

Medical Plans

Prescription Drugs and Vision Benefits

Depending on where you live, you may enroll for coverage under one of the two point-of-service medical plans—the CIGNA Point-of Service Plan or the CIGNA Open Access Plan. If there is no point-of-service network available, you may be eligible for coverage under the CIGNA Indemnity Plan group contract. Prescription drug benefits are different for the CIGNA Point-of-Service Plan and the CIGNA Open Access and the CIGNA Indemnity Plan. You are automatically covered for prescription drug benefits and vision benefits when you enroll in a medical plan. Medco administers the prescription plan which covers members in the CIGNA plans. Vision Service Plan (VSP) provides the same vision benefits under each medical plan. See the Summary of Benefits for a summary of the copayments, deductibles, coinsurance, and related limits under each plan.

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Highlights

Your Medical Benefits ...

... Offer Coverage Under One of the Point-of-Service Plans for Most Employees

If you have access to the CIGNA point-of-service network, you can enroll in one of the two Point-of-Service Plans under the group contract. The network for the CIGNA Point-of-Service and the CIGNA Open Access Plans is available across the state of Tennessee. If you temporarily reside outside of Tennessee and CIGNA has a local point-of-service network available, you may be provided use of that network and receive in-network benefits. CIGNA has discretion to determine network availability.

... Provide Coverage Under the CIGNA Indemnity Plan Group Contract for Employees Who Do Not Have Access to a Point-of-Service Network

If you live in an area where a CIGNA network is not available, you may be covered under the CIGNA Indemnity Plan.

... Let You Waive Coverage

You may also choose to waive coverage. If you initially waive coverage, you may enroll during the next Open Enrollment period or when you experience a Qualifying Life Event, as described within the "About Your Benefits" section.

... Provide Protection for Your Family

You may enroll your Eligible Dependents for coverage under the same plan in which you are enrolled.

There may be state legislative requirements regarding group insurance plans covering individuals in the state. If so, CIGNA will comply with those requirements—which may create situations where a benefit is considered differently than as stated in this summary of benefits. Whenever there is a conflict between the summary in this book and the applicable Certificate of Insurance, the Certificate governs. You may request a copy of the Certificate by following the steps outlined under the "Administrative Information" section of this book.

What happens to your benefits when ...

For more information about what happens to your medical, prescription drug, and vision coverage when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" section.

Your Prescription Drug Benefits ...

... Allow You the Flexibility to Use a Network Pharmacy or Any Pharmacy You Choose

While benefits are higher when you use a network pharmacy, you can go to any pharmacy you choose and still receive prescription benefits.

- Call Medco at 1-800-866-749-0097 for assistance with locating a network pharmacy. This number is listed on your Medco identification (ID) card.
- No claim form is required when you use a network pharmacy. When you fill a prescription at a non-network pharmacy or file a direct claim, you pay the deductible and then you pay a percentage of the eligible cost for up to a 30 day supply of most prescription drugs.

... Offer a Convenient Home Delivery Option

The home delivery option, designed for maintenance drugs, provides up to a 90 day supply of a drug. You will pay the required copayment. New prescriptions can be ordered by mail. Complete an order form and mail it with your prescription.

For Medco (CIGNA Open Access, Point-of-Service and CIGNA Indemnity Plans)

Mail: Medco Health Solutions of Dallas
P.O. Box 650322
Dallas, TX 75265-0322

Fax: Your doctor may fax your prescription to Medco. Have your doctor call 1-888-327-9791 for information on how to fax to Medco.

Internet Refills: www.medco.com

Telephone Refills: 1-800-473-3455. Have your ID card and your refill bottle with the prescription information ready.

The Vision Service Plan (VSP) offers increased benefits when you see an in-network provider. A list of VSP in-network providers is available on the provider directories link on the Internet at www.vsp.com or by calling VSP at 1-800-877-7195.

Point-of-Service Medical Plans

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How the Point-of-Service Plans Work

Both Point-of-Service Plans center on a network of physicians, hospitals and other health care providers who have agreed to provide care to patients at prenegotiated rates.

In-network primary care physicians are family or general practitioners, internists, and pediatricians who contract with CIGNA to provide their services and charge only the contracted fee amount. Primary care physicians are responsible for coordinating all health care and, when necessary, for making referrals to in-network specialists. In-network primary care physicians and specialists also handle all inpatient and outpatient precertification.

Preventive care, like simple health screenings and immunizations, can help prevent or detect serious illnesses early—when they are less expensive to treat and you are more likely to fully recover. Primary care physicians provide a full range of preventive care based on recognized medical guidelines for a person's age, gender, and personal and family health history. Preventive care services are also provided at no cost to you. This care includes:

- immunizations
- annual well-woman exam
- well-child care
- cholesterol screenings
- prostate exams
- mammograms
- routine physical exams.

With a Point-of-Service Plan, you have a choice—at the "point-of-service"—each time you need health care, to use only in-network providers or to use providers outside the network and receive fewer benefits.

Under the CIGNA Point-of-Service Plan:

- You must select a primary care physician for each covered family member.
- Your primary care physician must refer you to a specialist physician in order for you to receive in-network benefits (even in-network physicians). Otherwise, your benefits will be considered at the out-of-network rate. If the specialist refers you to another specialist, that referral must be made by the primary care physician. If you need more visits with the specialist than is approved, the primary care physician must get approval for more visits or the additional charges will be denied

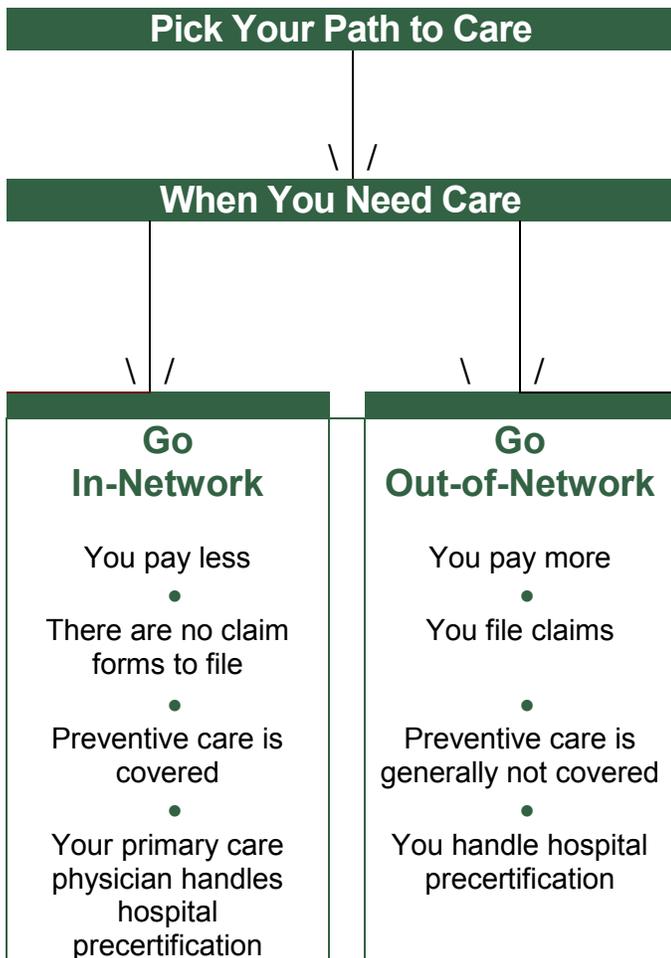
and you will have to pay them. Make sure you know how many visits are approved.

