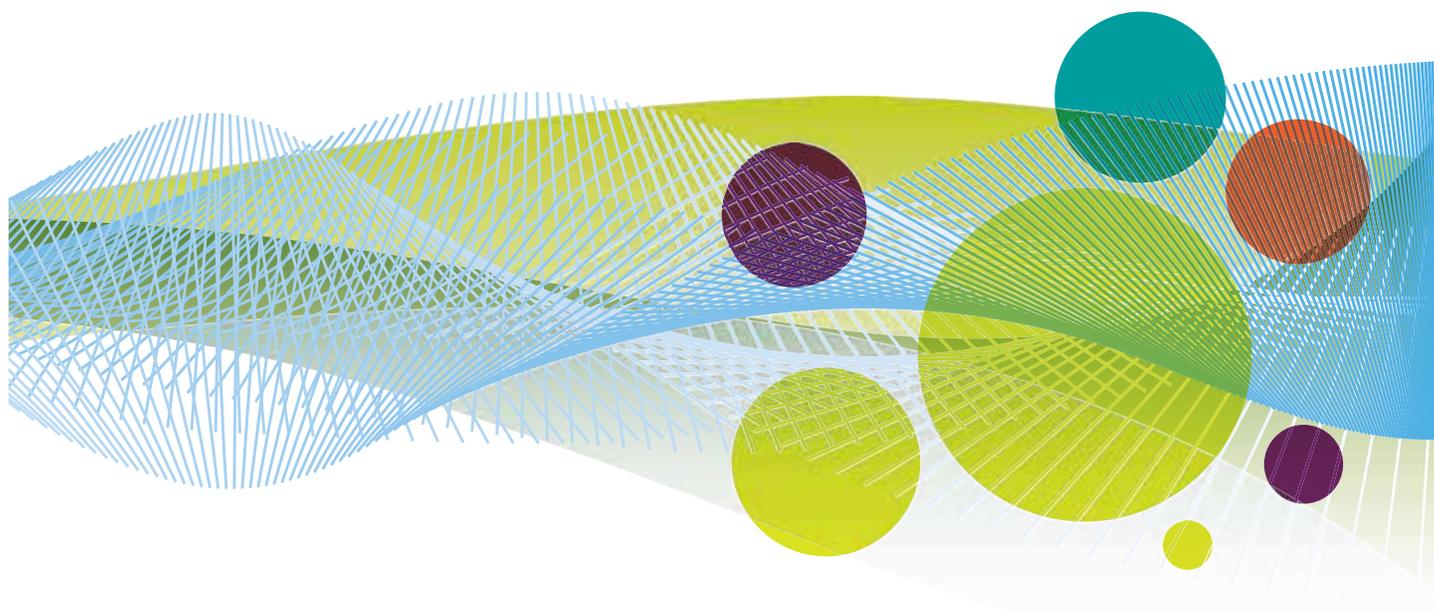


YourHealthCounts^{1 2 3 4 5 6 7 . . .}

2010 OPEN ENROLLMENT GUIDE



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Important Note:

This information describes only certain highlights of some of the company's benefit plans. It does not supersede the actual provisions of the applicable plan documents, which in all cases are the final authority. Company plans, programs, practices or processes may be amended, changed, or terminated by the company at any time without prior notice to, or consent by, participants. This notice does not constitute a contract of employment between the company and any individual, or an obligation by the company to maintain any particular benefit program, practice or policy.

Introduction

yourHealthcounts^{1 2 3 4 5 6 7 . . .}

Getting the most value from your benefits depends on how well you understand your plans and how to use them. Benefits are important; they provide support to you when you need it most. They're also personal: your life circumstances change from year to year and your financial and protection needs may change too.

Open Enrollment is a good time to review your family's changing needs, evaluate your existing plans and decide whether to continue with your current choices or make a change. Use the many resources available to make well-informed open enrollment decisions about your benefits for the coming year. Being proactive now will help you and your family to make Your Health Count! throughout the year ahead.

Open Enrollment allows you to:

- ❖ Change/enroll in a medical plan
- ❖ Change/enroll in a dental plan
- ❖ Change your current coverage level (Employee, Employee +1, Employee + Family)
- ❖ Add or remove dependents
- ❖ Change the tax status (before- or after-tax) of your premium deductions
- ❖ Enroll in 2010 Health Care and Child & Adult Day Care Flexible Spending Accounts (FSA).

Why this guide is important

This Guide provides information about your benefits to help you make well informed decisions during Open Enrollment. Take this opportunity to review your current benefit elections and decide if they'll meet your needs for the next year or whether you want to make changes in your coverage. In order to make informed choices, you should:

- ❖ Read the material in this enrollment guide and Your Book of Benefits
- ❖ Share the material with your family members
- ❖ Review your current enrollments on the web in the Benefits Participation Overview area of Employee Self Service (ESS)
- ❖ Review and compare the benefit plans that are available to you through your spouse's employer or other available plans

Calendar of Events

Open Enrollment begins

October 12

Schwab Retirement Plan Services Seminars

“Are You on Track For Retirement?”

October 20

10:30 a.m. Wigner Auditorium, 4500 N

1:00 p.m. 1060 Commerce Park Auditorium

October 21

8:30 a.m. Wigner Auditorium, 4500 N

Benefits and Wellness Fair

October 22 10:00 a.m. to 2:00 p.m.

Conference Center and Main Street

Benefits Staff, Medical, Dental & Wellness vendors available for Q&As

Open Enrollment closes at 4:00 p.m.

October 30

Deadline for submitting open enrollment elections

All enrollments, *including paper forms*, must be received in the ORNL or Y-12 Benefits Offices by 4 p.m. on Friday, October 30, 2009.

HA & Reward Points Plus wellness incentive campaign closes

October 31

Deadline for completing the Mayo Clinic Health Assessment

Deadline for earning and recording Reward Points

Note- Mayo Clinic technical support will not be available after 5:00 p.m. on Friday, October 30.

New coverages and HA incentive become effective January 1, 2010.

What's New for 2010

ORNL Open Enrollment begins Monday, October 12, 2009 and continues through Friday, October 30, 2009 at 4:00 p.m. During Open Enrollment you can enroll, re-enroll, or make changes to Medical, Dental, and Flexible Spending Accounts (FSA).

At a Glance...

- All Open Enrollment information is available from both ORNL's public and internal web sites at: <http://benefits.ornl.gov/openenrollment/2010/Pages/default.aspx>

Highlights for 2010:

- **Premiums for CIGNA medical coverage:**
 - are increasing for salaried employees
 - are decreasing for hourly, bargaining unit employees
- **Premiums for dental coverage:**
 - are increasing for casual employees
 - remain the same for all other employees
- **Adding a Dependent:** There are new steps to follow if you are adding a dependent to your medical and/or dental plan. A Certification of Dependent Status must be completed along with the medical and/or dental enrollment form. Paper versions of all documents must be completed and returned to the Benefits Service Center by the close of Open Enrollment. Forms are available on the Open Enrollment Forms tab.
- **Flexible Spending Accounts:** The Grace Period will not be available for accounts established for the 2010 plan year, although we expect to be able to offer the Grace Period in the future. For 2010, expenses must be incurred from January 1, 2010 through December 31, 2010. Any outstanding balances not claimed by March 31, 2011 will be forfeited.

No action is necessary if you:

- ❖ Don't want to change your medical or dental coverage,
- ❖ Don't need to change coverage for dependents, and you
- ❖ Don't want to enroll in FSA

However, to receive the new premium reduction, you must complete the HA and Reward Points

Mayo Clinic Health Assessment

- Again this year you have the opportunity to complete the Mayo Clinic Health Assessment (HA) and receive a personal Action Plan with information about your health strengths and risks, and the healthy choices available to you.
- Earn an incentive. Salaried employees who complete both the HA and the Reward Points Program by October 31, 2009 and are ORNL medical plan primary policyholders will receive an incentive of a \$30 monthly reduction on 2010 ORNL medical premiums, beginning in January.

What's New for 2010 cont'd

- Salaried employees include exempt, monthly paid employees, non-exempt, weekly paid employees, and Casual employees.
- Hourly employees are not eligible for the reduction this year. However, everyone's health is important and all employees and spouses are encouraged to take the HA.

Note to new hires: Employees who hired in from November 1, 2008 through October 31, 2009 do not have to complete the Reward Points program to be eligible for the 2010 incentive. However, you must complete the HA by October 31, 2009. Then begin Reward Points in November 2009 to earn the 2011 incentive.

