn't—covered, how to pre-certify, and other important information.

AETNA ELECT CHOICE EPO MEDICAL PLAN
1-800-345-5839 • WWW.AETNA.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE
How You Access Care	Go to any network provider.
Basis for Reimbursement	Benefits for network care are based on the **negotiated charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-certification** where required. Benefits for preventive care are also based on the negotiated charge. Reimbursements for those services and supplies covered when received from non-network providers are based on the **reasonable and customary charge** for **medically eligible expenses** and are subject to **pre-certification** where required.
Incentive Credits	You and your spouse have three opportunities to earn incentive credits (see page 5): • Take an online Health Assessment through ActiveHealth between January 1, 2016, and February 29, 2016: $75 per person (new hires have until December 31; see page 5) • Get an annual physical during 2016: $125 per person • Complete a four-call engagement with ActiveHealth during 2016: $300 per person (if identified as eligible for condition management).
Annual Deductible	
• Individual	$500
• Family	$1,000
Annual Out-of-Pocket Maximum	
• Individual	$3,000
• Family	$6,000
	Please note that the following do not apply to the annual out-of-pocket maximum: • prescription drug copays/coinsurance • amounts above the reasonable and customary charge • amounts you pay because you don't pre-certify the services and supplies required. You are responsible for paying these amounts in full.
Lifetime Maximum Benefit	Unlimited
Preventive Care	
• Annual physical examination	No copay; Plan pays 100%
• Routine pediatric care (to age 19)	No copay; Plan pays 100%
• Routine gynecological exam	No copay; Plan pays 100%
• Routine mammograms	No copay; Plan pays 100%
Outpatient Care	
• Physician office visit	$30
• Specialist office visit	$50
• Chiropractic care	$50/visit (maximum 20 visits/year)
• Outpatient surgery	15% after deductible
• X-ray and lab tests	15% after deductible (billed by separate facility)
Inpatient Hospital Care*	
• Physician and surgical services	15% after deductible
• Semi-private room and board	15% after $150/admission copay

* Must be pre-certified

continued

AETNA ELECT CHOICE EPO MEDICAL PLAN
1-800-345-5839 • WWW.AETNA.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE
Emergency Care	
• Emergency room visit	
• Facility charge	15% after $200 copay (ER copay waived if admitted; no coverage for non-emergency use of emergency room)
• Physician services	15% after deductible
• Ambulance service	15% after deductible
• Walk-in clinic	$30 (generalist); $50 (specialist)
• Urgent care facility visit	$50 copay
Maternity Care*	
• Prenatal office visits	No cost; Plan pays 100%
• All other physician's services	15% after deductible
• Hospital services	
• Mother	15% after $150/admission copay
• Child	15% after deductible
Mental Health/Substance Abuse Treatment*	
• Inpatient	15% after $150/admission copay
• Outpatient (therapist's visits)	$30 (provider's office); 15% after deductible (outpatient facility)
Other Covered Services	
• Physical, occupational or speech therapy	$30 copay (generalist); $50 copay (specialist); 15% after deductible (therapist) (combined maximum of 60 visits/year)
• Outpatient (private duty) nursing care*	15% after deductible (maximum 70 eight-hour shifts/year)
• Convalescent (skilled nursing) facility*	15% after $150/admission copay (maximum 90 days/year)
• Home health care	15% after deductible (maximum 120 four-hour shifts/year)
• Hearing exam (one every 24 months)	$30 (generalist); $50 (specialist)
• Hospice care*	15% after deductible
Prescription Drugs	Prescription drug coverage provided under the L-3 Communications Prescription Drug Plan (see page 31)
Dependent Age	Dependent children enrolled in the plan are covered to age 26

* Must be pre-certified

AETNA INTERNATIONAL MEDICAL PLAN

The Aetna International Medical Plan is available only to employees who are on a U.S. payroll but are on extended assignment outside the United States (generally six months or more).

- **Outside the United States:** The Plan pays benefits for all covered medical services and supplies you (and your enrolled dependents) receive from licensed/certified providers.
- **Inside the United States:** The Plan gives you (and your enrolled dependents) direct access to a network of doctors and hospitals that charge lower fees for services they provide to eligible participants. You can see any physician/specialist in the network at any time; you are not required to get a referral. Benefits depend on whether you go In-Network or Out-of-Network for your care.

Highlights of How the Aetna International Medical Plan Works

- For care received outside the United States, the Aetna International Medical Plan pays 100% with no deductible required.
- In the United States, the Aetna International Medical Plan pays the highest benefits for In-Network medical care and treatment, defined as care or treatment provided by an Aetna Open Choice PPO Plan network provider.
- Doctor's office visits generally are covered at 100% (for care received outside the United States) or 100% after a $30 copay (for care received from an In-Network provider in the United States).

All medically necessary care you receive from providers outside the United States will be paid at 100% with no deductible required.

- Other eligible In-Network expenses, such as those for hospitalization, surgery and chiropractic treatment are covered at 100% with no deductible (for care received outside the United States) or at 85% after you satisfy the $300/individual ($900/family) annual deductible (for In-Network care received in the United States). All benefits are subject to Plan limits.
- The Plan covers a wide range of preventive services, including an annual check-up and travel immunizations, at 100% with no copay (for care received outside the United States or from an In-Network provider in the United States).
- There are no claim forms to file for In-Network care you receive within the United States.
- When you receive care in the United States, it's up to you to decide whether or not to use In-Network providers each time you need medical attention.
- Most covered services received from Out-of-Network providers are reimbursed at 65% of the reasonable and customary charge after you satisfy the $500/individual ($1,500/family) annual deductible.
- Inpatient and outpatient treatment of mental health and substance abuse is covered at 100% with no deductible for care received outside the United States. For care received from an In-Network provider in the United States, the Plan pays 85% after the annual deductible for inpatient treatment and 100% after a $30 copay for outpatient treatment.
- If you are an international assignee and fill prescriptions outside the United States while on international assignment, the Plan covers prescription drugs the same as any other eligible expense (that is, the Plan pays 100%).
- Within the United States, you can get your prescriptions filled at participating pharmacies. (See the *L-3 Communications Prescription Drug Plan,* page 31, for more information.)

AETNA INTERNATIONAL MEDICAL PLAN
1-800-231-7729 (OR CALL COLLECT 1-813-775-0190) • WWW.AETNAINTERNATIONAL.COM

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
How You Access Care	Go to any licensed/certified provider outside the U.S. or any network provider in the U.S.	Go to any licensed/certified provider.
Basis for Reimbursement	In most cases, In-Network reimbursements are based on the **negotiated charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** in the U.S., where required.	In most cases, Out-of-Network reimbursements are based on the **reasonable and customary charge** for **medically necessary eligible expenses** and are subject to the **annual deductible** and to **pre-admission certification/continued stay review,** where required.
Annual Deductible		
• Individual	$300	$500
• Family	$900	$1,500
Annual Out-of-Pocket Maximum		
• Individual	$2,000	$4,000
• Family	$4,000	$8,000
	Amounts you pay toward meeting the In-Network annual out-of-pocket maximum apply toward meeting the Out-of-Network annual out-of-pocket maximum, and vice versa.	
	Please note that the following do not apply to the annual out-of-pocket maximum: copays for In-Network expenses; amounts you pay toward the annual deductible; amounts above the reasonable and customary charge, and amounts you pay because you don't get pre-admission certification/continued stay review for the services and supplies required. You are responsible for paying these amounts in full.	
Lifetime Maximum Benefit	Unlimited	
Preventive Care		
• Physical examination (1 every 12 months)	No cost	35% after deductible
• Routine pediatric care (to age 6)	No cost	35% after deductible
• Routine gynecological exam	No cost	35% after deductible
• Routine mammograms	No cost	35% after deductible
• Travel immunizations	No cost	35% after deductible
Outpatient Care		
• Physician office visit	No cost (international); $30 (U.S.)	35% after deductible
• Specialist office visit	No cost (international); $30 (U.S.)	35% after deductible
• Spinal manipulation services	No cost (international); 15% after deductible (U.S.)	35% after deductible
• Outpatient surgery	No cost (international); 15% after deductible (U.S.)	35% after deductible
• X-ray and lab tests (billed by separate facility)	No cost (international); 15% after deductible (U.S.)	35% after deductible
Inpatient Hospital Care		
• Physician and surgical services	No cost (international); 15% after deductible (U.S.)	35% after deductible*
• Semi-private room and board	No cost (international); 15% after deductible (U.S.)	35% after deductible*
Emergency Care	50% coverage for non-emergency use of emergency room	
• Emergency room visit	No cost (international); 15% after $150 copay (U.S.)	15% after $150 copay
• Ambulance service	No cost (international); 15% after deductible (U.S.)	35% after deductible
• Walk-in clinic	No cost (international); $30 (U.S.)	35% after deductible
• Urgent care facility visit	No cost (international); $30 (U.S.)	35% after deductible
Maternity Care		
• Prenatal office visits	No cost (no deductible); Plan pays 100%	35% after deductible*
• All other physician's services	No cost (international); 15% after deductible (U.S.)	35% after deductible*
• Hospital services		
• Mother	No cost (international); 15% after deductible (U.S.)	35% after deductible*
• Child	No cost (international); 15% after deductible (U.S.)	35% after deductible*

* Must be pre-certified

continued

NOTE: Unless otherwise indicated, amounts shown are what **you** are required to pay.