- A woman may "self-refer" to a network obstetrician/gynecologist.
- You may "self-refer" to a network mental health/substance abuse provider for individual or group therapy visits.
- Emergency (as defined in the Glossary) care does not require a primary care physician referral. However, you will need to call your primary care physician within 48 hours after the emergency to ensure in-network benefits and have your primary care physician coordinate any follow-up care.
- You do not need a referral from a primary care physician to see an optometrist for a routine eye exam. You use your vision benefit, not your medical benefit, for routine eye care.
- You can change a primary care physician on the web at www.mycigna.com or by calling CIGNA Member Services at the telephone number on your ID card.

Under the CIGNA Open Access Plan:

- You are not required to choose a primary care physician.
- If you select a primary care physician, the physician helps you get access to a specialist and handles any required precertification for you. These services may help avoid mistakes that can reduce the amount of benefits you receive.
- For maximum coordination of your medical care, it is recommended that you choose a primary care physician.
- You may see a specialist without a referral from a primary care doctor.

How the Point-of-Service Plans Work (cont'd.)



For deductibles, copayments, or coinsurance amounts refer to the Summary of Benefits for your plan.

If You Have an Emergency

If you have an Emergency, go to the nearest emergency facility for treatment—even if it is not a network facility. After you pay the copayment required by the plan, the plan pays 100 % of the cost of emergency room treatment. The copayment is waived if you are admitted to the hospital from the emergency room.

Someone must contact your primary care physician or CIGNA Member Services within 48 hours of your emergency treatment to ensure that in-network benefits are paid and to arrange for follow-up care.

If you go to the emergency room for a nonemergency, your expenses will not be covered.

If the situation is urgent, but not an emergency, you should contact your primary care physician first and follow his or her directions.

Definitions for "Emergency" and "Urgent Care" can be found in the Glossary.

Deductibles, Copayments, and Coinsurance

You and your Eligible Dependents may be required to pay a portion of the covered expenses for services and supplies. That portion is the deductible, copayment, or coinsurance:

- **Coinsurance** means the percentage of charges for covered expenses that you are required to pay under the plan.
- **Copayments** and **Deductibles** are those expenses to be paid by you or your Eligible Dependents for the services received.
- Deductible amounts are separate from, and not reduced by, copayments.
- Copayments and deductibles are in addition to any coinsurance.

How the Point-of-Service Plans Work (cont'd.)

The Network Credentialing Process

All network doctors—primary care physicians and specialists—must meet certain educational and professional requirements before they are admitted into the network. CIGNA has a regular credentialing process to ensure that the doctors in the network meet certain standards, such as:

- medical degree and current unrestricted state license
- admitting privileges at a network hospital
- board certification or board eligibility
- malpractice criteria
- good reputation among peers
- 24-hour emergency availability
- sufficient office hours to meet patient demand
- on-site review of office facilities.

CIGNA reviews its physicians regularly. If any physician does not meet the requirements, that physician will be dropped from the network.

Network hospitals are also credentialed. Hospitals are selected based on their facilities, services, medical outcomes, staff quality measures, and reputation in the community.

CIGNA has the right to change network doctors and network hospitals at any time and without advance notice.

Special Circumstances

The Point-of-Service Plans have certain provisions that apply to special circumstances. If you have any questions about these situations or others not described here, please contact CIGNA Member Services or the ORNL Benefits Office.

If you need care while traveling outside your network area

You are covered for Emergency care or Urgent Care on an in-network basis, as long as you call your primary care physician or CIGNA Member Services within 48 hours of receiving the emergency or urgent treatment. You must file a claim for reimbursement as soon as possible when you return. For other types of care, call your primary care physician to determine your best options.

If you are traveling outside the U.S. you should seek care and pay for any services provided at the time of treatment. If possible, obtain any medical records from the attending provider. When you return home, submit your claim along with documentation and a narrative describing the services provided. You must also submit proof of payment. Claims should be sent to the CIGNA claims address on the back of your ID card, to the attention of the Foreign Claims Unit. You may wait until you return home to contact your primary care physician.

If you are on an off-site assignment for more than 90 days

Contact the ORNL Benefits Office for information.

Residing in another location

If you or your Eligible Dependents will be residing temporarily in another location where there are in-network providers, you may be eligible for Point-of-Service benefits at that location. If you will be permanently residing outside the Point-of-Service network, refer to the “CIGNA Indemnity Plan” portion of the “Medical Plan” section and contact the ORNL Benefits Office for more information.

How the Point-of-Service Plans Work (cont'd.)

Out-of-Network Benefits

When you go out-of-network, you can use any physician or facility you like. After you meet an annual deductible, the plan pays the Reasonable and Customary Charges for most kinds of medically necessary services, until the annual out-of-pocket maximum has been reached, depending on which medical plan option you have selected.

The out-of-pocket maximum protects you from excessive medical costs by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of the Reasonable and Customary Charges for the rest of that year.

You must file claims to be reimbursed for out-of-network expenses. Claim forms are available from CIGNA Member Services or the ORNL Benefits Service Center.

If your physician recommends any nonemergency hospitalization or surgery, you are responsible for calling CIGNA Member Services for hospital precertification at least 7 days, or as soon as reasonably possible, before you are admitted to the hospital. If you do not call for precertification, your benefit will be reduced by 50%.

Reasonable and Customary Charges

Any charges above the Reasonable and Customary Charge are not covered by the plan, and you will not be reimbursed for that amount. Also, the amounts will not count toward the deductible or out-of-pocket maximum.

"Reasonable and Customary Charge" is defined in the Glossary.

The Family Deductible

Although the deductible applies separately to each covered family member, the plan contains a provision—called the family deductible—that limits the amount your family pays in deductibles each year.

You can also meet the family deductible with any combination of individual expenses. However, once one family member meets his or her individual deductible, any further expenses incurred by that person may not be applied to the family deductible. Once the family deductible is met, no other family member needs to meet the deductible for that year.

The Out-of-Pocket Expenses and Your Maximum Expenses

The out-of-pocket expenses are covered expenses incurred for in-network and out-of-network charges for which no payment is provided because of any applicable coinsurance. The out-of-pocket maximum limits the amount you pay for medical expenses in 1 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:

- non-compliance penalties for not following precertification requirements
- copayments
- deductibles
- charges above Reasonable and Customary Charge
- care that is received but not covered by the plan.

How the Point-of-Service Plans Work (cont'd.)

Out-of-Network Benefits (cont'd.)

Precertification

Precertification helps ensure that all inpatient and certain outpatient services are medically necessary and, in the case of hospital confinement, that the length of stay is appropriate.

If you stay in-network, you do not have to worry about precertification. Your in-network primary care physician or specialist will handle it for you. If you go out-of-network for care, you are responsible for calling CIGNA Member Services at least 7 days, or as soon as possible, before you are admitted to the hospital or receive outpatient diagnostic testing or procedures. If you do not call, your benefit will be reduced by 20 %.

When you call CIGNA Member Services for precertification, you need to provide the following information:

- your name, address and telephone number
- your physician's name and telephone number
- the date of your admission or services
- the reason for your admission or services.

For mental health and substance abuse admissions, whether in-network or out-of-network, you must call the mental health/substance abuse (MH/SA) number listed on your ID card. You do not call CIGNA Member Services.

Mental Health/Alcohol and Substance Abuse Treatment

You may "self-refer" to a network MH/SA provider for individual or group therapy visits. A primary care physician referral is not required.

CIGNA Member Services

CIGNA Member Services is a customer service line staffed by experienced and courteous representatives trained to answer your questions and provide information about your Point-of-Service Plan participation and benefits. CIGNA Member Services can help you:

- find out more about in-network primary care physicians, specialists and facilities
- get more information about plan features and procedures
- change primary care physicians
- order replacement ID cards
- register comments about network providers and services
- request out-of-network claim forms.