Medical

- The medical plans for 2010 remain the same as the plans that are currently offered.
- Premiums for salaried employees in both plans will increase for 2010.
- Premiums for hourly, bargaining unit employees in both plans will decrease for 2010.
- All eligible employees have the choice of the CIGNA Open Access or the CIGNA Point of Service (POS) plan.
- Prescription drug benefits will continue under Medco for both medical plans.
- The vision benefit continues under VSP and is the "VSP Signature Choice" plan. The vision benefit is the same in both medical plans.
- Both the Open Access and POS plans:
 - Utilize the CIGNA Tennessee Seamless provider network
 - Cover children through age 23
 - Offer a Disease Management program from Optimal Health
 - Offer online access to www.myCIGNA.com to view health-related information, benefit coverage information and claims status
 - Offer online access to www.Medco.com to order medications, compare brand-name and generic drugs, access formulary information, and view your prescription history
 - Offer online access to www.vsp.com to view benefits coverage, find a network provider, and review vision-related resources

For more information related to the Medical plans, see the Medical Plans section of this Guide, the Medical Plans Comparison for 2010, and Premiums.

Dental

- All eligible employees have the choice of the Delta Dental plan or the MetLife Dental plan for 2010. There are no changes in plan design for 2010.
- Premiums for all plans are increasing for casual employees for 2010. Dental premiums for all other employees remain the same for 2010.
- Both plans have a preferred provider network and an out-of-network benefit.

For more information related to the Dental plans, see the Dental Plans section of this Guide, the Dental Plans Comparison for 2010, and Premiums.

What's New for 2010 cont'd

Flexible Spending Accounts (FSAs)

- An FSA is an employer-sponsored plan that lets you deduct dollars from your paycheck and put them into a special account that's protected from taxes.
- You may establish a Health Care account and/or a Child and Adult Day Care account for eligible expenses you incur from January 1, 2010 through December 31, 2010.
- The Grace Period will not be available for accounts established for the 2010 plan year, although we expect to be able to offer the Grace Period in the future. For 2010, expenses must be incurred from January 1, 2010 through December 31, 2010. Any outstanding balances not claimed by March 31, 2011 will be forfeited.
- You may contribute up to \$5,000 in each account.

For more information see the FSA section of this Guide.

Optimal Health / Disease Management

Eligibility for disease management includes all employees, pre-65 retirees, spouses and dependents enrolled in our medical plans.

The Optimal Health Disease Management Program provides support, information and services to help you deal with Heart Disease, Chronic Obstructive Pulmonary Disorder (COPD), Asthma, Diabetes or Low Back Pain and improve your quality of life. It is provided at no cost, as part of your medical plan coverage. You can reach Optimal Health by calling 1-866-225-2980.

Claims and cost – What's the connection?

What's the connection between health care claims, cost and premiums? With auto and home insurance you pay a premium based on the value of your car or home and the insurance company pays any claims you may have. Our medical plan doesn't work that way. ORNL pays our own health care costs. CIGNA's role is to administer our plan designs and process our claims. The money that CIGNA uses to pay claims comes from the premiums that are paid by the company and employees.

In other words, we, not the insurance company, cover the costs of our claims. So we have to collect enough in premiums to cover our claims costs each year. It stands to reason that if we can lower the cost of our claims, we reduce the amount of premium needed to cover our costs. Each year builds on the previous year's experience, so 2010 premiums are set by looking at 2009 claims cost data and factoring for inflation.

Open Enrollment Overview

Coverage Elections

You have until 4:00 p.m. on October 30, 2010, to make your elections for Medical, Dental and Flexible Savings Accounts (FSAs). Participation in FSAs is not automatic—FSA participants must enroll each year. After October 30 your elections cannot be changed and your choices will stay in effect for all of 2010 unless you have a qualifying change in status (See the Glossary or the *Qualifying Life Events* section of *Your Book of Benefits* for more information).

When Coverage begins:

- ❖ If you enroll or make changes during the Open Enrollment period, coverage and/or changes will begin on January 1 of the following year.

Default Elections – What happens if you don't enroll:

- **Medical and/or Dental:** If you are currently enrolled in a medical plan and / or a dental plan, and don't take any action during Open Enrollment, your coverage will continue.
 - Open Access medical plan participants who do not cancel or make another election will remain in the Open Access plan.
 - POS medical plan participants who do not cancel or make another election will remain in the POS plan.
 - MetLife dental participants who do not cancel or make another election will remain in the MetLife dental plan.
 - Delta Dental participants who do not cancel or make another election will remain in the Delta Dental plan.
- **FSAs:** All employees who wish to participate in an FSA must enroll for 2010. Participation in prior years does not automatically continue. Note: The Grace Period will not be available for 2010 elections. For more information see the FSA section of this Guide.
- **No current coverage:** If you are not currently participating in a medical, dental or FSA plan, you must enroll now to participate in 2010. If you are not currently participating and you do not enroll, you are considered to have waived coverage.

Who is Eligible for Benefits

Employees:

- Full-time and part-time employees.
- Casual employees are eligible for most benefits. Casual employees are not eligible for FSA or Long Term Care.

Dependents:

If you are eligible for benefits, you may also enroll your eligible dependents for medical and dental coverage.

- There are new steps to follow if you are adding a dependent to your medical and/or dental plan. A Certificate of Dependent Status must be completed, along with the medical and/or dental enrollment form. Paper versions of all documents must be completed and returned to the Benefits Office by the close of Open Enrollment at 4:00 p.m., October 30, 2009. All forms are available on the Forms tab of the Open Enrollment website.

Open Enrollment Overview cont'd

- Eligible dependents generally include:
 - Your legal spouse
 - Unmarried children, to include your birth child, legally adopted child, and any other child for whom you have at least 50% legal responsibility and can claim as an IRS dependent. Stepchildren must reside with you.
 - CIGNA medical plans: Children through age 23
 - Dental (MetLife and Delta Dental): Children through age 23

For a complete definition, see the Glossary.

How to Enroll

You can enroll online from work or home, or you can print and complete paper forms. You can make additional changes up until Open Enrollment closes at 4:00 p.m. on October 30, 2009.

Online Enrollment

Online enrollment via Employee Self-Service (ESS) is convenient, and no paper signatures are required. You can also print a confirmation of your electronic elections for your records.

You can access ESS from work at <https://portal.ornl.gov/sites/bisd/apps/ess.aspx> and then select Benefits Open Enrollment. Or, you can access ESS from home by accessing the ORNL public website <http://benefits.ornl.gov/openenrollment/2010/Pages/default.aspx> and then selecting Enroll Now.

To access ESS you need an active UCAMS user id and password, and an SAP account. If necessary,

- Request a user id and password from the Computer Helpline at 241-6765
- Request an SAP account at: <https://home.ornl.gov/general/sap/sapAcctInstr.shtml>

A step-by-step tutorial is available on the ESS website. The tutorial and Online Open Enrollment Instructions are available on the Open Enrollment Website.

Reminder - Enroll Carefully!

- ❖ Be certain you "Make this Change" and "Submit" your online enrollments or changes, and carefully READ your confirmation statement sent to you via e-mail to verify your Employee Self Service (ESS) elections.
- ❖ Carefully READ the confirmation of enrollment elections sent to your home after the close of Open Enrollment.

Paper Enrollment

All enrollment forms are available on the Benefits Open Enrollment Forms tab or by calling ORNL Benefits (574-7474). Forms may be returned to the Benefits Service Center (One Call) or ORNL Benefits. You may make additional changes up until Open Enrollment closes.

Please retain copies of your enrollment forms until you have received your confirmation statement and verified that it is correct.

Remember that all enrollments, including paper forms, must be received by ORNL Benefits or the Benefits Service Center by 4:00 p.m. on Friday, October 30, 2009.

Open Enrollment Overview cont'd

Need more help?

- ❖ A step-by-step tutorial is available on the ESS website. The tutorial and Online Open Enrollment Instructions are available on the Open Enrollment Website.

Confirmation Statements

You will receive a confirmation of your enrollment elections. You should carefully review all confirmations to verify that your elections are correct.