PLAN PROVISION	COVERAGE	
	IN-NETWORK	OUT-OF-NETWORK
Mental Health/Substance Abuse Treatment		
• Inpatient	No cost (international); 15% after deductible (U.S.)	35% after deductible*
• Outpatient (therapist's visits)	No cost (international); $30 (U.S.)	35% after deductible**
Other Covered Services		
• Physical, occupational or speech therapy	No cost (international); 15% after deductible (U.S.)	35% after deductible
• Outpatient (private duty) nursing care	No cost (international); 15% after deductible (U.S.)	35% after deductible
	Combined maximum of 70 shifts/year In-Network and Out-of-Network	
• Convalescent (skilled nursing) facility	No cost (international); 15% after deductible (U.S.)	35% after deductible*
	Combined maximum of 120 days/year In-Network and Out-of-Network	
• Home health care	No cost (international); 15% after deductible (U.S.)	35% after deductible
	Combined maximum of 120 visits/year In-Network and Out-of-Network	
• Eye exam (one every 12 months)	No cost (after deductible for Out-of-Network care)	
• Hospice care	No cost (international); 15% after deductible (U.S.)	35% after deductible*
Prescription Drugs		
• International	No cost	
• In the United States	Prescription drug coverage provided under the L-3 Communications Prescription Drug Plan (see page 31)	
Dependent Age	Dependent children enrolled in the plan are covered to age 26	

* Must be pre-certified
** Certain outpatient mental health and substance abuse services and procedures must be pre-certified

Aetna International Employee Assistance Program

The Aetna International Medical Plan includes an International Employee Assistance Program that is geared to the unique needs of overseas employees and their families. The International EAP offers access to the following kinds of support:

- **Work and Life Resources**—services and direct referrals for you and your family, including resources for child care, elder care, parenting, adoption, child development, family issues, education searches, legal and financial consultation, and more.
- **Internet Resources**—the Aetna IEAP website (www.AetnaEAP.com) features interactive tools, self-assessments and easy-to-find information on a variety of relevant topics.
- **Counseling Services**—counselors are available 24 hours a day, 365 days a year. The EAP provides up to five visits with an EAP counselor per incident per year. Consultations will generally be via telephone, although face-to-face sessions may also be available in some countries.

You may reach the International EAP at any time, whether you need help with a crisis or just need someone to talk to.

- **By Phone:** call 1-800-231-7729 (toll free) and ask to be transferred to the Aetna International Employee Assistance Program. Refer to the international calling guide wallet card in your member kit for instructions on how to dial an international toll free number. If you cannot locate your country access code, and an operator cannot assist you, request that the operator connect you to this telephone number: 1-813-775-0190 (collect calls are accepted).
- **Online:** visit www.AetnaEAP.com. Use this Company ID to access the website: MYINTEAP.

International SOS

International SOS provides personal, medical and safety assistance to L-3 employees traveling on business outside their home country. Services include pre-travel information, health and safety advice, referrals to local, Western-trained doctors and access to medication. In addition, International SOS is available in an emergency to arrange medical transportation or care, contact your family and evacuate you to a center of medical excellence, if necessary.

To contact International SOS, call 1-800-523-6586 from within the U.S., call collect 1-215-942-8226 from outside the U.S., or log on to their website at www.internationalsos.com (password: 11BCPA000028).

THE L-3 COMMUNICATIONS PRESCRIPTION DRUG PLAN

Aetna is the prescription drug claims administrator for the following L-3 medical plans:

- Aetna Choice POS II Medical Plan
- Aetna Elect Choice EPO Medical Plan
- Aetna Out-of-Area Medical Plan
- Altius EPO Medical Plan
- Aetna International Medical Plan (for prescriptions filled in the U.S.).

If you are enrolled in one of these plans, you and your enrolled dependents are enrolled automatically in the L-3 Communications Prescription Drug Plan.

How the Prescription Drug Plan Works

This Plan is designed to help you afford prescribed drugs and medicines and to encourage you to fill your prescriptions in the most cost-effective way possible. You will receive a separate Aetna Pharmacy Management prescription drug card if you are in the Altius EPO or Aetna International Medical Plan. Benefits for prescription drugs depend on how you choose to fill your prescription, as shown in the chart below. The Plan will pay the full cost of eligible prescription drug expenses if you meet the annual prescription drug out-of-pocket maximum: $3,000 for an individual or $6,000 for a family.

What's a formulary? A drug formulary is an extensive list of safe and effective generic and brand-name prescription medications for which Aetna has negotiated manufacturer volume discount arrangements. For an up-to-date formulary list, visit Aetna's website at www.aetna.com, or www.aetnapharmacy.com, Aetna's website dedicated to pharmacy benefits. You can also call Aetna Member Services at 1-800-345-5839 if you have formulary questions.

2016 PRESCRIPTION DRUG COVERAGE*		
	RETAIL**	MAIL-ORDER/MAINTENANCE CHOICE***
Generic	$10	$20
Preferred Brand-Name****	20% ($20 minimum/$75 maximum)	20% ($40 minimum/$150 maximum)
Non-preferred Brand-Name****	30% ($50 minimum/$100 maximum)	30% ($100 minimum/$200 maximum)
Over-the-counter (OTC)***** • Store-brand • Brand-name	 $1 $3	 N/A N/A
Annual Out-of-Pocket Maximum • Individual • Family	$3,000 $6,000	

* If you are enrolled in the Aetna HSA Medical Plan or either Aetna HealthFund HRA, you pay the applicable prescription drug coinsurance shown on page 15 (Aetna HSA), page 19 (HRA I) or page 21 (HRA II). The copays/coinsurance shown in this chart do not apply to the Aetna HSA or the Aetna HealthFund HRAs.

** Retail coverage applies to specialty drugs as well.

*** For more than a 30-day supply, up to a 90-day supply.

**** If you choose to fill a prescription with a brand-name drug when a generic equivalent exists, you will be required to pay the applicable brand-name coinsurance **PLUS** the difference in cost, up to the full cost of the drug.

***** Axid, Claritin, Nexium 24HR, Nicoderm, Nicorette, Pepcid, Prevacid, Prilosec and Zantac only; prescription required; limits apply.

Using a Retail Pharmacy

You can use your Aetna Prescription Drug Program ID card to fill prescriptions at any participating Aetna retail pharmacy for up to a 30-day* supply per prescription or refill. You pay the copays/coinsurance shown in the chart on page 31. No annual deductible is required, and you don't have to file any claims.

Using the Mail-Order Pharmacy

The mail-order pharmacy is designed for those who take maintenance medications (medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma). To fill a prescription by mail, attach an original prescription to the "Prescription Order Form" and submit it to Aetna Rx Home Delivery, the Plan's mail-order prescription drug administrator. For a 31- to 90-day* supply per prescription or refill, you pay the copays/coinsurance shown in the chart on page 31.**

Mandatory mail-order prescriptions. If you take maintenance drugs, you must fill your prescriptions through Aetna Rx Home Delivery, or through the Maintenance Choice Program (see page 33), in order for benefits to be payable beyond the second refill. That is, if you use a participating non-CVS retail pharmacy to fill your maintenance prescriptions, the Plan will pay benefits only for the initial prescription and up to two refills. **No benefits will be payable for a third refill.**

If your doctor prescribes medication that you'll be taking for more than 30 days ("maintenance" medication), ask your doctor to give you two prescriptions at once: one for a 30-day supply and one for a 31- to 90-day supply. You can then fill the 30-day prescription at your local participating pharmacy and send the 31- to 90-day prescription to Aetna Rx Home Delivery. Keep in mind that certain medications, such as Class II, III and IV controlled substances, are exempt from mandatory mail-order requirements. Contact Aetna if you have questions about medications that are exempt.

HOW TO USE AETNA RX HOME DELIVERY FOR THE FIRST TIME	
STEP 1.	Ask your doctor for two signed prescriptions: one for an initial supply to be filled at your local participating retail pharmacy, and the second for an extended supply (up to one year) that you can receive through the mail from Aetna Rx Home Delivery once you and your doctor determine that the medication is right for you. Please note that in order for Aetna Rx Home Delivery to dispense Schedule II medications (such as Ritalin or Oxycontin) in any quantity greater than a 30-day supply, your physician must write the diagnosis on the prescription.
STEP 2.	Print your name, address and health plan member ID number on each prescription.
STEP 3.	Complete the Prescription Order Form for you and your eligible dependents who will obtain medications from Aetna Rx Home Delivery. (You will not need to complete this form when ordering refills, unless your information has changed.)
STEP 4.	Mail the completed Order Form, your original written prescription(s) and your copayment(s) to Aetna Rx Home Delivery.
HOW TO USE AETNA RX HOME DELIVERY FOR REFILLS	
Each time you receive medications by mail, you will receive a prescription receipt that includes a refill date indicating when your prescription can be refilled. (This information is also on your prescription's label.) You can request a refill after that date. Allow at least 14 days for processing your order.	
Website	Visit www.aetnanavigator.com, log in and complete all of the information requested. You can also track your prescription orders through this website.
Phone	Call Aetna Rx Home Delivery toll free at 1-800-504-2386 (TTY 1-800-823-6373). Provide your health plan member ID number, your prescription number and your credit card number.
Mail	Fill out the Prescription Order Form you received with your medications and mail your refill request to Aetna Rx Home Delivery.

* This limit applies even if the prescription designates a larger supply.

** If you are enrolled in the Aetna HSA Medical Plan or an Aetna HealthFund HRA Medical Plan and use the mail-order pharmacy, you pay the applicable coinsurance shown on page 15 (Aetna HSA), page 19 (HRA I) or page 21 (HRA II).

Using the Maintenance Choice Program

If you take maintenance drugs, you may fill your prescription at your local CVS/pharmacy through the Maintenance Choice Program, instead of Aetna Rx Home Delivery. The Maintenance Choice Program allows you to fill up to a 90-day supply of a maintenance prescription at your local CVS/pharmacy and in most cases enjoy the convenience of same-day refills and onsite pharmacist consultations.

If your doctor prescribes medication that you'll be taking for more than 30 days ("maintenance" medication), ask your doctor to give you a prescription for a 31- to 90-day supply. Simply fill the prescription at your local CVS/pharmacy as you would any standard retail prescription. You pay the same copay or coinsurance, whichever applies, as you would through the mail-order pharmacy. To find a CVS/pharmacy near you, visit www.aetna.com, log in to Aetna Navigator and choose "Find a Doctor, Pharmacy or Facility."

Over-the-Counter Drug Coverage

The Plan covers the following over-the-counter (OTC) drugs:*

- Axid
- Claritin
- Nexium 24HR
- Nicoderm
- Nicorette
- Pepcid
- Prevacid
- Prilosec
- Zantac.

You pay only a $1 copay (for the store-brand version) or a $3 copay (for the brand-name version) for up to a 30-day supply of these OTC medications, provided you obtain a **doctor's prescription** and use an Aetna network pharmacy. Your copay will cover the closest possible packaging based on the dosage your doctor indicates on the prescription. This means that depending on the number of pills per package, you may receive more than a 30-day supply for $1 (store-brand) or $3 (brand-name). However, you will never receive less.