In addition to Member Services:

You may locate participating providers in your CIGNA network by accessing www.cigna.com. Click on the "Provider Directory" link and follow the instructions for locating providers in your area.

As a CIGNA member, you have access to your benefit information through your own personalized CIGNA website – www.mycigna.com. There you can:

- locate participating providers
- change your PCP
- print a temporary ID card
- order a new ID card
- access your benefit information
- check the status of your claims.

If you go out-of-network, you must also call CIGNA Member Services for precertification.

Contacting CIGNA Member Services

For CIGNA Open Access and
CIGNA Point-of-Service Plans

1-800-CIGNA24 (1-800-244-6224)

Refer to your ID card for the Mental Health/Substance Abuse phone number.

Summary of Benefits

CIGNA Point-of-Service Plan		
	In-Network	Out-of-Network*
Annual Deductible Amount for injury, illness, or maternity	None	\$200 / individual \$400 / family
Out-of-Pocket Annual Limit (excludes deductible)	\$1,000 / individual \$2,000 / family	\$3,000 / individual \$6,000 / family
Pre-Existing Conditions	n/a	n/a
Maximum Lifetime Benefit	Unlimited	Unlimited
	In-Network	Out-of-Network*
Laboratory and X-ray	Covered 100%	Covered 80% of R&C* after deductible
Home Health Care (skilled visits only)—60 days per calendar year, in-network and out-of-network combined Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in 1 day, with a visit defined as a period of 2 hours or less.	Covered 100%	Covered 80% of R&C* after deductible
Durable Medical Equipment	Covered 100%	Not covered
External Prosthetic Devices—Requires approval by Health Plan	Covered 100% after \$200 deductible	Not covered

*R&C — Reasonable and Customary Charges

Summary of Benefits (cont'd)

CIGNA Point-of-Service Plan (cont'd.)

Hospital Care

	In-Network	Out-of-Network*
Inpatient Services: Operating room, X-ray, and laboratory services. Includes stand-alone facilities such as Birthing Center	Covered 100%	Covered 80% of R&C* after deductible
Outpatient Services: <ul style="list-style-type: none"> Outpatient surgery 	Covered 100%	Covered 80% of R&C* after deductible
<ul style="list-style-type: none"> Physician's Office 	Covered 100% after \$10 office visit copayment per visit	Covered 80% of R&C* after deductible
Transplant Coverage: <ul style="list-style-type: none"> Inpatient Facility 	Covered 100% at approved facilities	Not covered
<ul style="list-style-type: none"> Travel Benefit 	\$10,000 per transplant per lifetime available when using an approved facility	Not covered
Emergency Room Services (not covered if not true Emergency)	Covered 100% after \$50 copayment (waived if admitted)	Covered 100% after \$50 copayment (waived if admitted)
Ambulance Services (not covered if not true Emergency)	Covered 100%	Covered 100%
Urgent Care Facility (not covered if not true Emergency)	Covered 100% after \$25 copayment	Covered 100% after \$25 copayment
Inpatient Mental Health	Covered 100%	Covered 80% of R&C* after deductible
Inpatient Substance Abuse	Covered 100%	Covered 80% of R&C* after deductible

*R&C — Reasonable and Customary Charges

Summary of Benefits (cont'd)

CIGNA Point-of-Service Plan (cont'd.)		
Physician Care		
Services Covered	In-Network	Out-of-Network*
Maternity— Inpatient	Covered 100%	Covered 80% of R&C* after deductible
Skilled Nursing Facility 60 days per calendar year for in-network and out-of-network combined	Covered 100%	Covered 80% of R&C* after deductible
Hospice Care (inpatient and outpatient)	Covered 100%	Covered 80% of R&C* after deductible
Outpatient (short-term) Rehabilitation— 20 days in-network and out-of-network combined. Includes physical, speech, cardiac and occupational therapy	Covered 100% after \$10 copayment per visit	Covered 80% of R&C* after deductible
Primary Care or Specialist Office Visit	Covered 100% after \$10 copayment	Covered 80% of R&C* after deductible
Physician and Surgeon Services in Hospital	Covered 100%	Covered 80% of R&C* after deductible
Maternity Office Visits	Covered 100% after one-time \$10 office visit copayment	Covered 80% of R&C after deductible
Maternity Delivery (Physician charges)	Covered 100%	Covered 80% of R&C* after deductible
Preventive Health Services		
<ul style="list-style-type: none"> Well-Baby Care 	Covered 100% (including immunizations)	Not covered
<ul style="list-style-type: none"> Periodic Health Assessments 	Covered 100%	Not covered
<ul style="list-style-type: none"> Routine Gynecological Exams 	Covered 100%	Not covered
<ul style="list-style-type: none"> Routine Mammogram 	Covered 100% (no referral needed)	Covered 80% of R&C* after deductible
Other Services		
<ul style="list-style-type: none"> Hearing Aid Benefits 	Not covered	Not covered
<ul style="list-style-type: none"> Chiropractic Care (when medically appropriate)— 25 day limit per year 	Covered 100% after \$10 copayment per visit, (no referral needed)	Not covered

*R&C — Reasonable and Customary Charges

Summary of Benefits (cont'd)

CIGNA Point-of-Service Plan (cont'd.)

Physician Care

Services Covered	In-Network	Out-of-Network*
Substance Abuse: <ul style="list-style-type: none"> Outpatient 	Covered 100% after \$10 copayment per visit (no referral needed)	Covered 80% R&C* after deductible
Mental Health Service: <ul style="list-style-type: none"> Outpatient 	Covered 100% after \$10 copayment per visit (no referral needed)	Covered 80% of R&C* after deductible
Physician Services in Emergency Room	Covered 100%	Covered 100%
Infertility Treatment: <ul style="list-style-type: none"> Physician office visit, test, counseling Surgical Treatment—includes procedures for correction of infertility (in vitro fertilization, artificial insemination, GIFT, ZIFT**, etc.) 	Not covered	Not covered
Vision Exam Services <i>Provided by VSP</i>	No charge for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal or polycarbonate (for dependent children) Frames allowance of up to \$120 plus 20% off excess of \$120 every 24 months; OR Contact lens every 12 months covered up to \$120; allowance applies to cost of contacts and contact lens exam plus 15% off cost of contact exam. Eligible members may elect VSP Contact Lens Care Program for contact lens exam and initial supply of lenses	Allowance of up to: Exam: \$29.75 Single Vision: \$21.25 Bifocals: \$34.00 Trifocals: \$46.75 Frame: \$38.75 Elective Contacts \$105.00
<ul style="list-style-type: none"> Lens options 	20% discount on lens enhancements and upgrades	
<ul style="list-style-type: none"> Additional Discounts 	20% discount on additional prescription glasses and sunglasses. Laser vision correction services at reduced cost through VSP network doctors and contracted laser surgery centers	

Summary of Benefits (cont'd)

CIGNA Point-of-Service Plan (cont'd.)		
Prescription Drugs, Medco Pharmacy		
Services Covered	In-Network	Out-of-Network*
Retail Pharmacy (Up to 30 day supply)	Generic: 100% after \$5 copayment Preferred Brand: 100% after \$15 copayment Non-preferred Brand: 100% after \$35 copayment	Covered 80% after deductible
Home Delivery (Up to 90 day supply)	Generic: 100% after \$15 copayment Preferred Brand: 100% after \$45 copayment Non-preferred Brand: 100% after \$105 copayment	Not covered

*R&C — Reasonable and Customary Charges

** GIFT: gamete intrafallopian transfer; ZIFT: zygote intrafallopian transfer

Summary of Benefits (cont'd)