- If you enroll online you can immediately print a confirmation statement for your records.
- After you “SUBMIT” your elections, you will automatically receive an e-mail confirmation of your elections. If you do not receive an e-mail confirmation within 24 hours, please contact ORNL Benefits.
- If you log in and fail to submit, you will receive an e-mail the next day with the subject Open Enrollment Alert – No Action Taken. If you want to make changes, you should log back in to Open Enrollment, make your elections, and then click SUBMIT.
- After Open Enrollment closes, all employees will receive a printed confirmation statement at home during November.
- Notify the Benefits Service Center (One Call) immediately of any errors in medical or dental enrollments. Notify ORNL Benefits of any errors in FSA enrollment.

Should you have any questions, contact ORNL Benefits (574-7474) or the Benefits Service Center (One Call) (574-1500).

Mayo Clinic Health Assessment

The Mayo Clinic Health Assessment (HA) is a key tool to help you improve your health. Everyone who takes it will receive a personal Action Plan, which includes valuable information about your health and recommendations for improving your well-being. Your personal information is completely confidential; Mayo Clinic provides group data to ORNL that combine all employee responses into an aggregated report showing us what the most important health issues are at ORNL. We then use this data to guide our wellness and health care programs and activities for the coming year.

- Complete the Mayo Clinic Health Assessment anytime from September 14 through October 31.
- Simply log-on to the ORNL Mayo Clinic EmbodyHealth website at www.ornlwellness.com. If this is your first time to visit the site, you will need to register. Spouses who are ORNL employees should register using their own badge number. Non-ORNL spouses can use their spouse's ORNL badge number plus the letter "S".
- Assess your health risks and receive your personal, confidential Action Plan.
 - All employees and spouses are encouraged to participate and learn more about your health strengths and risks.
 - Biometric data provides the most accurate results; however, it is not required in order to complete the HA biometric section or to earn the incentive.
- Earn an incentive. Salaried employees who complete both the HA and the Reward Points Program and are ORNL medical plan primary policyholders will receive an incentive of a \$30 monthly reduction on 2010 ORNL medical premiums, beginning in January.
 - Salaried employees include exempt, monthly paid employees, non-exempt, weekly paid employees, and Casual employees.
 - Hourly employees are not eligible for the reduction this year. However, everyone's health is important and all employees and spouses are encouraged to take the HA.
- **Note to new hires:** Employees who hired in from November 1, 2008 through October 31, 2009 do not have to complete the Reward Points program to be eligible for the incentive. However, you must complete the HA by October 31, 2009. Then begin Reward Points in November 2009 to earn the 2011 incentive.
- Visit the Mayo Clinic booth at the Benefits & Wellness Fair on October 22 to learn more about the resources and tools on the EmbodyHealth web portal.
- Employees currently on or planning to take a Leave of Absence and employees on Short Term or Long Term Disability (Phase One) should refer to the Health Assessment FAQs for additional information.

Mayo Clinic Information Slideshow

- ❖ [View a short slide show to learn more about the Mayo Clinic EmbodyHealth web portal and the Mayo Clinic Health Assessment](#)

At ORNL, we're committed to helping our employees improve their health. Achieving this goal ensures a better quality of life for employees, higher productivity for the company and better control over health care costs for everybody. To do this effectively, we need to make sure we're offering health and wellness resources that match your needs. The Mayo Clinic Health Assessment (HA) helps us do that.

Mayo Clinic Health Assessment cont'd

Completing the Health Assessment will take only about 15 minutes. So, please join us in a lab-wide effort to improve our health and our health care services. Choices you make each day affect your health both now and in years to come. Because 'Your Health Counts!', take the Mayo Clinic Health Assessment and learn more about your health risks and what you can do to change them.

Go to www.ornlwellness.com to take the Mayo Clinic HA and learn more about the health resources available to you. If this is your first time to visit the site, you'll need to register as a new user. For additional information about the HA, see the Health Assessment website or the FAQs on the Open Enrollment website.

What is a Health Assessment (HA)?

The HA is a confidential questionnaire, developed by the medical experts at Mayo Clinic that helps you understand how everyday health habits and your family history could impact your health in the future. Completing the HA will take you only about 15 minutes. You receive a personal Action Plan with immediate feedback on your specific health strengths and risks. This personalized report points you to more information, tools and programs that address your particular needs. When you take the Health Assessment, your responses are completely confidential. UT-Battelle receives an aggregate report that contains no identifying information. This anonymous group report show us what the most important health issues are at ORNL so we can offer health and wellness programs that not only target the most prevalent health issues at ORNL but also keep healthy participants healthy.

What is the incentive and who is eligible?

The incentive is a reduction in ORNL medical plan premiums of \$30 per month for calendar year 2010, beginning in January. All salaried employees who are the primary policyholders of their ORNL medical plan coverage and meet the incentive requirements are eligible. This includes exempt employees, paid monthly, non-exempt, weekly paid employees, and Casual employees. Hourly paid union employees are not eligible for the reduction this year. However, everyone's health is important and all employees and spouses are encouraged to participate in healthy lifestyle activities through the Reward Points program and to take the HA to learn more about your risks and the healthy choices available to you.

What is a primary policyholder?

The primary policyholder is the employee who holds the coverage. Other family members, including spouses who are also employees, are covered as dependents.

What are the incentive requirements?

There are two requirements to earn the incentive:

1. Earn and record at least 750 points in the Reward Points program on the Mayo Clinic EmbodyHealth website from Nov. 1, 2008 through Oct. 31, 2009, AND,
2. Complete the 2009 Mayo Clinic Health Assessment by Oct. 31, 2009

What information do I need to complete the HA?

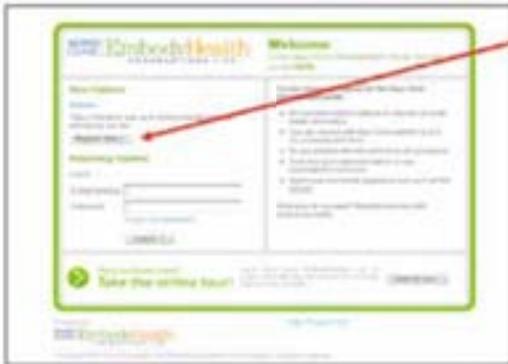
You'll get more accurate and useful results from your Health Assessment if you know your biometric measurements, including height, weight, blood pressure, blood sugar, triglyceride and cholesterol levels. Your data is not required for the incentive and is not shared with ORNL – In fact, all input is confidential. Mayo Clinic only provides ORNL with aggregate data, which we use to establish a baseline for developing appropriate wellness programs and activities.

There are several ways to obtain this information: Recent data (within the last 6 months) may be available from your doctor or a company physical. If you cannot get your measurements information, you can estimate these values and still receive meaningful results.

Mayo Clinic Health Assessment cont'd

1

How to Get Started



Click here to register

How do I access the Health Assessment (HA)?

Simply log-on to the ORNL Mayo Clinic EmbodyHealth web portal at www.ornlwellness.com. If this is your first time to visit the site, you will need to register. Spouses who are ORNL employees should register using their own badge number. Non-ORNL spouses can use their spouse's ORNL badge number plus the letter "S".

For more information, view a slide show about the Mayo Clinic Health Assessment and the EmbodyHealth Portal.

2

Mayo Clinic Health Assessment



During the Mayo Clinic Health Assessment campaign, you will see this welcome screen.

Click to begin the Health Assessment

4

Biometric Information



It's helpful to have the following information available when you take the Health Assessment:

- Weight
- Blood pressure
- Blood sugar
- Cholesterol
- Fasting triglycerides

Health Assessment Content



During the Health Assessment, you'll answer a series of questions about your health habits and medical history.

5

Action Plan



When you've completed the Mayo Clinic Health Assessment, you'll receive an Action Plan summarizing your health risks and strengths.

For additional information about the HA, see the Health Assessment website or the FAQs on the Open Enrollment website.

Medical Plans

Open Enrollment is the time you can:

- Enroll in another UT-Battelle offered medical plan
- Enroll in a medical plan if you currently do not have coverage under a UT-Battelle offered medical plan
- Add, drop, or update information on your eligible dependents
- Change your level of coverage (for example, Single to Family)

❖ Please keep in mind that if you are currently in the Open Access or POS plan, want to keep your current level of coverage, and do not want to enroll in FSA, you do not need to take any action during Open Enrollment.

Medical Plan Choices for 2010

All eligible employees have the choice of the CIGNA Open Access or the CIGNA Point of Service (POS) plan.