Please note:

- There are limits on the quantity and frequency of OTC drugs you may buy.
- You must have a doctor's prescription for the $1 (store-brand) or $3 (brand-name) copay to apply.
- You must fill your OTC prescription at an Aetna network retail pharmacy. You cannot use the Aetna Rx Home Delivery mail-order pharmacy.
- OTC drug coverage applies only to the nine drugs listed here.

How to receive OTC drug benefits. Here is how to take advantage of this benefit:

HOW TO USE THE OTC BENEFIT FOR THE FIRST TIME	
STEP 1.	Ask your doctor to write you a prescription for a 30-day supply of the OTC drug—just as he/she would for a prescription drug—and specify up to one year of refills.
STEP 2.	Bring your OTC prescription to an Aetna network retail pharmacy. For a list of participating pharmacies, visit www.aetna.com.
STEP 3.	Fill your OTC prescription for a 30-day supply as you would any other prescription drug and pay the applicable copay.

* The copays shown here do not apply to the Aetna HSA Medical Plan or the Aetna HealthFund HRAs. If you are enrolled in either of these plans, you pay the applicable prescription drug coinsurance shown on page 15 (Aetna HSA), page 19 (HRA I) or page 21 (HRA II).

Specialty Drug Coverage

Specialty medications are powerful, expensive drugs used to treat certain serious medical conditions. These drugs, which are covered with the same copays/coinsurance as other prescription medications, are typically self-injectable, infusible or complex oral medications. If you take specialty drugs, you **must** fill your prescription through Aetna Specialty Pharmacy® in order for benefits to be payable beyond the initial fill. That is, if you use a participating retail pharmacy to fill your specialty medication, the Plan will pay benefits only for the initial prescription. **No benefits will be payable for a refill at a retail pharmacy. Specialty drugs cannot be filled through Aetna Rx Home Delivery.**

To fill a prescription through Aetna Specialty Pharmacy, have your doctor fax your prescription to 1-866-FAX-ASRX (1-866-329-2779). To order refills, call 1-866-782-ASRX (1-866-782-2779).

For a list of covered specialty drugs, or for more information about specialty drug coverage, visit www.aetna.com or contact Aetna Specialty Pharmacy at 1-866-782-2779.

Coverage of Women's Contraceptive Drugs and Devices

Certain contraceptive drugs and devices approved by the U.S. Food and Drug Administration are covered at 100% with no deductible, for women who are capable of child-bearing. Prescriptions must be filled at an Aetna network pharmacy. Please note that only generic oral contraceptives are covered at 100%; if there is not a generic equivalent available, a medical exception will be required for the brand-name drug to be covered at 100%. For the list of eligible drugs and devices, visit www.aetna.com or contact Aetna Member Services at 1-800-345-5839.

No benefits are payable for drugs imported from Canada or any other country, even on an Out-of-Network basis. In addition, drugs imported from Canada are not eligible for reimbursement from a Health Care Flexible Spending Account.

YOUR DENTAL COVERAGE OPTIONS

At most L-3 business units, employees may choose between the Aetna PPO Dental Plan and the Aetna DMO Dental Plan. At certain business units, other dental plans are offered. The plan(s) available at your location are shown on your *Personalized Enrollment Worksheet.*

Please note the L-3 Dental Plans generally provide only limited benefits, which are intended to help you pay for common dental expenses. The Plans provide limited or no coverage for certain kinds of treatment, such as implants, that go beyond this modest intent. **Please do not assume benefits will be payable for any and all treatments recommended by your dentist.** Before you agree to any course of treatment, make sure you understand whether benefits will be payable for the treatment and, if so, the extent to which benefits will be payable.

NATIONAL DENTAL PLANS
Aetna PPO Dental Plan
Aetna DMO Dental Plan
Aetna International Dental Plan

Foreign-based employees. Employees on a U.S. payroll who work outside the United States generally have only one dental plan option available: the Aetna International Dental Plan.

The dental plan(s) available at your location are shown on your *Personalized Enrollment Worksheet.* Keep in mind that L-3 Dental Plans generally provide only limited benefits, which are intended to help you pay for common dental expenses. Please do not assume that benefits will be payable for any and all treatments recommended by your dentist.

AETNA PPO DENTAL PLAN

The Aetna PPO Dental Plan is designed to help you meet the expense of proper dental care. The Plan encourages preventive care and provides financial assistance toward the expense of a wide range of other dental services.

How the Plan Works

The PPO Dental Plan pays benefits for four categories of dental care: Preventive services, Basic services, Major services and Orthodontia. You share in the cost of your eligible dental expenses through deductibles and coinsurance, as explained below. Benefits are payable until you reach the $2,000 annual maximum benefit or the $2,000 orthodontia lifetime maximum benefit, as applicable.

PPO. The Dental Plan gives you access to the network of dentists in Aetna's Dental Preferred Provider Organization (PPO). If you choose a PPO dentist you will pay less, since these dentists discount their fees. For a directory of participating dentists in your area, go to the "DocFind" section of Aetna's website (www.aetna.com/docfind).

The deductible. There is no deductible for Preventive services. However, each participant has to satisfy a $100 deductible each calendar year before the Plan pays benefits for covered Basic, Major and Orthodontia services. (See the chart on page 37.) The family deductible is capped at three $100 individual deductibles. If you have "employee plus two or more dependents" coverage, once three members of your family satisfy their individual $100 deductibles, the entire family is considered to have met the deductible obligation for the rest of that calendar year.

Dental benefits are based on the negotiated charge when you use dentists in the PPO network and on the reasonable and customary charge when you use non-PPO dentists. You are responsible for any expenses over what Aetna determines is the reasonable and customary charge.

Coinsurance. For eligible dental services and supplies, the Plan pays a percentage of the negotiated charge (if you use PPO dentists) or the reasonable and customary charge (if you use non-network dentists). You are responsible for the remaining percentage, known as your "coinsurance." Keep in mind that since the negotiated charge generally is less than the reasonable and customary charge, the dollar amount you pay as your coinsurance will be less when you use PPO dentists.

In addition to deductibles and coinsurance, you are also responsible for any expenses over what Aetna determines is the reasonable and customary charge. (Only non-network dentists will charge more than what's considered reasonable and customary; PPO dentists are contractually obligated to charge the lower, negotiated amounts.)

Maximum benefits. The most the Dental Plan will pay is $2,000 a calendar year in **non-orthodontia benefits** for each participant. Orthodontia benefits, which are payable only for enrolled dependent children under age 19, are subject to a separate $2,000 lifetime maximum benefit. Please note when you use PPO dentists, you can get more services and supplies before you reach the $2,000 annual maximum benefit because PPO dentists generally charge less than non-network dentists.

Pre-treatment Estimate. The Pre-treatment Estimate is a special feature of the Dental Plan that lets you know which expenses you can expect the Plan to cover and what will be paid for a particular course of treatment. The Pre-treatment Estimate is exactly that: an estimate of the amount and scope of benefits payable under the Dental Plan. It is not a guarantee of benefit payments, which are determined upon your submission of a claim for the actual services and/or supplies rendered during a course of dental treatment. A Pre-treatment Estimate is recommended before starting a course of dental treatment that is expected to cost more than $400. This way, you have an idea of what the Plan will pay before you actually incur the expense.

Benefits when alternate procedures are available. Sometimes there are several ways to treat a dental problem, all of which provide acceptable results and are recognized by the profession as appropriate methods of treatment in accordance with broadly accepted national standards of dental practice. When alternate services or supplies can be used, the Plan will cover the least expensive services or supplies necessary to treat the condition. Of course, you and your dentist can still choose the more costly treatment method, in which case you would be responsible for any charges the Plan will not cover.

THE AETNA PPO DENTAL PLAN AT A GLANCE			
PREVENTIVE SERVICES	BASIC SERVICES	MAJOR SERVICES	ORTHODONTIA
No deductible required	**$100/Person deductible required (maximum 3 deductibles/family)**		
Plan Pays 100%	**Plan Pays 80%**	**Plan Pays 60%**	**Plan Pays 50%**
• routine oral examinations (twice in any calendar year) • cleanings (twice in any calendar year) • bitewing x-rays (one set in any calendar year) • full mouth x-rays (one set in any 36-month period) • topical application of fluoride for enrolled dependents under age 14 (twice in any calendar year) • sealants on each permanent molar and bicuspid once every three calendar years	• initial installation of space maintainers for enrolled dependents under age 12 (only for teeth A, B, I, J, K, L, S and T) • fillings • non-surgical and surgical periodontic treatment • root canal therapy • repair or recementing of crowns, inlays, onlays, bridgework or dentures • oral surgery for treatment of dental conditions • the addition of teeth to an existing partial removable denture	• onlays or crowns • initial insertion of fixed bridgework • initial placement or replacement of an existing partial denture or fixed bridgework • replacement of an existing removable denture or fixed bridgework by a new prosthesis • initial insertion of removable, complete or partial dentures	For enrolled dependent children under age 19 only: • diagnosis and treatment plan • braces • examinations and related x-rays • appliances • appliance adjustments
$2,000 Annual Maximum Benefit (in non-orthodontia benefits)			$2,000 Lifetime Maximum Benefit

Note: Benefits are based on the negotiated charge when you use PPO dentists and on the reasonable and customary charge when you use non-network dentists.

Refer to the Aetna PPO Dental Plan SPD booklet for more information about what is—and isn't—covered, how to request a Pre-treatment Estimate, and other important information.

AETNA DMO DENTAL PLAN

The Aetna Dental Maintenance Organization (DMO) works like an HMO for dental care. You must select a primary care dentist from the Aetna DMO network provider directory. If you enroll for family coverage, each family member can select his/her own primary care dentist. To find out if your dentist is in the DMO provider network, visit DocFind, Aetna's online provider directory (www.aetna.com/docfind) or contact Member Services (1-877-238-6200).

Please note that the Aetna DMO Dental Plan is available only to employees who live in an area with adequate access to DMO network dentists, as determined by Aetna. It is very important that you check the DMO network to make sure you find a dentist before choosing this option. Please note that not every provider listed in the directory will be accepting new patients. You should call the dentist's office and verify this prior to selecting a provider.

If you need treatment by a specialist, your dentist will arrange a referral to a specialist within the network. There is no coverage if you go out-of-network for your dental care (unless required by law in your state). However, DMO members may visit a network orthodontist without first obtaining a referral from their primary care dentist.