CIGNA Open Access Plan		
	In-Network	Out-of-Network
Annual Deductible Amount for injury, illness, or maternity	\$300 / individual \$600 / family	\$500 / individual \$1,000 / family
Out-of-Pocket Annual Limit (excludes deductible)	\$1,500 / individual \$3,000 / family	\$4,500 / individual \$9,000 / family
Pre-Existing Conditions	n/a	n/a
Maximum Lifetime Benefit	Unlimited	Unlimited
Services Covered	In-Network	Out-of-Network*
Outpatient Short-Term Rehabilitation—180 days per year for all conditions, in-network and out-of-network combined. Includes speech, occupational, physical and cardiac therapy	Covered 100%	Covered 60% of R&C* after deductible
Outpatient laboratory and X-ray: <ul style="list-style-type: none"> All charges billed by an independent facility. 	Covered 100%	Covered 60% of R&C* after deductible
Home Health Care (skilled visits only) Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in 1 day; with a visit defined as a period of 2 hours or less.	Covered 100%; unlimited days	Covered 60% of R&C* after deductible for up to 60 days per calendar year, reduced by any in-network days
Durable Medical Equipment	Covered 100%	Covered 60% of R&C* after deductible
External Prosthetic Devices—Requires approval by Health Plan	Covered 90% after deductible	Covered 60% of R&C* after deductible

*R&C — Reasonable and Customary Charge

Summary of Benefits (cont'd)

CIGNA Open Access Plan (cont'd.)

Hospital Care		
Services Covered	In-Network	Out-of-Network*
Inpatient Services: semi-private room, operating room, X-ray, and laboratory services. Includes stand-alone facilities such as Birthing Center.	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Outpatient Services: Outpatient surgery	Covered 90% after deductible and \$150 copayment per visit	Covered 60% of R&C* after deductible and \$300 copayment per visit
Transplant Coverage: Inpatient Facility	Covered 90% after deductible and \$250 copayment at approved facilities	Covered 60% of R&C* after deductible and \$500 copayment per admission
Travel Benefit	\$10,000 per transplant per lifetime available when using an approved facility	Not covered
Emergency Room Services	Covered 100% after \$100 copayment per visit (waived if admitted)	Covered 100% after \$100 copayment per visit (waived if admitted)
Ambulance Services	Covered 100%	Covered 100%
Urgent Care Facility	Covered 100% after \$50 copayment	Covered 100% after \$50 copayment
Inpatient Mental Health	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Inpatient Substance Abuse	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Maternity—Inpatient	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Inpatient Services at other healthcare facilities: <ul style="list-style-type: none"> Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-acute facility 60 days per calendar year for in-network and out-of-network combined 	Covered 90% after deductible	Covered 60% of R&C*
Hospice Care <ul style="list-style-type: none"> Inpatient 	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
<ul style="list-style-type: none"> Outpatient 	Covered 100%	Covered 60% of R&C* after deductible

*R&C — Reasonable and Customary Charges

Summary of Benefits (cont'd)

CIGNA Open Access Plan (cont'd.)		
Physician Care		
Services Covered	In-Network	Out-of-Network*
Primary Care Office Visit	Covered 100% after \$15 copayment	Covered 60% of R&C* after deductible
Specialist Office Visit	Covered 100% after \$30 copayment	Covered 60% of R&C* after deductible
Vision Exam Services Provided by VSP	<p>No charge for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal or polycarbonate (for dependent children) Frames allowance of up to \$120 plus 20% off excess of \$120 every 24 months; OR Contact lens every 12 months covered up to \$120; allowance applies to cost of contacts and contact lens exam plus 15% off cost of contact exam.</p> <p>Eligible members may elect VSP Contact Lens Care Program for contact lens exam and initial supply of lenses</p>	<p>Allowance of up to:</p> <p>Exam: \$29.75 Single Vision: \$21.25 Bifocals: \$34.00 Trifocals: \$46.75 Frame: \$38.75 Elective Contacts \$105.00</p>
<ul style="list-style-type: none"> Lens options 	20% discount on lens enhancements and upgrades	
<ul style="list-style-type: none"> Additional Discounts 	<p>20% discount on additional prescription glasses and sunglasses.</p> <p>Laser vision correction services at reduced cost through VSP network doctors and contracted laser surgery centers</p>	
Physician and Surgeon Services in Hospital	Covered 90% after plan deductible	Covered 60% of R&C* after deductible
Maternity Office Visits	Covered 90% after one-time office visit copayment	Covered 60% of R&C* after deductible
Maternity Delivery (Physician charges)	Covered 90% after plan deductible and \$250 copayment	Covered 60% of R&C* after deductible and \$500 copayment

Summary of Benefits (cont'd)

CIGNA Open Access Plan (cont'd.)		
Physician Care (cont'd.)		
Services Covered	In-Network	Out-of-Network*
Preventive Health Services:		
<ul style="list-style-type: none"> Well-Baby Care 	Covered 100% (includes immunizations)	Not covered
<ul style="list-style-type: none"> Routine Physical Exam 	Covered 100%	Not covered
<ul style="list-style-type: none"> Routine Gynecological Exams 	Covered 100%	Not covered
<ul style="list-style-type: none"> Routine Mammogram 	Covered 100%	Covered 60% of R&C* after deductible
Other Services		
<ul style="list-style-type: none"> Hearing Aid Benefits 	Covered 100%; \$750 maximum every 36 months	Hearing aid not covered
<ul style="list-style-type: none"> Hearing Exam 	Covered at 100% after \$30 copayment per visit	Exam covered 60% after deductible
<ul style="list-style-type: none"> Chiropractic Care 	Covered 100% after \$30 copayment; 25 day limit per year	Not covered
Substance Abuse—Outpatient	\$30 copayment per visit	Covered 60% R&C* after deductible
Mental Health— Outpatient	\$30 copayment per visit	Covered 60% of R&C* after deductible
Physician Services in Emergency Room	Covered 100%	Covered 100%
Infertility Treatment: <ul style="list-style-type: none"> Physician office visit, test, counseling Surgical Treatment— includes procedures for correction of infertility (in vitro fertilization, artificial insemination, GIFT, ZIFT,** etc.) 	\$30 copayment per office visit, then covered 100% Inpatient and outpatient facility same as inpatient and outpatient hospital benefits Physician services covered 90% after annual deductible Limited coverage; \$20,000 lifetime maximum	Covered 60% R&C* after deductible Limited coverage; \$20,000 lifetime maximum

*R&C — Reasonable and Customary Charge

** GIFT: gamete intrafallopian transfer; ZIFT: zygote intrafallopian transfer

Summary of Benefits (cont'd)

CIGNA Open Access Plan (cont'd.)

Prescription Drugs, administered by Medco

Services Covered	In-Network	Out-of-Network * and Direct Claims
Retail Prescription Drugs— up to a 30-day supply	<p>\$150 deductible per individual</p> <p>Generic: 20% (minimum \$10 copayment) after deductible</p> <p>Brand: 30% (minimum \$10 copayment) after deductible</p> <p>If actual cost is under \$10, then you pay actual cost</p>	50% of cost after \$150 deductible
Mail Order— Home Delivery	<p>Generic: \$15 copayment up to a 90 day supply</p> <p>Brand: \$35 copayment up to a 90 day supply</p>	Not covered

*R&C — Reasonable and Customary Charges

Administrative Information

Information about the administration of your medical benefits can be found in the section entitled “Administrative Information.”

Contacting CIGNA Member Services

For medical precertification, questions or concerns

1-800-CIGNA24 (1-800-244-6224)

CIGNA Indemnity Plan

If you do not have access to a Point-of-Service network, you may be covered under the CIGNA Indemnity Plan.