- The medical plans remain the same as the plans that are currently offered.
- Premiums for CIGNA medical coverage:
 - are increasing for salaried employees.
 - are decreasing for hourly, bargaining unit employees.
- Salaried employees who are the ORNL primary plan policyholder can earn a reduction of \$30 per month on 2010 medical premiums, beginning in January. See the HA section of this Guide for details.
 - Complete the Mayo Clinic Health Assessment (HA) by October 31.
 - Complete the Reward Points program by October 31.
- Both plans include the VSP Signature Choice vision plan. The vision benefit is the same in both plans.
- Prescription drug benefits are provided by Medco for both medical plans.
- Both the Open Access and POS plans:
 - Utilize the CIGNA Tennessee Seamless provider network,
 - Cover children through age 23,
 - Offer the Disease Management program from OptimalHealth,
 - Offer online access to www.myCIGNA.com to view health-related information, benefit coverage information and claims status,
 - Offer online access to www.Medco.com to order medications, compare brand-name and generic drugs, access formulary information, and view your prescription history,
 - Offer online access to www.vsp.com to view benefits coverage, find a network provider, and review vision-related resources.

Adding a Dependent:

❖ There are new steps to follow if you are adding a dependent to your medical and/or dental plan. A Certification of Dependent Status must be completed along with the medical and/or dental enrollment form. Paper versions of all documents must be completed and returned to the Benefits Service Center by the close of Open Enrollment. Forms are available on the Open Enrollment Forms tab.

Medical Plans cont'd

Is your doctor in the network?

- ❖ No matter which plan you are considering, it is important to know if your providers are in the Tennessee Seamless network. Current provider information is available on the CIGNA Website. See [How to Locate a CIGNA Network Provider](#).

Open Access

The Open Access plan design for 2010 is the same as the current plan. The plan features an annual deductible, co-pays, and co-insurance. You are not required to have a PCP although it is recommended that you select one physician who will coordinate your medical care. Referrals are not necessary in order to see a specialist. The pharmacy program, administered by [Medco](#), provides a prescription drug plan with retail and cost-saving home delivery options.

POS

The POS plan design for 2010 is the same as the current plan. A PCP is required, and you must have a referral to see a specialist. The pharmacy program, administered by [Medco](#), provides a drug formulary and 3-tier prescription drug plan with retail and home delivery.

The Open Enrollment process is NOT meant for changing your PCP. Call CIGNA member services, 1-800-244-6224, at any time to make any changes to your PCP.

Vision Services

Vision benefits are provided as part of your medical plan and are the same in both plans. Vision Service Plan (VSP) provides the Signature Choice plan for both Open Access and POS. The plan features include:

- Exams and lenses are covered in full, every 12 months
- Frames are covered up to \$120, every 24 months
- Contact Lens are covered up to \$120, every 12 months (includes contacts & exam)
- Laser vision correction is provided at reduced cost through VSP network doctors and contracted laser surgery centers

See the Comparison of Medical Plans for 2010 for details.

Plan design details and comparisons of the Open Access and POS plans are available in the [COMPARISON OF MEDICAL PLANS FOR 2010](#).

- ❖ An interactive Medical Plan Cost Comparison Worksheet tool is available to assist you in determining which medical plan may be more cost effective for you.

Medical Plans cont'd

Pharmacy Program

Pharmacy benefits are provided as part of your medical plan. The benefits, as described above and in the Medical Plans Comparison, are different in the two plans.

Medco is the provider for both Open Access and POS and is one of the premier pharmacy providers in the nation. Their mail order program has won multiple awards for quality of service and accuracy in filling prescriptions. We are pleased to be able to offer the Medco program to our medical plan participants.

Under both plans:

- If the usual and customary charge for a generic or preferred brand name drug is less than the co-payment amount, the member will pay the lesser amount.
- If a physician indicates "Brand Necessary" or "dispense as written" on a prescription, then only a preferred or non-preferred brand name medication can be dispensed.
- Prescription drug co-pays do NOT apply to the medical annual deductibles or to medical maximum out-of-pocket limits.

What is a drug formulary?

A formulary or preferred drug list is a list of prescription medications that includes brand-name and generic drugs that have been approved by the FDA as safe and effective. Drugs chosen for the formulary have gone through an extensive review process. They either represent an important therapeutic advance, or are clinically equivalent and possibly more cost-effective than other drugs not on the preferred drug list. In short, a formulary:

- ❖ Provides access to quality medications
- ❖ Promotes appropriate and cost-effective therapy
- ❖ Provides physicians with information relating to alternative therapies
- ❖ Gives members information to help them discuss medications with their physician and pharmacist

Disease Management program

Optimal Health provides disease management to employees and dependents enrolled in either of our medical plans, at no additional cost to you. The program helps patients with chronic illness avoid or minimize complications by focusing on education, prevention, compliance with well-accepted treatment protocols and wellness. Covered conditions include heart disease, diabetes, asthma, COPD, and back pain. Disease Management empowers a patient to take a more active role in his or her health care. To participate, call Optimal Health at 1-866-225-2980.

Factors to consider when selecting a medical plan

Since each employee's situation and needs are different, it is important to compare coverage, out-of-pocket expenses as well as premiums and pharmacy benefits to be sure you make the best choice for you and your family. In addition, you should consider your co-pays, co-insurance and other medical or dependent care expenses not covered by insurance to determine whether you may benefit from enrolling in a Flexible Spending Account for 2010. When making your health care decisions, you should think about the following questions:

Medical Plans cont'd

- How often do you or your family members require medical care? Are you likely to have a lot of medical expenses this year?
- How do you use your medical plan? Is it primarily for office visits and medical procedures, do you expect hospital admissions, or do you and your family use a lot of prescription medications?
- How do you feel about using a PCP as a gatekeeper to manage your care and provide referrals to specialists or would you prefer more freedom of choice?
- Can you receive better or less expensive medical coverage for yourself and your family under another medical plan (Open Access, POS, or your spouse's plan?)
- Do you or your family members take prescription drugs on a regular basis? Based on your medical plan selection, what would be the cost difference between the two drug designs?
- If you and your spouse both carry coverage – which plan is primary for your dependents' coverage? (The primary plan belongs to the parent whose birthday falls earlier in the year.)
- Can you use the Health Care Flexible Spending Account to pay for some medical expenses that are not covered by your health plan?

Getting the most from your medical plan

No matter which medical plan you choose, make sure you get the maximum benefit for your premium dollars. One of the best ways to reduce your costs and thus the rising cost of health care, is by practicing prevention. Preventive care is covered 100% after co-pay under both medical plans if you use an in-network provider.

Preventive care, like simple health screenings and immunizations, can help prevent or detect serious illnesses early – when they are less expensive and you are more likely to recover. This care includes:

- ❖ Immunizations
- ❖ Annual well-woman exam
- ❖ Well-child exam
- ❖ Cholesterol screenings
- ❖ Prostate exams
- ❖ Mammograms
- ❖ Routine physical exams

In many cases, more expensive treatments and procedures could be avoided through regular visits to a primary care physician, a healthy diet and exercise, and reducing other risky behaviors. Our life-style and health care decisions today impact our well-being and health plan costs for the rest of our lives.

According to the Centers for Disease Control and Prevention, chronic diseases such as heart disease, stroke, diabetes, and cancer account for approximately 75 percent of all health care costs. Although they are the most common and the most costly, they are also the most preventable. Today, with nearly 80% of disease in this country being preventable, practicing prevention has never been more important.

Dental Plans

The dental plans are separate from the medical plans offered. Therefore, you must elect and enroll yourself and your dependents separately.

Enrollment

- ❖ If you are currently enrolled in the MetLife or Delta Dental plan and do not wish to make any changes to your current election, you do not need to enroll again.

Open Enrollment is the time you can:

- Enroll in another UT-Battelle offered dental plan
- Enroll in a dental plan if you currently do not have coverage under a UT-Battelle offered dental plan
- Add, drop, or update information on your eligible dependents

Adding a Dependent:

- ❖ There are new steps to follow if you are adding a dependent to your medical and/or dental plan. A Certification of Dependent Status must be completed along with the medical and/or dental enrollment form. Paper versions of all documents must be completed and returned to the Benefits Service Center by the close of Open Enrollment. Forms are available on the Open Enrollment Forms tab.

Choices for 2010

All eligible employees have the choice of the Delta Dental plan or the MetLife Dental plan for 2010. There are no changes in plan design for 2010.