When you receive care that's provided or authorized by your primary care dentist, there is no annual deductible to meet before benefits become payable, no annual or lifetime benefit maximums, no annual limit on the number of visits, and no claim forms to submit. However, frequency limitations do apply to certain procedures.

You are responsible for paying your dentist a copay for certain covered services. Many preventive services do not require a copay. The chart in the *Aetna DMO Dental Plan* flyer available on the Benefit Center website shows current DMO copay requirements for certain services. Contact the Aetna claim office if you have questions about copays or covered services.

If for some reason you need to switch your primary care dentist during the year, you may do so, but you may not switch to the Aetna PPO Dental Plan, even if your DMO dentist leaves the network.

When you receive care that's provided or authorized by your primary care dentist, there is no annual deductible to meet before benefits become payable, no annual or lifetime benefit maximums, no annual limit on the number of visits, and no claim forms to submit. However, frequency limitations do apply to certain procedures.

AETNA INTERNATIONAL DENTAL PLAN

The Aetna International Dental Plan is available only to employees (and their enrolled dependents) who are on a U.S. payroll but are on extended assignment outside the United States (generally six months or more). The Aetna International Dental Plan pays benefits for necessary dental care, as shown in the following chart. Benefits are paid as a percentage of the reasonable and customary charge for eligible expenses, and are the same regardless of the provider you use. However, if you use a dentist in the United States who participates in Aetna Dental's PPO network, you will pay less, since these dentists discount their fees. For a directory of participating dentists in your area, go to the "DocFind" section of Aetna's website (www.aetna.com/docfind).

THE AETNA INTERNATIONAL DENTAL PLAN AT A GLANCE	
Annual Deductible • Individual • Family	 $50 $150
Diagnostic and Preventive Services (such as checkups, cleanings and x-rays)	Plan pays 100% (no deductible)
Basic Services (such as extractions, oral surgery, fillings, periodontics and root canal therapy)	Plan pays 80% after the deductible
Major Services (such as crowns, bridges and dentures)	Plan pays 50% after the deductible
Annual Maximum Benefit	$1,500 per person
Orthodontia	Plan pays 50% (no deductible), to a separate $1,000 lifetime maximum benefit per person

Contact Aetna International for more information.

To find out whether a specific dental expense is covered, contact Aetna International at 1-800-231-7729.

VISION CARE PLAN

Vision coverage is optional. If you want Company-sponsored vision coverage, you must elect the Vision Care Plan. Participation is not automatic when you enroll for Company-sponsored medical coverage.

The Vision Care Plan helps you pay for routine eye care. It is administered through VSP, which has established a nationwide network of doctors and participating retail chains who will treat you for less than what you'd pay when you use an Out-of-Network provider (known as an Open Access provider). VSP's participating retail chains include Costco® Optical, Visionworks®, Cohen's Fashion Optical, Wisconsin Vision, Heartland Vision and RxOptical®. Services received from participating retail chains are covered in full, as if they were network providers. For more information about participating retail chains, visit www.vsp.com.

While you do have the option of using an Out-of-Network provider, the out-of-pocket cost of your covered expenses will be much lower when you see a VSP network doctor or participating retail chain. To contact VSP, call 1-800-877-7195 or visit www.vsp.com.

How the Vision Care Plan Works

For adults, the Vision Care Plan covers one exam each calendar year; lenses each calendar year; and frames once every two calendar years or contact lenses each calendar year, as long as an ophthalmologist or optometrist provides these services. The Plan will pay benefits for prescription contact lenses or prescription eyeglasses. If you choose contact lenses, benefits become payable for frames the next calendar year following the date you obtained your contacts.

Under the KidsCare Plan, for children up to age 18, the Vision Care Plan covers an exam each calendar year; lenses each calendar year; and frames each calendar year. The Plan will cover a second exam during the same calendar year, if needed. In addition, if the child's prescription changes by at least .50 diopters during the calendar year, the Plan will cover an additional set of lenses in the same calendar year.

How benefits are paid depends on whether or not you use a VSP network doctor or participating retail chain for your care, as shown in the chart on page 41. Since VSP network doctors have agreed to provide their services to eligible employees and dependents for a pre-arranged fee, all you pay is the applicable copayment and the cost of any non-covered, elective and cosmetic items and any frame overage. VSP pays the rest directly to the doctor.

Some business units may cover safety glasses under the Vision Care Plan. Your local Human Resources Department will tell you if this applies at your business unit and if you qualify.

SCHEDULE OF VSP BENEFITS			
EXPENSE	MAXIMUM BENEFIT		BENEFIT FREQUENCY
	THROUGH A VSP NETWORK DOCTOR	THROUGH AN OPEN ACCESS (OUT-OF-NETWORK) PROVIDER	
Eye Exam*	100% after a $10 copay	Up to $50 after a $10 copay	Once each calendar year
Lenses (pair) • Single vision (for lenses and frame)	100% after a $20 copay	Up to $50 after a $20 copay	Once each calendar year
• Lined bifocal (for lenses and frame)	100% after a $20 copay	Up to $75 after a $20 copay	
• Lined trifocal (for lenses and frame)	100% after a $20 copay	Up to $100 after a $20 copay	
• Polycarbonate lenses for dependent children	100%	N/A	
Contact Lenses	Up to $60 copay toward contact lens exam (fitting & evaluation)** plus $175 toward lenses	Up to $120 after the $10 exam copay, if applicable	
Frames***	Up to $175 toward frames, after a $20 copay (for lenses and frame)****	Up to $70 after a $20 copay (for lenses and frame)	Once every two calendar years

* If your VSP network doctor offers retinal screening, you will pay no more than $39 for the screening.

** You will receive 15% off the cost of your contact lens exam (fitting and evaluation) from your VSP network doctor. Your maximum copay will be $60. If your contact lens exam costs less than $60, you pay the lesser amount. Please note that this discount is not available through VSP's participating retail chains, only VSP network doctors. In addition, VSP has partnered with leading contact lens manufacturers to provide VSP members exclusive discount offers, including mail-in rebate savings of up to $110 on eligible Bausch & Lomb contact lenses. Visit www.specialoffers.vsp.com for more information.

*** If you choose contact lenses, benefits become payable for frames the next calendar year following the date you obtained your contacts.

**** For frames valued over $175, you pay the difference, less a 20% discount. If you go to Costco® for your frames, you will receive a $95 frame allowance.

Discounts

The following discounts are available:

- If you use Plan benefits to purchase contact lenses and also purchase prescription glasses (lenses and a frame) from the same VSP network doctor on the same day as your covered exam, you will receive a 30% discount off the glasses. Or, receive a 20% discount from any VSP network doctor in the same calendar year as your exam.
- If you purchase more than one pair of prescription glasses (including prescription or non-prescription sunglasses) from the same VSP network doctor on the same day as your covered exam, you will receive a 30% discount off the second pair of glasses. Or, receive a 20% discount from any VSP network doctor in the same calendar year as your exam.

In addition, the VSP network doctor from whom you receive contact lens services will give you a 15% discount on the cost of your contact lens exam. This discount applies only to the cost of the exam, not the price of the contact lenses.

Additional Charges

There will be an extra charge if you select any of the following. These additional charges are set by VSP and average up to a 40% discount off doctors' usual and customary charges.

- blended lenses
- oversize lenses
- polycarbonate lenses for adults
- progressive multifocal lenses
- photochromic or tinted lenses other than Pink 1 or 2 allowance
- certain limitations on low vision care
- coated or laminated lenses
- cosmetic lenses
- optional cosmetic processes
- UV-protected lenses
- frames that cost more than your $175 allowance ($95 allowance at Costco)
- no-line multifocal lenses.

You are also responsible for paying any part of a charge that exceeds the scheduled benefit for services received from an Out-of-Network provider.

Diabetic Eyecare Plus Program

If you have diabetic eye disease, glaucoma or age-related macular degeneration (AMD), you can receive your routine eye care and follow-up medical eye care services from your VSP doctor. You can also receive preventive retinal screenings if you have diabetes but don't show signs of diabetic eye disease. Visit your VSP doctor as often as needed, and you only pay a $20 copay for services. Plus, there's no referral necessary within the VSP network. Ask your VSP doctor for more information.

Laser Surgery

VSP's Laser Vision Care Program offers significant discounts on laser surgery from participating laser surgery facilities. After surgery you may use your frame benefit (if eligible) for non-prescription sunglasses from any VSP network doctor. Contact VSP at 1-800-877-7195 or go to www.vsp.com for more information.

How to Use the Plan

Using a VSP network doctor or participating retail chain. Follow these steps to use a VSP network doctor or participating retail chain for your vision care.

Step 1.	Call VSP at 1-800-877-7195 or go to www.vsp.com to find a VSP network doctor or participating retail chain.
Step 2.	When you call to make an appointment, identify yourself as a VSP member and give the office your first name, last name and date of birth plus the patient's name (if different). They will contact VSP to verify your eligibility.
Step 3.	At your visit, pay your copayment and/or any other required amount directly to the VSP network doctor or participating retail chain—and that's it. The doctor's office will make its own arrangements for reimbursement and handle any other administrative tasks required.

If you use an Open Access (Out-of-Network) provider. An Open Access provider is any eye care or eyewear provider who is not part of VSP's preferred network. If you use an Open Access provider, there are two ways to use the Plan:

- **File a claim with VSP:** You pay for services at the time they're provided and then request reimbursement from VSP. Contact VSP's Customer Service Department at 1-800-877-7195 or log on to your benefits at www.vsp.com for an Open Access claim form. You may upload receipts to file online, or print out the form and mail it to VSP with your attached receipts. You must provide proof of the claim to VSP within six months of the date the services were furnished. After the copayment is subtracted from the provider's charge, VSP will reimburse your covered expenses up to the maximum benefits shown on the schedule.
- **Ask the provider to file a claim for you:** Some Open Access providers have the ability to check eligibility and benefits and handle claims. If your provider will file a claim on your behalf, you generally will not need to pay for services in full. Rather, you pay the provider the balance from subtracting the maximum benefit allowance shown on the schedule from the provider's total bill. VSP will reimburse the provider the benefit allowance directly.

Vision provider service contracts. Premiums, charges or membership fees you pay to a provider for a service contract are not eligible vision care expenses and are not covered under the Vision Care Plan.