For more information on ...	See Page ...
How the CIGNA Indemnity Plan Works	43
Summary of Benefits	45

How the CIGNA Indemnity Plan Works

Under the Indemnity Plan, you may receive care from any provider you choose. After you meet your annual deductible, the plan pays 80% of Reasonable and Customary Charges for medically necessary services and supplies until you reach the annual out-of-pocket maximum.

The out-of-pocket maximum protects you from excessive medical costs by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of Reasonable and Customary Charges for eligible medical expenses for the rest of that year.

You must file claims to be reimbursed for your eligible expenses. Claim forms are available from the ORNL Benefits Service Center or CIGNA Member Services.

You must also call CIGNA Member Services to precertify any nonemergency hospitalization or outpatient diagnostic test or procedure. If you do not call, your benefit will be subject to a penalty.

Reasonable and Customary Charges

All Indemnity Plan benefit payments are subject to Reasonable and Customary Charges. Any charges above Reasonable and Customary Charges are not covered by the plan, and you will not be reimbursed for them. Also, these amounts will not count toward the deductible or out-of-pocket maximum.

See the Glossary for a definition of "Reasonable and Customary Charge."

The Family Deductible

Although the deductible applies separately to each covered family member, the plan contains a provision called the family deductible, which limits the total amount you pay in deductibles each year.

You can meet the family deductible with any combination of individual expenses. However, once one family member meets his or her individual deductible, any further expenses incurred by that person may not be applied to the family deductible. Once the family deductible is met, no other family member needs to meet the deductible for that year.

Contacting CIGNA Member Services

For questions on eligibility, CIGNA Indemnity Plan benefits, or claims

1-800-CIGNA24 (1-800-244-6224)

This telephone number is also listed on your ID card.

How the CIGNA Indemnity Plan Works (cont'd.)

The Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay for medical expenses in 1 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:

- non-compliance penalties for not following precertification requirements
- charges above Reasonable and Customary Charges
- care that is received but not covered by the plan.

Second Surgical Opinion

Second surgical opinions are not mandatory but are covered by the plan with certain limitations. If your physician recommends surgery, the plan pays 100% of the Reasonable and Customary Charge for a second surgical opinion, with no deductible. If additional opinions are necessary, they will be covered at 80% of Reasonable and Customary Charges.

Preadmission and Post-Confinement Testing

The plan pays 100% of the cost of preadmission and post-release testing performed on an outpatient basis within 14 days before a scheduled admission, or within 14 days after you leave the hospital, provided the testing is related to your surgery.

If the preadmission tests are performed and your admission is later cancelled, or if the tests are duplicated while you are in the hospital, the plan will pay 80% of Reasonable and Customary Charges for the tests, after you meet the deductible.

Mental Health/Alcohol and Substance Abuse Treatment

After you meet the deductible, the Indemnity Plan pays 80% of Reasonable and Customary Charges for mental health/alcohol and substance abuse treatment, up to the limits described in the chart on the following pages. Inpatient care must be precertified by contacting the MH/SA number shown on your ID card.

For copayments, deductible amounts, and other summary information about your CIGNA Indemnity Plan, please refer to the "CIGNA Indemnity Plan Summary of Benefits," which follows.

Summary of Benefits

CIGNA Indemnity Plan	
Annual Deductible Amount for injury, illness or maternity	\$400 Individual \$800 Family
Out-of-Pocket Annual Limit (includes deductible)	\$2,000 individual \$4,000 family
Pre-Existing Conditions	n/a
Maximum Lifetime Benefit	Unlimited
Hospital Care	
Services Covered	
Inpatient Services: semi-private room, operating room, X-ray, and laboratory services	Covered 80% of R&C* after deductible
Outpatient Services: <ul style="list-style-type: none"> Outpatient surgery Outpatient professional services—surgeon, radiologist, pathologist, anesthesiologist X-ray and laboratory services 	Covered 80% of R&C* after deductible
Organ Transplant Coverage	Covered 80% of R&C* after deductible Travel services maximum when transplant procedure is performed at a LifeSource Facility: \$10,000 per transplant
Emergency Room	Covered 80% of R&C* after deductible
Inpatient Mental Health	Covered 80% of R&C* after deductible
Inpatient Substance Abuse	Covered 80% of R&C* after deductible
Maternity —Inpatient	Covered 80% of R&C after deductible
Inpatient services at other health care facilities: <ul style="list-style-type: none"> Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities 	Covered 100% of R&C* Up to 60 days confinement per calendar year maximum
Ambulance Services	Covered 80% of R&C* after deductible
Outpatient short-term rehabilitation. <ul style="list-style-type: none"> Includes cardiac, physical, speech, and occupational therapy Contract year maximum is unlimited	Covered 80% of R&C* after deductible

*R&C — Reasonable and Customary Charges

Summary of Benefits (cont'd)

CIGNA Indemnity Plan (cont'd.)	
Physician Care	
Services Covered	
Physician Office Visit <ul style="list-style-type: none"> • Surgery performed in the physician's office • Allergy Treatment/Injections • Maternity office visits 	Covered 80% of R&C* after deductible
Vision Exam Services <i>Provided by VSP</i>	<p>In Network: No charge for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal, or polycarbonate (for dependent children) Frames allowance of up to \$120 plus 20% off excess of \$120 every 24 months;</p> <p>OR</p> <p>Contact lens every 12 months covered up to \$120; allowance applies to cost of contacts and contact lens exam plus 15% off cost of contact exam.</p> <p>Out of Network: Allowance of up to:</p> <p>Exam \$29.75 Single Vision 21.25 Bifocals 34.00 Trifocals 46.75 Frame 38.75 Elective Contacts 105.00</p>
Chiropractic Care	Covered 80% of R&C* after deductible 25 day limit per year
Emergency Care at Doctor's Office	Covered 100% of R&C*
Urgent Care Facility	Covered 80% of R&C* after deductible
Physician and Surgeon Services in Hospital	Covered 80% of R&C* after deductible
Allergy Serum (dispensed by the physician in the office)	Covered 80% no deductible
Maternity Delivery (physician charges)	Covered 80% of R&C* after deductible
Preventive Health Services: <ul style="list-style-type: none"> • Well Child care (including immunizations) • Annual routine physicals, adult immunizations, Well Woman care • Mammogram, pap test, or prostate specific antigen Test (PSA) 	Covered 100% of R&C*

*R&C — Reasonable and Customary Charges

Summary of Benefits (cont'd)

CIGNA Indemnity Plan (cont'd.)	
Hearing Aid Benefits	Not Covered
Laboratory and X-ray <ul style="list-style-type: none"> MRIs, MRAs, CAT Scans and PET scans 	Covered 80% of R&C* after deductible
Physician Care	
Services Covered	
Home Health Care (skilled visits only) Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in 1 day; with a visit defined as a period of 2 hours or less.	Covered 100% of R&C*, no deductible Up to 60 days per calendar year maximum
Hospice Care	Inpatient services covered 80% of R&C*, maximum 60 days per lifetime. Inpatient room and board at the semi-private room rate Outpatient services same as Home Health Care benefit Bereavement Counseling covered 80% after the deductible, visits subject to the Plan's outpatient mental health limit
Substance Abuse	Outpatient covered 80% of R&C* after deductible
Mental Health Service:	Outpatient covered 80% of R&C* after deductible
Physician Services in Emergency Room	Covered 80% of R&C* after deductible
Durable Medical Equipment	Covered 80% of R&C* after deductible
Infertility Treatment	Limited coverage Artificial insemination lifetime maximum: 3 attempts per menstrual cycle with a maximum of 8 cycles per lifetime (total attempts allowed is 24) In Vitro fertilization, GIFT and ZIFT** lifetime maximums: 4 attempts
External Prosthetic Devices – Requires approval by Health Plan	Covered 80% of R&C* after deductible
Dental Care—Limited to charges for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth	Inpatient and outpatient facility benefit and physicians services covered 80% after the deductible
Temporomandibular Joint Disorder (surgical & non-surgical treatment)	Covered 80% of R&C* after deductible
Chemotherapy & Radiotherapy	Inpatient services 80% of R&C* after deductible Outpatient services covered 100% of R&C*

*R&C — Reasonable and Customary Charges

** GIFT: gamete intrafallopian transfer; ZIFT: zygote intrafallopian transfer

Summary of Benefits (cont'd)

CIGNA Indemnity Plan (cont'd.)