- Premiums for all plans are increasing for casual employees for 2010. Dental premiums for all other employees remain the same for 2010.
- Both plans have a preferred provider network and an out-of-network benefit.

Plan design details and comparisons of the plans are available on the Comparison of Dental Plans for 2010. Both plans feature the option of using network dentists that offer the advantages discussed in the sections below.

Preventive Care visits

Both plans allow for 2 preventive care visits each year for cleanings and x-rays. The MetLife plan covers 1 visit every 6 months whereas Delta Dental covers 2 visits in a 12 month period. The difference is subtle but can have an impact on when you should schedule your visits. For more information, see the Dental section of the FAQs.

Dental Plans cont'd

Using a MetLife Network Dentist

Although you are not required to use a network dentist, there are several advantages to you:

- You may use any dentist in the nation, however, using a MetLife participating dentist will lower your out-of-pocket costs due to negotiated discounts
- Network dentists meet strict credentialing criteria
- No claim forms to file

Out-of-network charges are based on the reasonable and customary charges of all providers within a 3-digit zip code for each procedure, and MetLife's negotiated rate.

To find a network dentist, visit the MetLife website at www.metlife.com. Under Products & Services select Dental, then enter your zip code under Find a Dentist to see a list of participating dentists in your area. See How to Locate a Dental Network Provider.

The Delta Dental Network

Delta Dental provides you the freedom to use any dentist, but there are advantages to using a participating, in-network dentist:

- A variety of incentives and lower out-of-pocket cost options
- No balance billing. Dentists accept an agreed-upon fee schedule
- No claim forms to file

If you use an out-of-network provider, they will be reimbursed at 51% of Delta Dental's fee schedule and you will be billed for the balance.

Participation in the Delta Dental Plan of Tennessee is open to all dentists licensed in Tennessee; however, Delta Dental Plan of Tennessee makes no representations or warranties for dentists who participate in the program. It is the patient's responsibility to determine a dentist's qualifications.

To find a network dentist, visit the Delta Dental website at www.deltadentaltn.com and select the "Need a Dentist?" feature. Select the Delta Premier plan option and complete the search form to see a list of participating dentists in your area. See How to Locate a Dental Network Provider.

Flexible Spending Accounts

Participation in FSA is not automatic. You must re-enroll annually during open enrollment.

Flexible Spending Accounts (FSA) can help you stretch your health care and child and adult day care budget while at the same time reducing your taxable income. That is because the accounts let you use before-tax dollars to pay certain health and dependent day care expenses.

You may choose to enroll in one or both of the following accounts:

- **Health Care FSA**, which can be used to pay for certain medical, mental health, dental, vision, and drug expenses for you, your spouse, and your dependents on a before-tax basis.
- **Child and Adult Day Care FSA**, which can be used to pay for day care and elder care expenses for eligible dependents on a before-tax basis when such care enables you (and your spouse, if you are married) to work. Eligible dependents include your children under age 13, your disabled spouse, or disabled dependents of any age (including parents).

Who is eligible to participate?

- ❖ Full-time and part-time employees are eligible to participate.
- ❖ Casual employees are not eligible.

The Grace Period for FSAs

- ❖ The Grace Period will not be available for accounts established for the 2010 plan year, although we expect to be able to offer the Grace Period in the future. For 2010, expenses must be incurred from January 1, 2010 through December 31, 2010. Any outstanding balances not claimed by March 31, 2011 will be forfeited.

How Much You Can Contribute

You may contribute up to \$5,000 per account each year. For the Child and Adult Day Care FSA this is a household limit. If your spouse also elects a Day Care or Dependent Care account through their employer, your combined contribution is limited to \$5,000. For the Health Care FSA you may contribute up to \$5,000, regardless of your spouse's participation in a Health Care FSA.

Child and Adult Day Care FSA and the Federal Income Tax Credit

If you are currently paying for dependent day care, you may be familiar with the federal income tax credit, which allows you to subtract a percentage of your dependent day care expenses from the federal taxes you owe. The percentage depends on your taxable household income.

IRS rules state you cannot claim the same expenses under both the Child and Adult Day Care FSA and the federal tax credit. As a result you have to decide which one is more advantageous to you. Because individual circumstances vary, you may want to seek professional tax advice.

Thinking of going Casual? Should you move to Casual status during 2010, your participation in Health Care and Child and Adult Day Care FSAs will end, and you will not be able to continue contributions or claim any expenses incurred after the date of your change of employment.

Flexible Spending Accounts cont'd

How the Accounts Work

To help you decide whether or not to participate, the following is a step-by-step guide to how the accounts work:

- **Decide How Much to Contribute**

When you enroll, you must indicate how much money you want to contribute to each account. To help you decide, refer to the FSA Health and Child and Adult Day Care Worksheet and Health Care FSA Expense Eligibility list in this section.

- **The Before-Tax Advantage**

If you choose to participate, your contributions are automatically withheld from your paycheck before federal, state (where permitted), and FICA taxes have been taken out. They will then be deposited into the appropriate FSA. As a result, your taxable income is reduced and, therefore, you save money on taxes.

The amount of money you can save depends on a number of factors, including your income, marital status, and number of dependents. The following chart illustrates what could happen if you set that money aside in an FSA, as opposed to simply paying those expenses with ordinary “after-tax” dollars. Suppose a married staff member with one tax exemption has \$1,500 in eligible medical expenses. The following example shows the possible savings available when the Health Care FSA is used.

| EXAMPLE OF TAX SAVINGS | | |
|---|-----------------|-------------|
| | Non Participant | Participant |
| Annual Pay | \$40,000 | \$40,000 |
| Before Tax / Health Care FSA | - 0 - | \$ 1,500 |
| Taxable income before personal exemptions | \$40,000 | \$38,500 |
| Taxes paid (2008 married filing joint) | | |
| • Federal | \$ 3,576 | \$ 3,360 |
| • FICA (Social Security + Medicare) (7.65%) | \$ 3,060 | \$ 2,945 |
| After-tax medical payment | \$ 1,500 | - 0 - |
| Spendable income | \$31,864 | \$32,195 |
| Tax Savings | -0- | \$ 331 |

This example only shows how much you can save on federal and FICA (Social Security) taxes. Depending on where you live, you may be able to save money on your state and local taxes as well.

Flexible Spending Accounts cont'd

- **Pay Your Expenses Up Front**

Throughout the year, whenever you incur an eligible health or dependent day care expense, you will pay that expense as you normally would. Be sure to save receipts and other appropriate documentation (including Explanations of Benefits [EOB] forms for medical, dental, and vision expenses) so that you can file a claim for reimbursement.

- **File a Claim for Reimbursement**

Whenever you incur an eligible expense, submit proof of payment to Ceridian, our FSA Claims Administrator. Forms are available on the ORNL Benefits website, along with instructions for filing a claim. Or you can submit your claims on-line and print a confirmation page that you can send along with your receipts. You have until March 31 following the year in which you participated to turn in your reimbursement claims.

Reimbursements will be made to the same financial institution and account you elected for your payroll deposit. If you wish to designate a different institution, or if you do not participate in payroll direct deposit, you will need to complete ORNL-703, Enrollment for Direct Deposit of Flexible Spending Account Reimbursements.

Claims Administration

- ❖ Your current payroll banking information will automatically be sent to Ceridian, the FSA administrator for ORNL. However, should you prefer a different direct deposit account, or if you do not participate in payroll direct deposit, print the Direct Deposit Form provided in ESS, complete the form, attach a voided check, and mail it to the address on the form

Over-the-Counter (OTC) Drugs

Contributions made to the Health Care FSA can be used for certain over-the-counter (OTC) drugs. This includes such non-prescribed items as antacids, allergy medicine, pain relievers, antibiotic creams/ointments, and cold medicine. However, this does not include dietary supplements, vitamins, and cosmetic treatments. Itemized receipts are necessary for reimbursement. See the Health Care FSA – Expense Eligibility - Important Reminder for a list of the documentation required.

FSA Health and Child and Adult Day Care Worksheet

Use this worksheet to help you determine your health care and dependent day care annual contribution for the upcoming plan year. If you would like to do your calculations online, you may also access the online FSA Calculator at www.ceridian.com/myceridian/fsacalculator.

You may want to review your health and dependent day care expenses in your check book and/or credit card statements from last year to help you decide how much to set aside in your FSA next year.