Vision coverage is optional. If you want Company-sponsored vision coverage, you must elect it. For a directory of VSP network doctors in your area or for other information about the Vision Care Plan, call VSP at 1-800-877-7195 or go to www.vsp.com.

KEY ISSUES TO FACTOR INTO YOUR HEALTH PLAN SELECTIONS

- The Company pays most of the cost for the medical and/or dental coverage you elect; you pay your share through pre-tax payroll deductions.*
- Look closely at your 2016 medical plan contributions. In most cases, the Aetna HSA Medical Plan will be the lowest-cost medical plan option. To help you factor costs into your medical plan election, use the Decision Center's **Health Plan Evaluator** tool, which will include your L-3 Aetna claim history. You can use this information or modify it to more accurately estimate your 2016 out-of-pocket health care costs for each medical plan. This tool makes it easy for you to estimate the total costs associated with each option and make the best choice for you and your family. Look for it on the Benefit Center's home page when you log on to enroll.
- If you are considering the Aetna HSA Medical Plan, keep in mind that it has two parts: an HSA-compatible high deductible health plan, which offers similar coverage as the Aetna HealthFund HRA Medical Plans, and a Health Savings Account, which is quite different from a Health Reimbursement Account. For example, an HSA holds employee contributions in the form of real money and offers tax benefits, while an HRA holds Company contributions in the form of Benefit Dollars and offers no tax advantages. Be sure to factor the differences into your decision.
- If you elect the Aetna HSA Medical Plan or the Aetna HealthFund HRA, use WellMatch to search for network providers and medical services, as well as estimate the cost before you go. Log on to www.WellMatchHealth.com to get started.
- In general, the more dependents you cover, the greater your contributions. Refer to your *Personalized Enrollment Worksheet* to see the contribution requirement of each coverage option available to you.
- If you extend coverage to your family, they must be enrolled in the same plan you elect for yourself. For example, if you enroll in the Aetna HSA Medical Plan, you cannot enroll your dependents in an HMO, and vice versa.
- If you have coverage available elsewhere (through your spouse's employer-sponsored plan, for example), consider whether it would be more practical for you to cover your dependents (or yourself) under that plan instead of an L-3 medical or dental plan. Remember: benefits payable under L-3 plans are coordinated with benefits payable under your spouse's employer-sponsored plan. Generally, there is little or no advantage to having dual coverage.
- If you waive coverage for you and/or your family now, you must wait until next year's annual enrollment to elect it, unless you have a qualifying event.
- If you waive L-3 medical coverage for yourself and/or your dependents, you may be liable under the federal coverage requirements imposed by the Affordable Care Act. It is your responsibility to comply with the requirements of any health care coverage laws in your state of residence. If you live in a state that requires you to have medical coverage and you waive coverage for 2016, the Benefit Center will contact you about proof-of-coverage requirements.
- Dental Plan benefits are limited each year, as are benefits for certain other kinds of treatment and supplies (such as chiropractic care). If you expect that you will exceed Plan limits, consider using a Health Care Flexible Spending Account or a Dental and Vision Flexible Spending Account (for Aetna HSA Medical Plan participants only) to pay excess expenses with tax-free dollars (see page 44).

Not all plans described in this *Benefit Planner* are available at all business units. The plans available at your location are shown on your *Personalized Enrollment Worksheet.*

* Certain employees may be required to pay all or most of the cost of coverage at certain business units.

THE FLEXIBLE SPENDING ACCOUNTS

There are three types of Flexible Spending Accounts (FSAs) available:

- The Health Care Flexible Spending Account (HCFSA)
- The Dental and Vision Flexible Spending Account (DVFSA)
- The Dependent Day Care Flexible Spending Account (DDCFSA)

All of them let you set aside tax-free dollars which you can then use to pay certain health care and dependent day care expenses. Since you are using tax-free dollars to pay these expenses, you lower your federal income and Social Security taxes. This can offset the cost of many of your out-of-pocket health care expenses (such as copays, deductibles and coinsurance) and ease the financial burden of caring for your children or other IRS-recognized dependents while you work.

- **The Dental and Vision FSA is for Aetna HSA Medical Plan participants only.** You can use this account to pay for eligible **dental and vision care** expenses not covered by your L-3 Plans or any other health care coverage. **Medical expenses are not eligible** for reimbursement through the DVFSA.
- You can use the **Health Care FSA** to pay for eligible **health care** expenses that are not covered by your L-3 health care coverage or any other health care coverage you may have. **Please note prescriptions are required for OTC medications; see page 46.**
- You can use the **Dependent Day Care FSA** to reimburse yourself tax-free for certain **dependent day care expenses** you have because you (and your spouse, if you are married) work or are looking for work.

Participation in the HCFSA, DVFSA and/or the DDCFSA is not automatic. You must enroll to participate, and you must re-enroll every Plan Year if you want to continue participating.

How the Accounts Work

The tax advantage. The IRS lets the Company take your FSA deduction out of your pay before federal income and FICA taxes are paid. That lowers your taxable income, so you pay less federal income, Social Security and, in most states, state income tax.

Deposits. You can contribute up to $2,550 a year to your HCFSA or DVFSA, and up to $5,000 a year to your DDCFSA. (The IRS sets additional limits on your DDCFSA contributions if you're married and your spouse has a DDCFSA through his or her employer.) The amount you choose will be deducted from your pay and deposited into your account equally throughout the year. You deposit money into each account separately. You cannot transfer money between the accounts. Your deposits for the year can be used to pay eligible expenses you incur between January 1 and December 31. **However, up to $500 of unused HCFSA or DVFSA funds will roll over into the following Plan Year.**

If you're unsure of how much money you should put into your account(s) or if you're interested in seeing your potential tax savings, visit WageWorks' website (www.wageworks.com) to use their online calculators. From the WageWorks homepage, click on "Calculate Savings" and then select "Health Care" or "Dependent Care."

Reimbursements. The money you receive is tax-free—your money goes in tax-free and comes out the same way. There are **three** ways to use the money in your account(s) to reimburse your eligible expenses:

- **Use your WageWorks Card.** You will receive a personalized WageWorks Card by mail once you enroll in the Health Care or Dental and Vision FSA. (Please note the WageWorks Card cannot be used to reimburse dependent day care expenses.) Whenever you make an eligible health care purchase or pay a health care provider, you can use it just like a debit card. Simply swipe the card at health care merchants that take Visa and the expense is paid directly from your account—so there's no need to pay the expense out-of-pocket, file a claim form and wait for reimbursement. In effect, you're "reimbursing" yourself immediately, on the spot. See page 47 for IRS limitations on where you can use your card.
- **Pay online through *Pay My Provider*.** You can pay bills directly from your account(s) using the online *Pay My Provider* tool. Simply log in at www.wageworks.com, select "Request Pay My Provider" and fill in the requested information. You will be required to submit a copy of your itemized receipt to WageWorks for the payment to be processed. With *Pay My Provider,* you can request a one-time payment or schedule a recurring payment for eligible services, such as orthodontia treatments, regular chiropractic care or day care. WageWorks will issue payment to your provider within 2–3 business days of your request being approved.
- **File a claim with *Pay Me Back*.** You can use *Pay Me Back* to get reimbursed for eligible expenses you pay for out of pocket. To do so, log in at www.wageworks.com, select "Health Care" or "Dependent Care," and print out a *Pay Me Back* form. Fill in all the information requested on the form, attach your receipt(s), sign it and follow the instructions to fax or mail it to WageWorks.

  You can also file *Pay Me Back* claims online by selecting the online claim form and filling in all the information requested. Scan your receipts and other supporting documentation and upload them, or print the pre-populated online claim form, attach your receipt(s), sign it and follow the instructions to fax or mail it to WageWorks.

WageWorks' website. The WageWorks website is a convenient one-stop location for information about your account, including claim activity. When you register on WageWorks' website, be sure to include your email address in your profile to take advantage of automatic email notifications regarding the status of your claims, direct deposits and card transactions.

EZ Receipts mobile application. The WageWorks EZ Receipts app allows you to check current health care and dependent day care account balances on-the-go. You also can submit claims for both health care and dependent day care accounts, as well as WageWorks Card receipts for health care expenses, instantly.

Key Facts About the Accounts

Consider the following before making your account elections.

The Dental and Vision FSA is for Aetna HSA Medical Plan participants only. The DVFSA can be used with your HSA; however, it is for eligible dental and vision expenses only. See table on page 47.

$500 HCFSA and DVFSA carryover allowed. Up to $500 of your unused FSA funds will roll over into the next Plan Year. Any funds remaining in your FSA above $500 will be forfeited. The rollover amount is in addition to and does not affect the $2,550 maximum annual amount you are permitted to elect. You are not required to enroll in the HCFSA or DVFSA for the next Plan Year to use your carryover funds.

Even if you or your family members aren't covered by an L-3 health care plan, you can still use the HCFSA or DVFSA. Your spouse and dependent children under age 26 (see page 54 for dependent eligibility requirements) are considered eligible dependents for HCFSA and DVFSA purposes, while a dependent for DDCFSA purposes is a child under age 13 who is claimed as a dependent on your federal income tax return, or anyone living with you whom you claim as a dependent on your federal income tax return and who is mentally or physically incapable of self-care.

Use your DDCFSA money in the current Plan Year. You must use all the money in your DDCFSA each Plan Year. The IRS does not allow it to be returned to you or carried over to the next Plan Year. You have until March 31 of the following Plan Year to submit claims for eligible expenses you had the previous Plan Year.

Project your health care expenses carefully. You cannot fund your account(s) as you go along; you must decide how much to deposit for the Plan Year before each Plan Year begins. Once you decide your contribution amount, you generally cannot change it during the Plan Year, unless you have a qualifying event, as determined by the IRS.

You can't double-dip. If you use a DDCFSA for child care expenses, you can't use the same expenses to claim the tax credit the government allows on work-related dependent day care expenses. Similarly, any expenses reimbursed by a HCFSA or a DVFSA cannot also be claimed as deductions when you file your income tax return.

Active enrollment required every year. Each year, during annual enrollment, you must decide whether or not to deposit money into the accounts. So if you have an account now and want one next year, too, you have to re-elect it to continue your participation. Similarly, if you waive participation when it is first available to you, you'll have to wait until the next annual enrollment period to set up an account unless you have a qualifying event, as determined by the IRS. If you're thinking of using the DDCFSA to pay for child or elder care, keep in mind that, in general, to be eligible for reimbursement, dependent day care expenses must be incurred because you and your spouse (if you're married) both work or are looking for work.