Prescription Drugs, administered by Medco

Services Covered	In-Network	Out-of-Network * and Direct Claims
Retail Prescription Drugs— up to a 30-day supply	<p>\$150 deductible per individual</p> <p>Generic: 20% (minimum \$10 copayment) after deductible</p> <p>Brand: 30% (minimum \$10 copayment) after deductible</p> <p>If actual cost is under \$10, then you pay actual cost</p>	50% of cost after \$150 deductible
Mail Order— Home Delivery	<p>Generic: \$15 copayment up to a 90 day supply</p> <p>Brand: \$35 copayment up to a 90 day supply</p>	Not covered

*R&C — Reasonable and Customary Charges

Important Telephone Numbers

For questions on eligibility, plan benefits, claims or precertification
1-800-CIGNA24 (1-800-244-6224)

For mental health/substance abuse (MH/SA)
1-800-274-4573

These telephone numbers are also listed on your ID card.

Administrative Information

Information about the administration of your medical, prescription drugs, and vision benefits can be found in the section entitled "Administrative Information."

Information for All Medical Plans

For more information on ...	See Page ...
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Information for all Medical Plans

Certification Requirements

For all medical plans, all inpatient hospital admissions, outpatient diagnostic tests and outpatient procedures must be reviewed to certify the medical necessity of the admission, test, or procedure.

For the CIGNA Point-of-Service Plans, if you are using an in-network physician for care, the in-network physician is responsible for contacting CIGNA to certify the admission, test, or procedure. If you are using an out-of-network physician, you are responsible for requesting certification. If you are using an out-of-network physician and you do not obtain approval through certification, penalties will apply.

For the CIGNA Indemnity Plan, you are responsible for requesting certification. If you do not obtain approval through certification, penalties will apply.

For certification, call CIGNA Member Services at 1-800-244-6224.

Preadmission Certification/Continued Stay Review for Hospital Confinement

Preadmission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of a hospital confinement when you or your Eligible Dependent requires treatment in a hospital:

- as a registered bed patient
 - for a partial hospitalization for the treatment of mental health or substance abuse
- or*
- for substance abuse residential treatment services.

PAC should be requested prior to any nonemergency treatment in a hospital described above. In the case of an emergency admission, the Review Organization should be contacted within 48 hours after the admission. For an admission due to pregnancy, the Review Organization should be contacted by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued hospital confinement.

Covered expenses incurred will be reduced by 20% for hospital charges made for each separate admission to the hospital:

- unless PAC is received:
 - (a) prior to the date of admission;

or

 - (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- hospital charges for bed and board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR;
- and*
- any hospital charges for treatment listed above for which PAC was requested, but which was not certified as medically necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which CIGNA has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Information for all Medical Plans (cont'd.)

Outpatient Certification Requirements

Outpatient Certification refers to the process used to certify the medical necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a free-standing surgical facility, other health care facility, or a physician's office. The toll-free number on the back of your ID card should be called to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures.

Outpatient Certification is performed through a utilization review program by a Review Organization with which CIGNA has contracted. Outpatient Certification should be only requested for nonemergency procedures or services and should be requested at least 4 working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered expenses incurred will be reduced by 20% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but which was not certified as medically necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Diagnostic tests and outpatient procedures that require certification include, but are not limited to:

- advanced radiological imaging – CT scans, MRI, MRA or PET scans
- hysterectomy.

Prior Authorization/Pre-Authorized

For the CIGNA Point-of-Service Plans, the term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Services that require Prior Authorization include, but are not limited to:

- inpatient hospital services
- inpatient services at any participating other health care facility
- residential treatment
- outpatient facility services
- advanced radiological imaging
- nonemergency ambulance
and
- transplant services.

Emergency Hospitalization

If you have a medical emergency and are admitted to the hospital, someone must call for precertification within 2 days of your admission or on the first business day following your admission, if later.

For precertification call:

1-800-CIGNA24 (1-800-244-6224)

Information for all Medical Plans (cont'd.)

Expenses Not Covered

In addition to the coverage limitations shown on the plan's Summary of Benefits, there are some expenses that are not covered. They include, but are not limited to:

- expenses for supplies, care, treatment, or surgery that are not medically necessary
- to the extent that you or any one of your Eligible Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- to the extent that payment is unlawful where the person resides when the expenses are incurred
- charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected injury or sickness
- for or in connection with an injury or sickness which is due to war, declared or undeclared
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary, or convalescent care.
- for or in connection with experimental, investigational or unproven services (as defined and determined by CIGNA).
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, such as abdominoplasty/panniculectomy
- redundant skin surgery; removal of skin tags, acupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy, and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within 6 months of an injury to sound natural teeth, (b) charges made by a hospital for bed and board or necessary services and supplies, or (c) charges made by a free-standing surgical facility or the outpatient department of a hospital in connection with surgery
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: (a) medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and (b) weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision
- unless otherwise covered by the plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons, including, but not limited to, employment; insurance or government licenses; and court-ordered, forensic, or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this plan

Information for all Medical Plans (cont'd.)

Expenses Not Covered (cont'd)

- infertility services except as provided by the plan, including infertility drugs; surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures; and any costs associated with the collection, washing, preparation, or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage
- reversal of male or female voluntary sterilization procedures
- transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation—except as provided by the plan
- medical and hospital care and costs for the infant child of an Eligible Dependent, unless this infant child is otherwise eligible under this plan
- nonmedical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school counseling, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism, or mental retardation
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected
- consumable medical supplies other than ostomy supplies and urinary catheters, except as provided by the plan
- private hospital rooms and/or private duty nursing unless determined by the utilization review physician to be medically necessary
- personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an injury or sickness
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures, and wigs
- hearing aids, except as provided by the plan, including but not limited to semi-implantable hearing devices, audiant bone conductors, and bone-anchored hearing aids. A hearing aid is any device that amplifies sound
- aids or devices that assist with nonverbal communications
- medical benefits for eyeglasses, contact lenses, or examinations for prescription or fitting thereof (these services are covered under the VSP), except that covered expenses will include the purchase of the first pair of eyeglasses, lenses, frames, or contact lenses that follows keratoconus or cataract surgery
- charges made for or in connection with routine refractions, eye exercises, and surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- treatment by acupuncture
- all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the plan
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary

Information for all Medical Plans (cont'd.)

Expenses Not Covered (cont'd)

- membership costs or fees associated with health clubs, weight loss programs, and smoking cessation programs
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease
- dental implants for any condition
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where, in the utilization review physician's opinion, the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- blood administration for the purpose of general improvement in physical condition
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
- cosmetics, dietary supplements, and health and beauty aids
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism
- for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit (including Workers' Compensation)
- telephone, e-mail, and Internet consultations, and telemedicine
- massage therapy
- for charges which would not have been made if the person had no insurance
- to the extent that charges are more than Reasonable and Customary Charges
- expenses incurred outside the United States, unless you or your Eligible Dependent is a U.S resident and the charges are incurred while traveling on business or for pleasure
- charges made by any covered provider who is a member of your family or your Eligible Dependent's family
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Information for all Medical Plans (cont'd.)

