Annual Notification of Benefit Rights

The Mental Health Parity Act of 1996

How will the Mental Health Parity Act affect my benefits?

Under MHPA, group health plans, insurance companies and HMO's offering mental health benefits will no longer be allowed to set annual or lifetime limits on mental health benefits that are lower than any such limits for medical and surgical benefits. A plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose such a limit on mental health benefits. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including Lymphedemas (swelling associated with the removal of lymph nodes).

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with other benefits under your plan or coverage.

Newborns' and Mothers' Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable).

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lost eligibility for that other coverage (or if the employer stops contributing toward your dependents' other coverage). However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Keep in mind you will also need to request enrollment within **30 days** if you and/or your dependents lose coverage resulting from a legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Under these rights, a group health plan is required to provide a special enrollment period for yourself and/or your dependents.

If an employee or dependent becomes eligible for a state-granted premium subsidy towards employer health coverage, the employee can request enrollment under the employer's health plan within 60 days of the date the employee or dependent is determined by Medicaid or SCHIP to qualify for the subsidy.

If an employee or dependent loses coverage under Medicaid or SCHIP, the employee can request enrollment under the employer's health plan, again within 60 days of the date the employee or dependent loses eligibility.

To request special enrollment or obtain more information, contact your HR department or Advanced Professionals, Insurance and Benefit Solutions, Inc. (408) 363-0977.

General Notice of Preexisting Condition Exclusion

The medical plan options provided by this company impose a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy not to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should provide your new insurance carrier with a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a certificate, but you do have prior health coverage, you will need to obtain one from your prior plan or issuer. There are other ways that you can show you have creditable coverage. Please contact your HR department if you have questions regarding the preexisting condition exclusion or need help demonstrating creditable coverage.

Important Notice from your Employer about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and new prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **On January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare.**
2. **Your employer has determined that the prescription drug coverage offered by your current carrier is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.**
3. **Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and it can help you decide whether or not you want to enroll.**

The Medicare Part D program provides beneficiaries with assistance paying for prescription drugs. The drug benefit, added to Medicare by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), began in January 2006. Unlike coverage in Medicare Parts A and B, Part D coverage is not provided within the traditional Medicare program. Instead, beneficiaries must affirmatively enroll in one of many hundreds of Part d plans offered by private companies. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

The Annual Enrollment Period for Part D runs from November 15 – December 31. During this period people with Medicare can enroll in a plan or change their enrollment from one plan to another. Individuals who are already in a plan should decide whether it will be right for them in 2009. Keep in mind that your existing prescription drug coverage is, on average, as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. You are eligible for two months special enrollment (SEP) to join the Medicare drug plan if you lose your current creditable prescription drug coverage, through no fault of your own. If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days, your Medicare drug premium can increase (penalty) by at least 1% per month not enrolled. You may also have to wait for the annual enrollment period: November 15[t] – December 31.

If you do decide to enroll in a Medicare prescription drug plan and drop your employer's prescription drug coverage, be aware that you may not be able to get your employer's coverage back at a later date.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. See pages 9 – 11 of the CMS disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/creditablecoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

The Standard Drug Benefit

The Medicare law establishes a standard Part D drug benefit. Plans must offer a benefit package that is at least as valuable as the standard benefit. The standard benefit is defined in terms of the benefit structure, not the particular drugs that must be covered. The standard benefit in 2008 has a $275 deductible and 25% coinsurance up to an initial coverage limit of $2,510 in total drug costs, followed by a coverage gap (the so-called "donut hole") where enrollees pay 100% of their drug costs until they have spent $4,050 out of pocket, excluding the Part D premium. Thereafter, enrollees pay 5% of total drug costs. The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

For more information about this notice or your current prescription drug coverage contact your Human Resources Department or call Advanced Professionals at (408) 363-0977.

***NOTE*:** You may receive this notice in the future such as before the next Medicare prescription drug coverage enrollment period or if coverage changes or you may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "***Medicare & You 2009***" handbook. You will receive a copy of the handbook in the mail from Medicare every year or you can download it from the Medicare website: www.medicare.gov. Link: http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

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

- Visit www.medicare.gov for personalized help.
- CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance: http://www.cms.hhs.gov/creditablecoverage/
- Call your State Health Insurance Assistance Program (Refer to your copy of the Medicare & You Handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

ERISA

WHAT ARE MY RIGHTS UNDER THE PLAN?