You can get up-to-the-minute Health Care and/or Dependent Day Care FSA account information at any time by logging into your account at www.wageworks.com. You can also speak to a WageWorks representative Monday through Friday, 8 a.m. to 8 p.m., Eastern Time, by calling 1-877-WageWorks (1-877-924-3967).

Prescription required for over-the-counter medications. All over-the-counter medications (except insulin) require a prescription to be eligible for reimbursement through a HCFSA. You must have a doctor's prescription specifying the name of the medication and how often it is to be used. You cannot use your WageWorks Card for these medications; you must file a claim with *Pay Me Back* and submit a copy of your prescription. (This requirement applies to medications only—not to over-the-counter supplies such as bandages or contact lens solution.)

Key Facts About the WageWorks Card

Consider the following when using your WageWorks Card.

Health care only. You may use the WageWorks Card to pay for eligible health care products and services only. You must use *Pay My Provider* or *Pay Me Back* to pay for (or get reimbursed for) eligible dependent day care expenses.

Activation required. You will receive a WageWorks Card automatically when you enroll in the Health Care or Dental and Vision Flexible Spending Account. To use it, you must activate it first. Follow the directions with your card to complete the activation process. Please note if you received a WageWorks Card previously, you must use the same card in 2016. You will not receive a new WageWorks Card for your 2016 HCFSA or DVFSA, as applicable. Instead, your 2016 election will be "loaded" onto your current card the first time you use it in 2016.

Don't discard your card. If you're a new participant and are receiving a WageWorks Card for the first time, please note that your card will come in a plain, unmarked envelope (just as your credit cards do). Please don't discard it by mistake.

Credit, not debit. When you swipe your card at the checkout, choose "credit" and then sign for the transaction or contact WageWorks to enable a pin for use as a debit card option.

Merchant limitations. The WageWorks Card may be used only at merchants that have been certified for the IRS-required Inventory Information Approval System (IIAS). **All merchants (health care and non-health care) must be IIAS-certified in order for your card to work at those locations.** If a merchant is not IIAS-certified, you will need to pay the eligible expense out of pocket and file a claim with *Pay Me Back* to be reimbursed. Log on to www.sig-is.org for a complete list of IIAS-certified merchants.

Save your receipts. Save all your receipts or other documentation that describes the items you have paid for with your card, even if you use the card at an IIAS-certified merchant. It may be requested by WageWorks or the IRS to verify you used your account to pay for eligible products or services. You will be required to reimburse your account if you cannot provide documentation to show the card was used for eligible health care products or services.

Current expenses only. You may use the WageWorks Card only for expenses incurred while you are a FSA participant. IRS regulations prohibit use of the card to pay for eligible expenses received in the past or to be received in the future.

If you need more cards. If you lose your card, if it is stolen or if you want to order additional cards, contact WageWorks by phone, or log in to your account at www.wageworks.com, to order cards for yourself and/or your dependents. Please note that you may order an additional card for each of your dependents.

SAMPLE EXPENSES THAT QUALIFY FOR FSA REIMBURSEMENT

HEALTH CARE	DENTAL AND VISION FSA (HSA PARTICIPANTS ONLY)	DEPENDENT DAY CARE
• deductibles, coinsurance and copayments • over-the-counter medications used to treat illness or injury (doctor's prescription required) • expenses that exceed plan limits (e.g., more than the Medical Plan's limit on chiropractor visits in a year) • medical, dental and vision care expenses not covered under any health plan (such as contact lens solution and hearing aids) • infertility treatment • any other health care expenses allowed as deductions by the IRS on your federal tax return that are not reimbursed by any other plan or taken as deductions for tax purposes (such as tuition for a special school for severely learning-disabled children).	• expenses that exceed dental and vision plan limits (e.g., more than the Dental Plan's limit on orthodontia care) • dental and vision care expenses not covered under any health plan (such as contact lens solution)	• fees for day and/or elder care provided by individuals • fees for day care provided by a day care center • costs for a nursery school or summer day camp. **Note:** Dependent day care expenses are reimbursable only if the person you pay for providing day care reports those payments as income. (You must provide the caregiver's Social Security or tax ID number when submitting claims for reimbursement.)

Log on to WageWorks' website (www.wageworks.com) for a complete list of eligible health care and dependent day care expenses.

KEY ISSUES TO FACTOR INTO YOUR FSA PLANNING

- The **Dental and Vision Flexible Spending Account (DVFSA)** is for HSA Plan participants only. If you are enrolled in one of the other medical plan options, you are able to participate in the HCFSA.
- You cannot change your HCFSA, DVFSA, or DDCFSA contribution amounts during the year (unless you have a qualifying event).
- You must decide how much to contribute each year during the preceding annual enrollment period.
- The amount you choose to contribute to your account(s) for the year will be divided equally by the number of pay periods in the calendar year and deducted from each paycheck on a pre-tax basis.
- If you leave the Company during the year, FSA claims will be reimbursed only for expenses incurred on or before the date you terminate employment. (You may elect to continue to participate in the HCFSA or the DVFSA, as applicable, via COBRA for the rest of the calendar year, in which case your contributions—including the 2% COBRA administrative fee you pay—are made with after-tax dollars.)
- You have until March 31, 2017, to submit claims for eligible expenses incurred while a 2016 HCFSA, DVFSA or DDCFSA participant.
- Up to $500 from your HCFSA or DVFSA will roll over to the next Plan Year. Any funds remaining above $500 will be forfeited. The rollover amount is in addition to and does not affect the $2,550 annual amount you are permitted to contribute to a HCFSA or DVFSA. You are not required to enroll for the next Plan Year to use your carryover funds.
- You must use all the money in your DDCFSA each Plan Year. The IRS does not allow it to be returned to you or carried over to the next Plan Year.
- If you're thinking of using the DDCFSA, keep in mind that in general, to be eligible for reimbursement, dependent day care expenses must be incurred because you and your spouse (if you're married) both work or are looking for work.
- If your spouse is eligible to maintain a Dependent Day Care Flexible Spending Account, each of you can have one. You cannot, however, claim the same expenses for reimbursement nor exceed the $5,000 combined annual contribution limit.
- Having a Dependent Day Care Flexible Spending Account may limit the tax credits you may be able to take for dependent day care expenses. You may use both the Flexible Spending Account and the tax credit, provided you do not claim the same expenses for both. In most cases, for those whose annual salary is less than $40,000, using the tax credit instead of the Dependent Day Care Flexible Spending Account may be more beneficial. Consult a tax advisor for more guidance.

Health Care FSA rollovers and the HSA. IRS rules forbid you from having a regular Health Care Flexible Spending Account if you also have a Health Savings Account. If you are currently enrolled in a HCFSA, elect the Aetna HSA Medical Plan and have a HCFSA balance remaining at the end of 2015, here's what will happen in 2016:

- You have until March 31, 2016 to use your remaining 2015 HCFSA balance for eligible medical expenses incurred before January 1, 2016.
- You can choose to pay for eligible medical expenses incurred on or after January 1, 2016 with funds from your HSA or out of your own pocket. You may also elect to make a separate contribution in 2016 to the DVFSA for dental and vision expenses incurred on or after January 1, 2016.
- Any balance remaining in your 2015 HCFSA, up to $500, as of April 1, 2016 will automatically roll over into your 2016 Dental and Vision FSA (if you have one) or be forfeited (if you don't). Amounts above $500 will be forfeited.

COMMUTER BENEFITS PROGRAM

The Commuter Benefits Program, which is administered by WageWorks, lets you pay qualified commuting costs through automatic pre-tax and after-tax payroll contributions.

Eligible Expenses

Qualified commuting costs include expenses incurred for the following:

- public transportation such as bus, light rail, regional rail, streetcar, trolley, subway or ferry
- commercial vanpool
- parking at or near work
- parking at or near public transportation for your commute.

Ineligible commuting costs include transportation costs that are not work-related, carpool costs, expenses for other family members, gasoline, tolls, mileage, taxis and limousines. For a complete list of eligible transportation expenses, visit www.wageworks.com.

You cannot use the Commuter Benefits Program for expenses reimbursed elsewhere (e.g., via your business unit's expense report procedures).

How the Program Works

The IRS allows you to set aside up to $130/month* for transit and vanpool expenses and up to $250/month* for parking expenses on a pre-tax basis. Any commuter expenses above the IRS limits (that is, any transit or vanpool expenses over $130/month and any parking expenses over $250/month) are taken out of your paycheck on an after-tax basis.

Reimbursements for public transportation. To arrange automatic payments for public transportation, use *Buy My Pass.* Log in to your account at www.wageworks.com and select your transit provider and pass type. WageWorks automatically will send you your transit pass or tickets in the mail each month, in time for the month they are valid. If you use a SmartCard or other electronic pass, it will be reloaded each month automatically.

* Please note IRS limits are subject to change.

Reimbursements for parking. There are two ways to reimburse yourself for eligible parking expenses:

- ***Pay My Parking***. If you elect *Pay My Parking,* WageWorks automatically will pay your parking expenses each month. To use *Pay My Parking,* log in to your account at www.wageworks.com, select your parking provider and monthly amount. WageWorks will take care of it from there.
- ***Pay Me Back.*** You can use *Pay Me Back* to get reimbursed from your account for eligible parking expenses you pay for out-of-pocket because your expenses vary from month to month or because your parking provider accepts cash only. To use this option, log in to your account at www.wageworks.com, select "Commuter" and then choose "Print Pay Me Back Claim Form" to print the form. Fill in all the information requested on the form, attach your receipt(s), sign it and follow the instructions to fax or mail it to WageWorks. Claims will not be paid without a valid receipt.

How to Enroll

To enroll in the Commuter Benefits Program, go to www.wageworks.com and select "Register Now." (If you participate in an FSA and have already registered on the WageWorks website, you do not need to complete the registration process again. Simply log in and click on the "Commuter" tab.) You can also enroll via phone by calling the WageWorks Learning Center at 1-877-WageWorks (1-877-924-3967), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time.

You can enroll, make changes or stop participating at any time. Initial enrollment, election changes and termination are effective the first of the month following the date you request them, provided you do so by the 10th of the month prior to the month you want your election to take effect. For example, to increase your contributions for March 2016, you must do so no later than February 10, 2016. For more information about the Commuter Benefits Program, log on to www.wageworks.com or call 1-877-WageWorks (1-877-924-3967).