Flexible Spending Accounts cont'd

| Health Care FSA | Child and Adult Day Care FSA |
|--|---|
| <p>To determine your expenses, review health care expenses from last year and consider any anticipated new health care expenses for you, your spouse and your dependents.</p> <p>Annual Health Care Expenses</p> <p>Deductibles \$ _____ Medical, dental, vision, drugs</p> <p>Co-payments/co-insurance \$ _____ The amount not paid by your medical, dental, vision, or drug coverage</p> <p>Amounts paid over plan limits \$ _____ Over reasonable and customary allowance \$ _____ Over psychiatric limits \$ _____</p> <p>Expenses not covered by insurance \$ _____ Over the counter drugs</p> <p>Vision care \$ _____ Glasses, contacts, solution, exams, etc. not covered by insurance</p> <p>Dental care \$ _____ Cleanings, orthodontics, crowns, etc. not covered by insurance</p> <p>Treatment/therapies \$ _____ Medical equipment \$ _____</p> <p>Other anticipated health care expenses _____ \$ _____ _____ \$ _____ _____ \$ _____</p> <p>Total Estimated Annual Health Care Contribution</p> <p style="text-align: right;">Total \$ _____</p> | <p>To determine your expenses, enter in the estimated annual amounts you will pay for child and/or elder care.</p> <p>Annual Child Care Expenses</p> <p>Day care center \$ _____ In-home care \$ _____ Nursery and pre-school \$ _____ (not kindergarten)</p> <p>After-school care \$ _____ Au pair services \$ _____ Summer day camp \$ _____</p> <p>Annual Elder Care Services</p> <p>Day care center \$ _____ In-home care \$ _____</p> <p>Total Estimated Annual Dependent Care Contribution</p> <p style="text-align: right;">Total \$ _____</p> |

Flexible Spending Accounts cont'd

Health Care FSA – Expense Eligibility

Important Reminder

For each expense, you must submit documentation from the provider or a third party that includes the following:

- Date
- Amount
- Provider
- Type of service.

Some expenses may require additional documentation to establish eligibility, such as a physician's statement that a certain expense will treat your existing medical condition.

This is a sample list and it may be amended during the plan year at any time without notice. All expenses submitted are reviewed and approved according to Internal Revenue Code Section 125 guidelines. For a comprehensive list, please go to: www.myceridian.com/hfsa-expenses.

Sample Eligible Expenses

- Acupuncture
- Alcoholism Treatment
- Ambulance Service
- Artificial Limbs
- Aspirin
- Birth Control Pills
- Braille Books and Magazines (in excess of the cost of a regular edition)
- Car Controls for the handicapped
- Chiropractic Care
- Condoms
- Contact Lenses
- Crutches
- Dental Expenses (excludes bleaching or whitening)
- Dental Implants
- Denture Supplies
- Dermatologist Fees
- Diagnostic Tests
- Durable Medical Equipment (with prescription and letter of medical necessity)
- Equipment for the Disabled
- Flu Shots
- Guide Dog Expenses
- Glucose Kits (including Test Strips)
- Hearing Aids and Batteries
- Hearing Exams
- Hearing Treatment
- Hospital Services (excluding phone & TV)
- Immunizations
- Infertility treatments
- Insulin Pump
- Lab Fees
- Lamaze Classes (mother's cost only)
- Lasik Surgery
- Legal Abortion
- Medical Services, treatment

- Midwife
- Mileage to and from Medical Services
- Optometrist Fees
- Ophthalmologist Fees
- Organ Transplants
- Orthodontia Treatment
- Orthotics
- Osteopath Fees
- Over-the-Counter Medication
- Oxygen
- Periodontal Fees
- Physical Exams
- Physical Therapy
- Pregnancy Tests
- Prenatal Care
- Prescription Drugs
- Prescription: Eyeglasses, Sunglasses and Reading Glasses (excluding sunglass clips)
- Psychiatric Fees
- Psychologist Fees
- Psychotherapy
- Radial Keratotomy, PRK
- Services for Diagnosed Severe Learning Disabilities
- Short-Term Storage of Sperm or Embryo
- Smoking Cessation Drugs & Programs
- Special Schools for the Disabled
- Sterilization
- Substance Abuse Treatment
- Sunscreen and Sunblock Products
- Surgery (medically necessary)
- Telephone for the Deaf
- Therapy for Mental/Nervous Disorders
- Transportation for Medical Care
- Vaccinations

- Weight-Loss Programs (must be prescribed by a physician to treat a specific medical condition)
- Wheelchairs
- X-ray Fees

Sample Non-eligible Expenses

- Baldness Treatments
- Breast Pump Rental or Purchase
- COBRA Premiums
- Cosmetic Surgery, Procedures, Services and Products (non-medically necessary)
- Dancing Lessons
- Dental Veneers or Bonding (non-medically necessary)
- Diapers or Diaper Service
- Doula Expenses
- Electrolysis
- Electronic Toothbrushes
- Exercise Equipment
- Family/Marriage Counseling
- Funeral Services
- Hair Transplants
- Health Club Dues and Memberships
- Herbal & Holistic Drugs or Remedies
- Insurance Premiums
- Marijuana or other controlled substances (even for medical purposes)
- Maternity Clothes
- Special Diet Foods
- Swimming Lessons
- Teeth Bleaching, Whitening
- Vacation expenses (even if recommended by a doctor)
 - Varicose Vein Treatment
- Varicose Vein Treatment

Questions? Call Ceridian at 1-877-799-8820

Other Benefit Options

Open Enrollment is also a good time to review the benefit options that are available to you any time during the year.

Life and Accident Insurance

You may enroll, cancel or change coverage for special accident insurance at any time. You may enroll, cancel or change coverage for basic life, supplemental life, spouse or dependent life at any time with an approved statement of health. Open Enrollment is an excellent time to review your family needs for financial security and to adjust your levels of coverage. Questions to consider include: What is your family situation? Would your personal savings and current levels of insurance provide adequate protection for your family if you were to die?

One thing to remember is that most people are more likely to be injured than die. If this were the case, think about how you would meet your expenses. Look at your options under UT-Battelle's Special Accident Insurance Plan and the amount of coverage you can receive for a minimal monthly payment.

Also, this is a good time to review your beneficiaries and make sure they are up to date. You can check your insurance coverage and your beneficiaries on the ESS website <https://portal.ornl.gov/sites/bisd/apps/ess.aspx> by clicking on the Benefits Participation Overview. To enroll in life or special accident insurance, submit form ORNL-745 (UCN-20992) – Enrollment Form for Group Life Insurance Benefits or UCN-21012 – Life Insurance Company of North America Personal Accident Insurance.

Long-term Care Insurance

You may wish to consider taking advantage of long-term care insurance offered through UT-Battelle and administered by MetLife. Coverage is available for eligible employees, retirees, and their family members (neither Casual employees nor their family members are eligible):

- Spouses or surviving spouses
- Parents and parents-in-law
- Grandparents and grandparents-in-law

Long-term care insurance provides coverage for the type of care that medical and disability insurance – and even Medicare – were not designed to cover. Care includes help with simple daily activities such as eating, bathing or dressing that you or a family member would need due to an accident, long illness or just the natural aging process. Long-term care can be provided in your own home, nursing home or other facility.

For more information, to enroll or request an enrollment kit, visit the MetLife Web site (www.metlife.com) or call toll-free 1-800-438-6388.

401(k) Retirement Savings Plan

Are you participating in the UT-Battelle 401(k) retirement savings program to the fullest extent necessary to maximize your financial security at retirement? Along with UT-Battelle's Pension Plan, your 401(k) plan is another source of retirement income down the road. The earlier you start contributing; the better off you'll be in the long run. If you are not participating – start now! Most employees may contribute from 2.5% up to 75% of salary. UT-Battelle makes a matching contribution to your 401(k) plan of 100% on the first 2% that you contribute, then 50% on the next 4%. So, for each dollar you contribute, up to 6 percent of your salary, UT-Battelle is giving you a 4 percent match. In order for you to reap the benefits of this “free money”, you must complete 3 years of credited service and be enrolled in the plan.

Other Benefit Options cont'd

Each year the IRS set limits on tax-advantaged contributions. Limits for 2010 will be communicated when released by the IRS. For 2009 you can contribute up to \$16,500 on a pre-tax basis. If you are age 50 or older, you can contribute an additional \$5,500 catch-up amount. Highly compensated employees (HCEs) who are age 50 or older may contribute the additional catch-up amount by using the flat dollar contribution method.