Filing Claims

If you stay in-network under the Point-of-Service Plans, your network provider is responsible for filing your claims.

To file a claim for out-of-network treatment under the Point-of-Service Plans or for any treatment under the Indemnity Plan, you must complete a claim form and send it to CIGNA within 90 days after the plan year in which services have been rendered. Be sure to:

- include the account number listed on your ID card
- use a separate form for each covered dependent
- indicate whether you would like reimbursement of a payment you have made sent to you. Otherwise, it will be sent to the provider.

You can either attach itemized bills or have your physician complete the physician's section of the form. Either way, the following information must be provided:

- patient's full name, date of birth, and relationship to you
- physician's full name, address, and tax identification number
- diagnosis code
- date and charge for each service.

Claims forms can be obtained from CIGNA Member Services or the ORNL Benefits Service Center.

Coordination of Benefits

If you or any of your Eligible Dependents is covered under another medical plan, CIGNA determines how benefits from all such plans will be coordinated, as described in the plan document that governs the company plan under which you are covered (refer to the "Administrative Information" section in this book on how to obtain a plan document).

Medicare Eligibility

Benefits will also be coordinated with benefits you, your spouse, or an Eligible Dependent receives or is eligible to receive under Part A and Part B of Medicare in accordance with Medicare Secondary Payer rules.

If you are an active employee who is age 65 or older or your spouse is age 65 or older, federal law requires that Medicare be a secondary payer to the medical plan if you are enrolled in the plan.

However, Medicare is a secondary payer to the Company's medical plan for up to 30 months for Medicare beneficiaries who have Medicare solely because of end stage renal disease. At the end of the 30-month period, Medicare becomes the primary payer until your (or your spouse or Eligible Dependents) coverage for end stage renal disease ends.

If you are an active employee who is age 65 or older or your spouse is age 65 or older or eligible for Medicare due to disability, federal law requires that Medicare be a secondary payer to the medical plan if you are enrolled in the plan. If you are in Phase 2 of long-term disability and eligible for Medicare, Medicare is primary.

The medical plan reduces its benefits for you (your spouse or Eligible Dependents) if you are eligible for Medicare when Medicare would be the primary coverage, regardless of whether the person entitled to Medicare is actually enrolled in Medicare. In other words, if you are not an active employee and you (or your spouse or Eligible Dependents) are eligible for Medicare or if you are eligible for Medicare as a result of end stage renal disease, the medical plan will pay secondary to any Medicare benefits that would be primary, regardless if you are enrolled for Medicare. Medicare benefits that would be paid are determined as if the person entitled to Medicare were covered under Medicare Parts A and B.

Other Important Information

Right to Reimbursement (Subrogation)

Under ERISA, plan fiduciaries have a duty to maximize reimbursements from you and your Eligible Dependents, including exercise of subrogation and the right of reimbursement. "Subrogation" means the plan's right to pursue your claims for charges paid by the plan, against another person, entity or organization, and/or your or their insurer. The "Right of Reimbursement" means repayment to the plan from a judgment, settlement, or other type of recovery for benefits that the plan advanced toward your benefits. The plan's subrogation and reimbursement rights, as well as the rights assigned to it, are limited to the extent to which the plan has advanced, or will advance, benefits and any costs and fees associated with the enforcement of its rights under the plan.

You must repay the applicable Company-sponsored medical plan from any recovery related to the benefits advanced by that plan, whether by lawsuit, settlement, or otherwise. The plan's right of subrogation and refund applies to all types of recoveries, including (but not limited to) insurance payments even if it is from your own insurance, reimbursements, cash payments and monies paid by way of judgment, settlement, or to reflect charges covered by the plan. This right of subrogation and reimbursement also applies when you are entitled to recover under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, or any liability plan.

As a condition of participation in the Company's medical plan, you and your covered Eligible Dependents must recognize the plan's right to subrogation and reimbursement and agree to cooperate with the plan fully to permit the plan to recover the amounts it has paid or will pay on your behalf or on your covered Eligible Dependents' behalf for an injury caused by a third party. Except for claims paid by another Company-sponsored medical or dental plan, these rights provide this plan with first priority over any proceeds (regardless of whether such funds fully or partially compensate you for your losses) paid by or on behalf of any party or any insurance company to you relative to an injury or sickness for which benefits are advanced by this plan, including a priority over any claim for attorney fees or other costs and expenses. The plans' right to refund shall not be reduced under any common fund or similar claims or theories. In other words, the make-whole doctrine shall not apply. You shall timely inform the Plan Administrator of any settlement offers. As an additional condition of participation, you agree to hold in a plan-accessible trust for the plan's benefit under these subrogation provisions any and all proceeds of a settlement, arbitration award, or judgment. You or your covered Eligible Dependent may keep the portion of any

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recovery from or settlement with the third party or its insurer for your out-of-pocket medical expenses not covered by the plan such as copayments and deductibles, and your reasonable attorney's fees to obtain the recovery.

Accepting payments advanced under the Company's medical plan automatically assigns to the applicable plan any rights you may have to recover payments for those expenses from any party and any insurer. This subrogation right allows the plan to pursue any claim which, in the opinion of the Plan Administrator, you may have against any party and/or any insurer, whether or not you choose to pursue that claim.

The Company's medical plan shall automatically have a first-priority equitable lien to the extent the applicable plan paid benefits from any party or insurance company on any amount recovered by you. This equitable lien shall remain in effect until the applicable plan is repaid in full. The Company and the Plan Administrator reserve the right to reduce any future benefit payments for you until the obligation to reimburse the plan is satisfied. You shall execute any documents necessary to secure this right.

When in the opinion of the Plan Administrator, a right of subrogation and/or reimbursement exists, you will be required to execute and deliver a Subrogation/Right of Reimbursement Agreement in the form prescribed by the Plan Administrator. You shall also respond to questionnaires and requests for information and documents as well as do whatever else is needed to secure the plan's right of subrogation/right of reimbursement. Claims related to the injury or sickness may be suspended until the Subrogation/Right of Reimbursement Agreement and other forms provided by the Plan Administrator have been properly completed, signed, and returned. In addition, you agree to do nothing to prejudice or diminish the right of the plan to subrogate or receive reimbursement. You agree not to accept any settlement that does not fully compensate or reimburse the Company's medical plan without first acquiring the Plan Administrator's written approval of such settlement.

The Company's medical plan shall not share the costs of, or pay any part of, the attorney's fees incurred in obtaining any recovery against the person, entity, or organization causing the injury or sickness, or its insurer. Additionally, the plan reserves the right to recover reasonable attorney fees from you that are incurred while enforcing its right to subrogation and reimbursement.

Other Important Information (cont'd.)

Newborns' and Mothers' Health Protection Act of 1996

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 generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Insurance After Age 65—During Active Service

If you continue working after age 65, you have the right to make one of the following elections:

- **Continue primary coverage under the Company medical plan.** In this case, the plan will pay benefits first. If your claim is for an item or service that is also covered by Medicare, you may receive all or part of the unpaid balance of the claim, up to any Medicare limitation.
- **Elect primary coverage under Medicare.** In this case, Medicare will pay your medical claims. If you elect primary coverage under Medicare, you must, under the law, cancel your coverage under the Company plan.

Dependent Coverage In the Event of Your Death

If you should die while in active service, your spouse and Eligible Dependents may elect to continue medical coverage for 3 months at the active rate for the coverage level selected.