VOLUNTARY INSURANCE PLANS

PersonalPlans Voluntary Benefits

The PersonalPlans Voluntary Benefits program makes it easy for you to shop for and, if you like, purchase voluntary benefit plan coverage. PersonalPlans Voluntary Benefits are offered on an employee-pay-all basis and administered by Mercer Health & Benefits Administration LLC (Mercer Voluntary Benefits).

Here is what each plan offers:

- **Group Universal Life Insurance** gives you the opportunity to purchase life insurance of one to eight times your pay for yourself and lesser amounts for your family at affordable group rates, as well as to build a cash reserve in a tax-advantaged accumulation account called the Cash Fund. If your family status changes you can increase your coverage by one multiple of your base annual salary without having to provide evidence of good health, as long as you do so within 60 days of the family status change.
- **Group Auto and Home Insurance** gives you access to special group rates and discounts (available in most states to those who qualify) for your personal insurance needs. Policies available include auto, home, condo, mobile/motor home, renters, recreational vehicle, boat, and personal excess liability ("umbrella").

Please note that if you have Group Universal Life or Voluntary AD&D Insurance coverage, your coverage amount or participation details will **not** be displayed on the Benefit Center website or on your *Personalized Enrollment Worksheet*. To view the details of your GUL or VADD Insurance, visit the Mercer Voluntary Benefits website at www.personal-plans.com/L3.

- **Voluntary AD&D Insurance** provides high-limit accidental death and dismemberment coverage for you and your eligible family members. You may choose Voluntary AD&D coverage of one to ten times your base annual salary, rounded to the next higher $1,000, up to a $1,500,000 maximum benefit. The full coverage amount—your "principal sum"—is payable if you die accidentally, with partial benefits payable if you are severely injured or paralyzed in an accident while coverage is in effect. If you elect family coverage, each eligible member of your family has his/her own coverage amount, expressed as a percentage of your principal sum:
  - **Spouse:** 60% of your principal sum, up to a $300,000 maximum benefit
  - **Children:** 15% of your principal sum for each child, up to a $50,000 maximum benefit per child.
- **Group Legal Insurance** gives you access to a network of attorneys for a variety of legal needs, including estate planning, financial matters, real estate matters, defense of civil lawsuits, family law, traffic offenses, document preparation and review, immigration assistance, juvenile matters and consumer protection. Most services provided by a network attorney are covered in full, while services provided by non-network attorneys are payable up to plan maximums. Please note that **you may enroll in the Group Legal Insurance Plan only while you are actively employed and only during the enrollment period,** and you must remain in the Plan for the entire 2016 Plan Year. If you are enrolled in the Group Legal Insurance Plan in 2015, your Plan participation will continue

automatically in 2016; if you want to drop coverage, you must do so during the 2016 enrollment period. New hires must enroll within 60 days of the date they become eligible, and must remain in the Plan for the remainder of the Plan Year. Note that Group Legal Insurance is suspended while you are on an unpaid leave of absence; upon your return to work, you must contact the L-3 Benefit Center to reinstate your coverage.

- **Identity Theft Protection** helps you and your family safeguard your finances, reputation and credit. Coverage includes identity monitoring and restoration, credit monitoring and internet surveillance to detect information misuse. In addition, coverage also includes digital identity reporting, an online vault for securely storing documents and credit cards, lost wallet replacement assistance, solicitation reduction to cut down on unwanted mail and telephone solicitations, and social media monitoring. Coverage also includes a $1,000,000 identity theft insurance policy to help pay legal defense expenses and cover lost wages due to identity theft.
- **Aetna Hospital Income Plan** provides a cash benefit that can help you pay for out-of-pocket expenses when you have an eligible inpatient hospital stay. The Hospital Plan pays a one-time, annual lump sum benefit of $1,000 for the first inpatient hospital admission each plan year. The Plan pays an additional $100 per day for each day up to 10 days (inpatient days do not need to be consecutive). The Plan also pays an additional $100 per day if any of these 10 days are in an intensive care unit. If you choose to enroll your dependents, each dependent will receive the same cash benefit. This cash benefit is paid in addition to any benefits you may receive under your medical health plan. It's important to note that the Aetna Hospital Income Plan provides limited coverage and is not intended to substitute for comprehensive medical plan benefits.
- **MetLife Critical Illness Insurance.** This coverage pays a cash benefit directly to you if you have a heart attack, stroke, kidney failure or are diagnosed with cancer, Alzheimer's disease or a similarly serious condition on the Plan's list. When you enroll, you choose the benefit amount—either $15,000 per event, up to a $45,000 maximum benefit, or $30,000 per event, up to a $90,000 maximum benefit—and whether to also enroll your spouse and eligible dependent children. You can use the money for everyday expenses or to help cover your medical plan's deductible, copays or coinsurance. The Plan may pay additional benefits if your condition recurs. Enrollment in MetLife Critical Illness Insurance is available only at annual enrollment or at a qualifying life event.

How to Enroll in the PersonalPlans Voluntary Benefits Plans

You must enroll in the Aetna Hospital Income Plan, MetLife Critical Illness Insurance, Group Legal Insurance and Identity Theft Protection through the L-3 Benefit Center. To enroll in other PersonalPlans coverage or to get more details about it, call Mercer Voluntary Benefits at 1-800-642-5722 or visit www.personal-plans.com/L3. If you terminate employment with L-3, contact Mercer Voluntary Benefits for your coverage continuation options.

TRICARE Supplement Plan

The TRICARE Supplement Plan is a voluntary medical plan available only to TRICARE-eligible domestic employees (that is, those who retired from U.S. military service, are married to or are surviving spouses of U.S. military retirees, or are otherwise eligible for TRICARE). If you enroll in the Plan, you pay the full cost of coverage on a **pre-tax** basis. It pays the difference between what TRICARE pays for eligible expenses and the TRICARE-allowed amount for those expenses after the plan deductible has been met. Benefits depend on whether you have TRICARE Standard or Extra or TRICARE Prime. Please note that L-3 does not sponsor the TRICARE Supplement Plan, so different eligibility rules may apply. To determine if you are eligible for TRICARE, go to www.tricare.mil and use the DEERS (Defense Enrollment Eligibility Reporting System). Please note that if you are over age 65, you can participate in the TRICARE Supplement Plan only if you live or work overseas (in which case you must still be eligible for Medicare Part A and enrolled in Medicare Part B), or you are not eligible for Medicare and TRICARE is your primary benefit option. For more information on the TRICARE Supplement Plan, visit www.asicorporation.com/L-3.

Please note that L-3 does not sponsor the Critical Illness Insurance, Group Universal Life, Group Auto and Home, Group Legal Insurance and Identity Theft Protection Plans, nor the TRICARE Supplement Plan.

EMPLOYEE ASSISTANCE PROGRAM

The L-3 Employee Assistance Program (EAP)—known as LifeMatters—is available to all L-3 employees and their dependent family members 24 hours a day, 365 days a year, at no cost. When you call, a professional counselor will speak with you about your concerns and offer a variety of services, including:

- **Counseling (on the phone and in-person)** for stress, family difficulties, depression and anxiety, chemical dependency, crisis situations or any other personal or family problem
- **Senior Care services to assist you in caring for a loved one,** including in-home assessments, facility evaluations, family consultations and ongoing senior care management services
- **Breaking Free smoking cessation program** for helping you quit smoking through counseling sessions with a "quitting coach" and other resources
- **Life care resources and referrals** for child care providers and needs, health and wellness and other work/life balance concerns
- **Financial consultation with a certified financial counselor** for debt management and consolidation, budgeting, credit report review or correction, information on mortgages, loans or other financial arrangements and college or retirement planning
- **Legal consultation (over the phone or in-person)** for consumer law, traffic citations, family law, estate planning and other personal law issues.

In addition, LifeMatters provides online and telephone self-assessments for concerns, including adaptation to change, stress, alcohol and drug abuse, anxiety and depression.

LifeMatters is provided by Empathia, Inc., an independent consultation firm. Your use of the program and any information you share is confidential, except when your safety or the safety of another individual may be at risk.

For more information, call LifeMatters at **1-800-634-6433** or visit them online at www.mylifematters.com (password: L3C1). From overseas, call collect to **1-262-574-2500**.

OTHER INFORMATION

Confidentiality of Health Care Information

L-3's Health Plans are required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official *HIPAA Privacy Notice,* which is posted on the L-3 Benefit Center website at https://L-3.benefitcenter.com, is summarized here.

The intent of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as "protected health information" (PHI). Your Health Plans will not use or disclose your protected health information without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. In particular, the Plans will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any benefits provided under another employee benefit plan.

Our plans also hire professionals and other companies to advise the plans and help administer and provide health care benefits. The plans require these individuals and organizations, called "Business Associates," to comply with HIPAA's privacy and security rules. In some cases, you may receive a separate notice from one of the plan's Business Associates (for example, your medical plan's claims administrator). The notice will describe your rights with respect to benefits administered by that individual/organization.

Under federal law, you have certain rights where your protected health information is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

The *HIPAA Privacy Notice* was updated effective September 23, 2013 to describe the following additional protections provided as a result of recent changes in the law:

- Although the Plan may use your protected health information for underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits, the Plan will not use or disclose protected health information that is genetic information about you for underwriting purposes.
- The Plan cannot use or disclose your protected health information for marketing purposes or sell your protected health information without your authorization.
- You have the right to be notified if there is a breach of your unsecured protected health information. In the event of a breach requiring notice, you will be notified by the Plan or, if applicable, the Business Associate responsible for the breach.

If you have questions about the privacy of your health information or if you would like a copy of the revised *HIPAA Privacy Notice,* please contact the L-3 Benefit Center. You may also access the revised *HIPAA Privacy Notice* on the L-3 Benefit Center website at https://L-3.benefitcenter.com.

Women's Health and Cancer Rights Act Notice

Under the Women's Health and Cancer Rights Act of 1998, participants who receive medical and surgical benefits in connection with a mastectomy, and who elect breast reconstruction in connection with such mastectomy, will be provided with coverage in a manner determined in consultation

with the patient and attending physician for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Contact the claims administrator of the plan you elect for more information.