Our plan offers 4 asset allocation models to help you create an investment strategy that's right for you. The SMarT (Save More for Tomorrow) Program allows you to automatically increase your contributions each year to help you reach your target.

As you think about saving, keep a long-term view in mind. Your 401(k) investments are not about what's happening in the market today – but, rather, what happens in the market over the long haul.

To enroll or make changes contact our recordkeeper, Schwab Retirement Plan Services at 1-800-777-4015 or on the web at www.401kaccess.com/oakridge.

Using the Employee Assistance Program (EAP)

Did you know that UT-Battelle offers the Employee Assistance Program free of charge? The program is a confidential service designed to help you and your family resolve personal problems that may affect your health, family life, or job performance. Provided by Magellan Health Services, the EAP is available 24 hours a day, 7 days a week. Program counselors are available for consultations during business hours and are on call for emergencies. To speak to a counselor or make an appointment, call 1-800-888-2273 or visit Magellan Health on the web at www.magellanassist.com.

A counselor is available on-site to work directly with employees and groups.

Dr. Patrice Ryan, Clinical Psychologist, is available Wednesdays and Thursdays.

Contact her directly at:

865-241-4673

e-mail: ryanpm1@ornl.gov

4500S, Room F-048

Glossary of Terms

Below are some of the key terms used in this Enrollment Guide. For a more extensive list of terms, see the Glossary section of Your Book of Benefits.

Annual Reinstatement – Any benefits you receive reduce your lifetime maximum. Each January 1, the Open Access plan provides an Annual Reinstatement that automatically increases your maximum by the amount of benefits paid, up to \$5,000.

Balance Billing – The practice of a provider billing a patient for all charges not paid for by the insurance plan, which is typically for those charges that are above the plan's reasonable and customary charges (see explanation below) or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed co-payments, coinsurance, and deductibles.

Beneficiary – The person, organization or trust that you name to receive any life, accident, pension plan or savings program benefits if you die.

Coinsurance – The percentage of charges you are required to pay under the plan. For example, 90%/10% plan coinsurance means the plan pays 90% of your covered costs and you are responsible for paying the remaining 10% after you meet the deductible. Coinsurance amounts apply to your out-of-pocket maximum.

Coordination of Benefits (COB) – A method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

Co-payment (Co-pay) – The amount you and your enrolled dependents are required to pay for the services received – in addition to any Coinsurance or Deductible. Deductibles are not reduced by Co-payments. Co-payment amounts do not apply to out-of-pocket maximums.

Coverage – The types and amounts of benefits provided under a plan or an insurance contract. Also may refer to the level or tier of insurance such as – Employee Only, Employee Plus One (Dual) or Family.

Covered Expense – An eligible expense for which a medical or dental plan will provide a benefit.

Deductible – The amount you are required to pay for covered expenses before the plan pays. It is in addition to any Coinsurance or Co-payments

- **Annual Individual Deductible** – The amount you pay for medical or dental expenses for a covered person each year before the plan pays for eligible expenses.
- **Annual Family Deductible** – The amount you pay for medical expenses each year for your family before the plan pays expenses for covered family members. The maximum each person can contribute to the family deductible is the individual deductible amount.

Disease Management – Protocols and interventions by medical professionals with patients and their families for the purpose of assisting with treatment options and services needed to manage a chronic condition. The goal of these services is to improve outcomes, coordinate patient needs, educate and counsel the family, and in the process help to reduce cost to the plan and the patient by making full use of appropriate services. It is included as part of your medical plan coverage and provides support, information and services to help you deal with Heart Disease, Chronic Obstructive Pulmonary Disorder (COPD), Asthma, Diabetes or Low Back Pain and improve your quality of life.

Eligible Dependents –

Generally:

- Your legal spouse
- Unmarried children, to include your birth child, legally adopted child, and any other child for whom you have at least 50% legal responsibility and can claim as an IRS dependent. Stepchildren must reside with you.

Glossary of Terms cont'd

- CIGNA medical plans: Children through age 23
- Dental (MetLife and Delta Dental): Children through age 23

For a complete definition, see the Glossary section of Your Book of Benefits.

Employee Designations

- **Hourly Employees** - ORNL employees who are governed by the terms of the collective bargaining agreement.
- **Salaried Employees** - ORNL employees on the exempt monthly and nonexempt weekly payrolls who are not governed by the terms of the collective bargaining agreement. This includes Casual employees.

Formulary – A list of preferred, commonly prescribed prescription drugs. These drugs are chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost, also known as a “preferred drug list.”

Gatekeeper – A term used to describe one role of a primary care physician in a managed care network that requires its members to have their care approved, arranged or authorized by the member’s primary care physicians. This includes referrals to other professionals as appropriate.

Guesting/Guest Privileges – A medical plan benefits option that, under certain circumstances, can provide an in-network level of coverage to covered persons who are temporarily outside of their “home” network service area for 90 days or longer.

Health Assessment (HA) – An HA is a tool to gather medical and lifestyle related information to determine health risk. There is a strong relationship between high risk and high health care cost. An HA helps in identifying the overall health of the population and also helps in determining what programs are needed to improve the general health status of the population.

In-Network Provider – An array of varied practitioners and provider types, such as hospitals, out-patient surgery, laboratory services, imaging or other testing facilities, within a plan’s service area that provide covered health care services to the plan’s members, usually through a practitioner or provider contract. When in-network physicians are utilized, benefits are usually higher than out-of-network benefits because of pre-negotiated discounts.

Managed Care Plan – A health plan that seeks to manage the cost, accessibility, and quality of care and has a defined system of selected providers that contract with the plan. Members have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a pre-negotiated basis.

Maximum Annual Benefit – The maximum amount of eligible benefits a plan will pay for an individual in one plan year.

Maximum Lifetime Benefit – The maximum amount of eligible benefits a plan will pay for an individual during his or her lifetime.

Network – A group of health care providers who have agreed to provide care for pre-negotiated rates, as well as to comply with quality assurance procedures and patient service standards.

Over-The-Counter Drug (OTC) – A drug that consumers can purchase without a physician’s prescription.

Open Access – Open access plans allow members to see participating providers, usually specialists, without referral from the health plan’s gatekeeper.

Out-of-Network Provider – Any practitioner or provider that does not contract with a selected carrier. Out-of-network benefits are usually lower than in-network benefits because providers do not offer discounted fees and employees must pay all charges the insurer deems to be reasonable and customary.

Out-of-Pocket Maximum – The out-of-pocket maximum limits the amount you pay for medical expenses in one year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses. Certain expenses do not count toward the out-of-pocket maximum:

Glossary of Terms cont'd

expenses for prescription drugs, substance abuse treatment (under the CIGNA Open Access plan), co-payments, deductibles, charges above reasonable and customary, and any penalties for failing to pre-certify your hospitalization.

Point of Service (POS) Plan – A medical plan that uses contracts with physicians, hospitals and other providers of care who offer medical services to enrollees at a discount. Participants may use any provider inside or outside of the POS network, but there is a financial incentive for you to stay within the network.

Pre-certification – The process of obtaining certification or authorization from the health plan for hospital admissions or for surgery. Failure to obtain pre-certification often results in a financial penalty, up to and including denial of any payment.

Prescription Drug – A drug that can only be purchased with a physician's prescriptio

- **Generic:** Generic drugs are those whose active ingredients, safety, dosage, quality and strength are identical to that of its brand counterpart. These medications are covered at the generic co-payment or coinsurance under a two- or three-tier plan and typically cost less than brand drugs.
- **Preferred-brand:** Preferred-brand drugs are those which generally have no generic equivalent. These medications are covered at the preferred brand co-payment or coinsurance under a three-tier plan.
- **Non-preferred brand:** Non-preferred brand drugs are those which generally have equally effective and less costly generic equivalents and/or have one or more preferred-brand options. A participant or his/her provider may decide that a medication in this category is best. These medications are usually covered at the highest co-payment or coinsurance level in a three-tier plan.
- **Specialty Drug:** While specialty drugs do not have a standard industry definition, these drugs often have one or more of the following characteristics; often injected or infused, expensive relative to traditional treatment, need special handling (e.g. refrigeration), limited access to only a few pharmacies, require clinical support to maximize a patient's outcome, and have orphan drug status (drugs funded by the government for rare conditions).