The following statement is required by federal law and regulations concerning your rights under the plan:

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Examine, without charge, at the plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the plan Administrator. The plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the plan or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suite in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. It may do so, for example, if it finds your claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

WHAT IS THE CLAIMS REVIEW PROCEDURE UNDER THE PLAN?

All general claims or requests should be directed to the plan Administrator of the plan. If a claim under the plan is denied in whole or in part (either because you receive a written denial or because you do not receive notice of the action taken within a reasonable time period), you may ask for a review of your claim. You have 60 days after your claim is denied to ask the plan Administrator for this review. During this 60-day period, you have the right to look at all relevant documents and to give your views and comments in writing. The plan Administrator must make a decision within 60 days after it gets your request for review, unless special circumstances require a longer time (but not more than 120 days after you have asked for the review). The decision of the plan Administrator must be given to you in writing and must include specific reasons for the decision, with specific references to the plan provisions on which the decision is based.

If you have any questions, please contact the plan Administrator.

HIPAA

HIPAA Notice of Privacy Practices for Personal Health Information

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

PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Dear Employee:

This is your Notice of Privacy Practices from ONStor. Please read it carefully. You have received this notice because of your employee benefits. Accuray, Inc. strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to Accuray, Inc. as "us", "we", or "our".

This notice describes how we protect the protected health information we have about you which relates to your ONStor employee benefits and how we may use and disclose this information. Protected Health Information includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to your Protected Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (HIPAA). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact Susan Harvell at 408-963-2400 or you may submit questions in writing directly to: ONStor, Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008.

We are required by law to:

- Maintain the privacy of your Protected Health Information (PHI);
- Maintain the privacy of your Electronic Protected Health Information (EPHI)
- Provide you this notice of our legal duties and privacy practices with respect to your PHI, and;
- Follow the terms of this notice.

We protect your PHI from inappropriate use or disclosure. Our team members, and those companies that help us service your team member benefits, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer the plans.

We will not disclose your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your team member benefits.

The main reasons for which we may use or disclose your PHI are: 1) to assist you in researching medical, dental, flexible spending account, and/or COBRA claims problems; 2) for benefit enrollment purposes and/or 3) for team member benefit plan administration. The following describes these and other possible uses and/or disclosures, together with some examples.

- **For Payment**: We may use and disclose PHI to assist you in researching claims disputes. For example, we may review PHI, at the team member's request, which is contained on claims submitted by medical or dental providers in an effort to verify that the claims were paid correctly.

- **For Health Care Operations**: We may also use and disclose PHI for benefit plan operations. These purposes include evaluating a team member's eligibility and administering the team member benefit plans. We may also disclose PHI to a business associate for benefit plan enrollment purposes. PHI may also be disclosed as part of the benefit plan renewal process so that we can make an informed decision regarding any such prospective changes to benefit plans.

- **Where Required by Law or for Public Health Activities**: We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities. We may also release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

- **To Avert a Serious Threat to Health or Safety**: We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services**: We may use PHI to provide you with information about benefits available to you under your current benefits plans.

- **For Law Enforcement or Specific Government Functions**: We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Required as Part of a Regulatory or Legal Proceeding**: If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **Other Uses of PHI**: Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about a specific right, please write to us at the location listed in our discussion of that right.

- **Right to Inspect and Copy Your Personal Health Information**: In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. To inspect and copy PHI, you must submit your request in writing to ONSTOR, Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. An individual chosen by us who was not involved in the original decision to deny your request will conduct the review. We will comply with the outcome of that review.

- **Right to Amend Your Personal Health Information**: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to ONStor,

Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- Is not part of the PHI kept by or for us; or
- Is not part of the PHI that you would be permitted to inspect and copy

- **Right to a List of Disclosures**: You have the right to request a list of the disclosures we have made of PHI about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes or national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to ONStor, Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**: You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care of payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. To request a restriction, you must make your request in writing to ONStor, Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both and to whom you want the limits to apply. We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications**: You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to ONStor, Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to File a Complaint**: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with ONStor, please forward all correspondence to ONStor, Human Resources Department, 254 East Hacienda Ave., Campbell, CA., 95008. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions about how to file a complaint, please contact ONStor, Human Resources Department, 254 East Hacienda Ave., Campbell, CA, 95008.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future. You will receive a copy of any revised notice from ONStor by mail, email, hand delivery or other appropriate means.