If you had at least 10 years of full-time Company service and were retirement eligible under the pension plan when you died, your spouse and Eligible Dependents may elect to continue medical coverage until your spouse reaches age 65. Your spouse and any Eligible Dependent children will share the cost with the Company.

If you had less than 10 years of full-time Company service and were retirement eligible under the pension plan when you died, your spouse and Eligible Dependents may elect to continue medical coverage until your spouse reaches age 65. Your spouse and any Eligible Dependent children will pay the full cost.

If you were not eligible to retire under the pension plan when you died, after the initial 3 month continuation, your Eligible Dependents may elect to continue coverage for an additional 33 months under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Continuation Coverage. However, if your spouse becomes covered under another group plan, his or her coverage under this plan will terminate immediately, as will coverage for any dependent who becomes covered by any other group health plan or Medicare. However, if the other group plan contains pre-existing condition exclusions affecting the covered individuals, coverage under the Company plan may continue.

Other Important Information (cont'd.)

Continuation of Medical Coverage (COBRA)

You and your covered dependent may continue your medical coverage in certain cases when coverage would otherwise end. Refer to COBRA within the "Administrative Information" section.

Proof of Prior Coverage

After your coverage terminates, a certificate of health insurance coverage will automatically be provided and mailed to your last known address within a reasonable period of time. If applicable, another certificate will be provided after the COBRA continuation coverage ends. In addition, you may request another certificate within 24 months after coverage terminates.

Coverage for Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the health plan must cover:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce symmetrical appearance
- prostheses and physical complications in all stages of mastectomy, including lymphedema.

This coverage must be the same as for any other benefit under the plan.

Administrative Information

Information about the administration of your medical benefits can be found in the section entitled "Administrative Information."

References to the Medical Plan also include the program and services available from the Health Services Division. Please see the summary on Health Services Division for additional details of benefits available under that program.

On-Site Medical Services

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Introduction

The ORNL Health Services Division assists in achieving and maintaining the highest physical and emotional health of all employees so that optimal job performance may be achieved with minimal stress, thereby reducing absenteeism, enhancing productivity, and prolonging the employee's productive years. The ORNL Health Services Division is a self-insured, self-administered workplace-based medical services facility that provides outpatient healthcare to current employees with authorized badge access to ORNL facilities. For purposes of the reporting and disclosure obligations of the Employee Retirement Income Security Act of 1974, it is a component of the Medical Plan.

Services offered include the following:

- Evaluations
- Laboratory Procedures
- Immunizations
- Occupational Vision
- Emergency Response
- Programs to Promote Healthy Living
- Behavioral Health Programs
- Physical Therapy

Eligibility

You are eligible to receive benefits and services from the Health Services Division if you are employed and paid as a Regular Full-Time Employee of the Company working on a regular basis, a Regular Part-Time Employee working a fixed schedule, a Full-Time Temporary Employee who is hired to work at least 12 months, or a Casual Employee working on an ad hoc or intermittent basis. Casual Retirees are not eligible to participate in any active employee benefit plans.

Individuals who are paid as independent contractors or who are leased from another employer are not employees and are not eligible to participate in the benefit plans described in this benefit summary book.

The terms "Regular Full-Time Employee," "Regular Part-Time Employee," "Full-Time Temporary Employee," "Casual," and "Casual Retiree" are defined in the Glossary.

Enrollment

Benefits and programs that are offered through the Health Services Division are provided as long as you are an eligible employee. No enrollment is necessary.

Services Provided

The Health Services Division provides care and services for both occupational and non-occupational illness and injury. Services offered by Health Services Division include the following:

Evaluations

- Medical History
- Physical Examination
- Prostate-Specific Antigen (PSA) Examination (males 40 and over)
- Laboratory Multiphasic Testing/Review Results
- Diagnostic Assessment
- Recommendations
- Treatment/Referral to Primary Care Physician

Laboratory Procedures

- Hematology
- Blood Chemistries
- Urinalysis
- Stool Hemocult
- Rapid Strep Test
- Electrocardiogram
- Pulmonary Function Test
- Audiometry
- Vision Testing
- Chest and Other X-Rays
- Breath Alcohol Testing
- Urine Collection for Drug Testing
- PSA with physical only

Immunizations

- Tetanus/Diphtheria
- Influenza
- Hepatitis A (at risk employees and for business travel)
- Hepatitis B (at risk employees only)
- Allergy Desensitization
- Tuberculin Skin Testing
- Hepatitis A (only for company required travel)
- Typhoid (only for company-required travel)
- Polio (only for company required travel)
- MMR (only for company required travel)
- Periodic – Voluntary

Occupational Vision

- Prescription Safety Glasses
- Adjustments/Repairs

Emergency Response

- Emergency Care Including Cardiopulmonary Resuscitation and Advanced Cardiac Life Treatment
- Disaster Planning
- Emergency Response Team

Programs to Promote Healthy Living

- Hypertension (Classes)
- High Blood Pressure Clinic
- Diabetes Program (Classes)
- Cholesterol (Classes)

Behavioral Health Programs

- Emotional/Mental Health/Stress Counseling
- Smoking Cessation Program/Counseling
- Diabetes Group Support Session & Individual Counseling
- Weight Reduction Counseling
- Referrals for the Employee Assistance Program, Outside Counseling through Magellan

Physical Therapy—Clinical Services

- Musculoskeletal Examination
- Joint Range of Motion
- Neurological Testing
- Posture Assessment
- Joint Mobility/Stability
- Functional Tests
- Gait Analysis
- Manual Muscle Tests

Physical Therapy—Individualized Exercise Programs

- Spine Stabilization
- Postoperative Strengthening
- Progressive Resistive Exercises
- Stretching Programs
- Proprioceptive Training
- Home Exercise Programs

Physical Therapy—Treatment Modalities

- Joint Mobilization
- Soft Tissue Mobilization
- Ultrasound
- Muscle and Nerve Stimulation
- Cervical and Pelvic Traction
- Hot and Cold Packs
- Paraffin Bath
- Thermoplastic Splinting

Cost of Services

There is no cost to you when you access any of the services available through the Health Services Division.

Accessing Services

The Health Services Division clinic is operated by ORNL. The Health Services Division is accessible during the following times:

Division Hours:	7:30 a.m. – 4:30 p.m.
Doctors Hours:	7:30 a.m. – 4:30 p.m.
Allergy Shots:	Mon.-Thur. 1-3 p.m.
Blood Pressure Clinic:	Tue. Only - 10-11 a.m.
Clinical Psychologists:	(Days & Hours vary)
Occupational Vision:	7:30 a.m. – 4:00 p.m.

The following are the contact numbers to use in order to schedule an appointment or to obtain additional information:

Appointments—physicals, labs, misc.:	(865) 574-7437
Other illnesses/injuries—no appointment necessary	
Appointments—Psychologist:	(865) 574-7431
Appointments—Safety Glasses:	(865) 574-7440
Doctors :	(865) 574-7431
Nurses:	(865) 574-7434
Lab:	(865) 574-7433
X-Ray:	(865) 574-7438
Physical Therapy:	(865) 241-4220
Website:	https://portal.ornl.gov/sites/eshq.hsd

How Changes Affect Your Benefits

If your employment with ORNL is terminated, you will no longer have access to Health Services Division as of your last day of employment.

Claims and Appeal Procedures

Claims for services will be processed by the Health Services Division. If you disagree with the outcome of a claim or feel you have been denied a service for which you are eligible to receive from Health Services Division, you may file an appeal. For appeal procedures, see “Claims Review & Appeals” in the “Administrative Information” section. In addition, the collective bargaining agreement contains information related to the resolution of disputes for hourly employees.