Primary Care Physician (PCP) – A physician specializing in family practice, general practice, internal medicine, or pediatrics. Primary care providers often oversee the total care of patients, referring the patient to other professionals as appropriate.

Qualifying Change in Status – Defined by the Internal Revenue Code and generally includes a change in your legal marital status, a change in the number of your dependents, loss of coverage under another group health plan, change in your employment or your dependent's employment that affects benefits, loss of dependent status, and a change in residence which results in a loss of coverage. Any election you make due to a qualifying change in status must be on account of and consistent with the change in status. Additionally, our Book of Benefits and our provider contracts stipulate that a request for change must be received within 30 days of the change in status.

Reasonable and Customary (R&C) Charges – Whether an out-of-network health care expense is "reasonable and customary" is determined by taking into account a number of factors including your geographic area, the complexity of the procedure, how frequently the procedure is performed, and the charges for similar procedures. The R&C charge as determined by the plan may be more or less than the amount charged by your provider and other providers in your local geographic area. In general, if you submit a claim for charges that exceeds the R&C amount, your benefit will be based on the R&C amount only. You must pay the difference yourself, and that difference will not count toward your deductible or out-of-pocket maximum.

Tips for Open Enrollment

You may feel that you have no control over the rising cost of health care, but you may be able to minimize its impact and make the most of the benefits you have. The best thing you can do is to “shop” for benefits carefully, using the same type of decision-making process you use for other major purchases.

- 1. Take advantage of the tools available to you.** That includes this 2010 Open Enrollment Guide, online access to health plan information, provider directories, and Open Enrollment materials.
- 2. Take advantage of the Mayo Clinic Health Assessment (HA) and receive an incentive for 2010.** The HA is a confidential questionnaire, developed by the medical experts at Mayo Clinic, that helps you understand how everyday health habits and your family history could impact your health in the future. Salaried (both monthly and weekly paid) employees who complete the HA and the Reward Points program and are ORNL medical plan primary policyholders will receive an incentive of a \$30 monthly reduction on 2010 ORNL medical premiums, beginning in January. Although not eligible for the reduction this year, hourly paid union employees and all spouses are encouraged to take the HA to learn more about your risks and the healthy choices available to you. The HA campaign and Reward Points close on October 31.
- 3. Be a smart shopper.** If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits because the wrong decision could be costly. Ask yourself the following question: Are you choosing the right health plan coverage for you and your family? There are a lot of resources available to help you with your decisions including the 2010 Open Enrollment Guide, online access to health plan information, provider directories, and Open Enrollment materials.
- 4. Re-think your health plan choices.** Don't blindly re-enroll for next year based on what benefits you had this year, especially if your income changed, the benefit options have been altered or if your family circumstances are different. Anticipate your family's health care issues and carefully study the benefit plan(s) being offered. With health care costs expected to continue to increase in the double-digits, this Open Enrollment period provides an opportunity for you to re-evaluate your health plans to make sure they meet your health care and financial needs. You should consider the following questions: Are you satisfied with your current medical, vision services and prescription drug plan? Are you satisfied with your current primary care physician (PCP) acting as your gatekeeper or would you prefer more flexibility? Be sure to review these questions and decide if you need to make a change.
- 5. Take advantage of your health care flexible spending account (FSA).** Consider enrolling in the health care FSA, even if the tax savings won't be large. The health care FSA helps you pay, in a tax-effective way, for predictable health expenses not covered by your health plans. Examples of expenses that can be reimbursed through your health care FSA include: prescription drugs, contact lenses and solutions, and deductibles and co-payments not covered by the health plans. Electing to contribute a portion of your before-tax income to a spending account can stretch money available for health care services and lower your taxable income at the same time. Most over-the-counter medications are now eligible, which means you could save tax dollars on pain relievers, antacids and allergy medications, among others.

Tips for Open Enrollment cont'd

- 6. Take advantage of your child and adult day care FSA , if appropriate.** The child and adult day care FSA helps you pay for childcare and other dependent care expenses in a tax-effective way, by electing to contribute a portion of your before-tax income to a spending account. A dependent care FSA can only be used for daycare expenses for children who are under 13 or are disabled to allow both parents to work or attend school full-time. It can also be used for adult daycare that allows you, as the guardian, to work.
- 7. Don't miss the deadline! Pay attention to the deadline for submitting your enrollment choices.** This year, open enrollment ends October 30. If you fail to enroll on time, you won't be able to take advantage of the health care or child and adult day care FSAs, and you will have to wait until next year to make changes or enroll in the medical or dental plans. Plus, if you wait until the last minute to enroll, you won't be able to do your research to get the most out of your benefits.

The Mayo Clinic Health Assessment campaign and the Reward Points program close on October 31. Note that Mayo Clinic technical service will not be available after 5:00 p.m. on Friday, October 30.

- 8. Keep a record of your enrollment and follow up.** You can enroll electronically through Employee Self Service (ESS) or manually using paper forms. If you enroll electronically, you will immediately receive an email confirming your elections, for your review and records. (You will receive an alert if your attempt to enroll is unsuccessful.) Carefully review your e-mail confirmation and make sure it is accurate. No matter how you enroll, be sure to keep a copy of your enrollment elections in your personal files. There may be questions that arise during the year regarding your coverage, and you will be glad that you have copies of your enrollment forms to refer to. In addition, remember to confirm the changes you made during Open Enrollment when you receive your Confirmation Statement in the mail in November. If you changed medical plans or providers and haven't received an ID card by mid-January, follow up with the Benefits Service Center.
- 9. Open Enrollment is October 12, 2009 to October 30, 2009 at 4 p.m.**

Open Enrollment Directory

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|---|-------------------|--|--|
| Open Enrollment Website (accessible from ORNL and home via the Internet) | | http://benefits.ornl.gov/openenrollment/2010/Pages/default.aspx | |
| For questions or more information about plan coverage or claims, contact the provider directly or visit their website. It is often best to deal directly with the plan providers because they are the people most knowledgeable about which services are covered and the status of your claims. | | | |
| Healthcare Plans | | | |
| MEDICAL (Open Access and POS) | | | |
| • CIGNA | 1-800-244-6224 | CIGNA | www.cigna.com |
| PHARMACY (both medical plans) | | | |
| • Medco | 1-800-685-8869 | Medco | www.medco.com |
| VISION (both medical plans) | | | |
| • Vision Service Plan (VSP) | 1-800-877-7195 | Vision Service Plan (VSP) | www.vsp.com |
| DISEASE MANAGEMENT (both medical plans) | | | |
| • Optimal Health | 1-866-225-2980 | | |
| DENTAL | | | |
| • MetLife | 1-800-942-0854 | MetLife | www.metlife.com |
| • Delta Dental | 1-800-223-3104 | Delta Dental | www.deltadentaltn.com (choose DeltaPremier) |
| Other Benefit Plans | | | |
| EMPLOYEE ASSISTANCE PROGRAM | | | |
| • Magellan Health Services | 1-800-888-2273 | Magellan Health | www.magellanassist.com |
| • On-site Counselor | 1-865-241-4643 | | |
| FLEXIBLE SPENDING ACCOUNTS | | | |
| • Ceridian | 1-877-799-8820 | Ceridian | www.ceridian-benefits.com |
| LONG-TERM CARE | | | |
| • MetLife | 1-800-438-6388 | MetLife | www.metlife.com |
| 401(k) SAVINGS PROGRAM | | | |
| • Schwab Retirement Plan Services | 1-800-777-4015 | Schwab | https://www.401kaccess.com/oakridge |
| Open Enrollment Contacts | | | |
| ESS On-line enrollment helpline: | Becky Parks | 574-1604 | e-mail: parksrct1@ornl.gov |
| Computer Access Questions: | Computer helpline | 241-ORNL (241-6765) | |
| OneCall Benefits Service Center 865-574-1500 Toll Free: 1-877-861-2255 Fax : 865-241-0531 Telecommunications Device for Deaf: 865-241-4344 E-mail: Benefits@y12.doe.gov Address: PO Box 2115 602 Scarboro Road, MS-8258 Oak Ridge, TN 37831-2115 | | ORNL Benefits 865-574-7474 Toll Free: 1-866-576-7766 Fax: 865-241-3213 E-mail: ornlbenefits@ornl.gov Address: 1009 Commerce Park Drive, Suite 350 Oak Ridge, TN 37830 Plant Mail: 1009 COM; MS-6465 | |