Medicare Part D

As required by law, L-3 will notify you about whether or not the prescription drug coverage the Company provides to Medicare-eligible active employees constitutes "creditable coverage" under Medicare. That is, the notice will tell you whether the prescription drug coverage offered by your Company-sponsored plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

If you are a Medicare-eligible active employee, please read the notice carefully. It explains the options you have under Medicare prescription drug coverage, and can help you decide whether you want to enroll in a Medicare prescription drug plan. For more information about Medicare prescription drug coverage, go to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Wellness on the L-3 Intranet

The L-3 Intranet is your source for everything wellness-related. Log on to the Wellness Page for information, tools and tips on a wide range of wellness topics, including smoking cessation, healthy recipes, diet and nutrition and links to other wellness-related sites. To access the L-3 Corporate Intranet, log in at **https://webs.L-3com.com/.**

If you have any questions or problems activating your Corporate Intranet account, or accessing the Intranet, email **web.services@L-3com.com.**

If you get divorced, you must contact the Benefit Center immediately to remove your ex-spouse from coverage. Ex-spouses are not eligible for coverage under L-3 plans.

Dependent Eligibility Requirements

Your eligible dependents are your spouse and children, defined as follows:

- **Spouse.** Your spouse is your lawfully married spouse. A common-law spouse will also be considered a spouse for L-3 Communications Group Health Plan for Active Participants ("Plan") purposes, provided the common-law marriage took place in a state that treats common-law marriage as legal marriage and you satisfy applicable state law requirements (including any documentation requirements). Please note that a decree of divorce or legal separation requiring you to provide health coverage for your ex-spouse does not make your ex-spouse eligible for coverage under the Plan.

  Note: No change through December 31, 2016, for currently enrolled same-sex civil union or same-sex domestic partners. L-3 will continue to cover any currently enrolled same-sex civil union partner or same-sex domestic partner, and allow you to re-enroll your current same-sex civil union partner or same-sex domestic partner for 2016 (as long as there is no interruption in coverage). Beginning on or after January 1, 2017, L-3 will discontinue coverage for same-sex civil union partners and same-sex domestic partners. At that point only lawfully married spouses, whether same sex or opposite sex, will be eligible for coverage under L-3's health and welfare benefit plans.

- **Children.** Dependent children are your children under age 26, including:
  - your biological children
  - your lawfully adopted children. If you have started legal adoption procedures, the child is considered a dependent if he/she lives with you full-time and depends on you for support. If you are adopting a child from birth, the child is considered a dependent from birth.
  - your stepchildren
  - any other child, including a grandchild, niece, nephew, etc. for whom you have proof of legal guardianship or a court order providing you (or you and your spouse/same-sex domestic partner) with sole legal custody, as long as the child lives with you in a parent-child relationship, you provide the sole support to the child and you can claim the child as a dependent on your federal income tax return. If you have started legal guardianship procedures, coverage is effective with the filing of the application. For coverage

to continue, you must be appointed a legal guardian within three months of filing your application. Participants claiming that a child qualifies for coverage based on sole custody by the participant or the participant and spouse will be required to complete an affidavit and provide a court order demonstrating satisfaction of Plan requirements.

You may also cover any other dependent children for whom Plan coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN).

Making Changes Mid-Year

The IRS requires that your benefits paid with pre-tax employee contributions stay in effect throughout the full Plan Year (January 1–December 31) unless you have a "qualifying event." Please note that not all "qualifying events" enable you to make mid-year changes, and any change you are permitted to make must be directly related to the impact of the event on your benefits or eligibility. For example, it is not a qualifying event if you are a benefits-eligible part-time employee and you become a benefits-eligible full-time employee (or vice versa), because your benefit eligibility did not change. Contact the Benefit Center to discuss your specific situation.

L-3 abides by the IRS's definition of qualifying events, which includes:

- your legal marital status changes (e.g., through marriage, divorce, legal separation or annulment)
- the number of your dependents changes (e.g., through the birth or adoption of a child; a change in dependent status under the Internal Revenue Code; or the death of a child or spouse)
- you are required to cover a child pursuant to a Qualified Medical Child Support Order or a National Medical Child Support Notice
- your spouse or your dependent becomes employed or unemployed
- you, your spouse or your dependent takes or returns from an unpaid leave of absence
- your, your spouse's or your dependent's eligibility for benefits changes as a result of employment status changing from full-time to part-time (or vice versa) or from hourly to salaried (or vice versa)
- your dependent first meets or no longer satisfies the requirements for coverage because he/she reaches the limiting age or any similar circumstance
- you, your spouse or your dependent goes on strike or is locked out, or returns from a strike or lockout
- the coverage options available to you change because you, your spouse or your dependent changes residences or work sites
- you previously waived participation because you were covered under your spouse's group medical plan and you subsequently lose coverage under that plan
- you, your spouse or your dependent either becomes eligible or loses eligibility for Medicare or Medicaid coverage
- according to Internal Revenue Service guidelines, there's a significant change in your, your spouse's or your dependent's medical coverage
- you, your spouse or your dependent makes a change (or a change is made) under another employer group health plan
- you or your dependent loses eligibility under a Medicaid plan or a state child health insurance plan (SCHIP)
- you or your dependent becomes eligible for government assistance under a Medicaid plan or an SCHIP designed to help you pay for Plan coverage.

You can revoke coverage under a medical plan if:

- there is a change in your employment in which you go from working on average at least 30 hours per week to a position in which you are reasonably expected to average less than 30 hours per week, even if that reduction does not result in your loss of coverage under the plan; and
- you and your dependents who cease coverage under the plan state that you intend to enroll in another plan that provides "minimum essential coverage" effective no later than the first day of the second month following the month in which your plan coverage ends.

You can also revoke coverage under a medical plan if:

- you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, in accordance with rules set forth by the Department of Health and Human Services, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- you and any dependents who cease coverage under the plan provide evidence of your enrollment rights and state that you intend to enroll in a Qualified Health Plan through a Marketplace effective no later than the day immediately following the last day of your coverage under this plan.

If you have a qualifying event, you have 60 days from the event to change your coverage election. The change in your election must be due to and consistent with the qualifying event. (For example, if you are widowed mid-year, you could change from "employee and spouse" coverage to "employee only" coverage, but you couldn't drop your coverage.) The effective date of your election change is the date of the qualifying event. For example, if your election change is due to the birth of a child, the change is effective as of the child's date of birth.

An election change will not become effective until you provide the required enrollment materials, including appropriate written documentation of the reason for the change. **Please note that you will need a dependent's Social Security number to enroll that dependent.** (If the dependent does not yet have a Social Security number, you must provide one within 60 days, unless the process is delayed for reasons beyond your control. You are not required to report a Social Security number for a dependent who is not a U.S. citizen (and therefore does not have a Social Security number nor is eligible for Medicare). If the dependent becomes eligible for a Social Security number, you must provide it as soon as it is received.) **You also will need to complete the *L-3 Dependent Eligibility Questionnaire* and provide certain documents to prove that the dependent is eligible.**

Contact the Benefit Center as soon as you know that an event is about to take place (or immediately after it takes place) to make sure you allow yourself enough time to take the appropriate action. The Benefit Center will explain the procedure to you.

If you have a family status change, you have 60 days from the qualifying event to change your coverage election.

Payroll Deductions

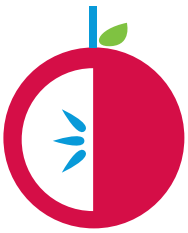
Any paycheck that includes hours worked will include the full deductions for health and welfare benefits for that pay period, even if you are a new hire or a terminating employee and only work a partial pay period. L-3 also has a process in place to reconcile missing payroll deductions in situations such as unpaid leaves of absence, family status changes, transfers, late enrollments, etc. Contact the Benefit Center for more information.

WHEN YOU NEED ASSISTANCE

FOR INFORMATION ON	TELEPHONE	WEBSITE
The L-3 Benefit Center General Questions About Your Benefits Qualifying Events Address Changes	**Phone:** 1-866-919-2424 (outside the U.S., call 1-412-505-6904) **Fax:** 1-855-291-5624	https://L-3.benefitcenter.com
Aetna Aetna HSA Medical Plan Aetna HealthFund HRA Medical Plans Aetna Choice POS II Medical Plan Aetna Elect Choice EPO Medical Plan Aetna Out-of-Area Medical Plan L-3 Communications Prescription Drug Plan Aetna Rx Home Delivery The Aetna PPO Dental Plan The Aetna DMO Dental Plan	1-800-345-5839 1-800-504-2386 1-800-879-4337 1-877-238-6200	www.aetna.com
Aetna International (for non-U.S.-based employees) Aetna International Medical Plan Aetna International Dental Plan	1-800-231-7729 or call collect 1-813-775-0190	www.aetnainternational.com
Fidelity Investments Health Savings Account	1-800-354-7125	www.NetBenefits.com
VSP Vision Care Plan	1-800-877-7195	www.vsp.com
WageWorks Health Care Flexible Spending Account Dental and Vision Flexible Spending Account Dependent Day Care Flexible Spending Account Commuter Benefits Program	1-877-924-3967	www.wageworks.com
Mercer Voluntary Benefits Aetna Hospital Income Plan MetLife Critical Illness Insurance Group Universal Life Insurance Group Auto and Home Insurance Voluntary AD&D Insurance Group Legal Insurance Identity Theft Protection	1-800-642-5722	www.personal-plans.com/L3
Selman & Company TRICARE Supplement Plan	1-800-638-2610	www.asicorporation.com/L-3
Empathia, Inc. LifeMatters Employee Assistance Program (EAP)	1-800-634-6433	www.mylifematters.com PASSWORD: L3C1
ADP COBRA Administration	1-877-324-4644	https://www.benedirect.adp.com
International SOS Assistance Outside the U.S.	1-800-523-6586 (outside the U.S., call collect 1-215-942-8226)	www.internationalsos.com PASSWORD: 11BCPA000028
ActiveHealth Management Health and Condition Management	1-866-606-6539	www.myactivehealth.com/L-3com
Aetna Short Term Disability (STD) Plan Long Term Disability (LTD) Plan	1-800-221-0807	www.wkabsystem.com ID: L3COMMS

Note: Not all plans listed in the chart above are available at all business units. See your *Personalized Enrollment Worksheet* to find out which plans are available to you.

NOTES



HEALTHY

FOCUS

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