

Administrative Information

This chapter contains information on the administration and funding of all the plans described in this book, as well as your rights as a plan participant. While you may not need this information for day-to-day participation in your benefit plans, you should read this chapter.

It is important for you to understand your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

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Plan Sponsor and Administrator

UT-Battelle, LLC, is the sponsor and the designated Plan Administrator of the employer plans described in this book. You can reach the Plan Administrator at:

UT-Battelle, LLC

c/o Plan Administrator, Employee Benefits
PO Box 2008, MS 6465
Oak Ridge, TN 37831-6465
(865) 576-0965

In carrying out its responsibilities under the plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to

control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the Plan Administrator are final, conclusive, and binding on all persons.

The term “Company” means UT-Battelle, LLC.

The term “ORNL Benefits Office” refers to the ORNL Benefits Department that operates under the sponsor and designated Plan Administrator of the plans.

Employer Identification Number

The employer identification number assigned by the Internal Revenue Service to UT-Battelle, LLC, is 62-1788235.

Plan Documents

This book summarizes the key features of each of the plans in the Company’s benefits program and applies to eligible retirees of the Company, including those represented by collective bargaining units to the extent that they have been negotiated and accepted by the duly certified representatives of participating units.

Complete details of each of the plans can be found in the official plan documents, certificates of coverage, and insurance contracts that legally govern the operation of the plans (the “Official Plan Documents”). For plans that do not have any other Official Plan Documents, the summary in this book constitutes the Official Plan Document. Copies of the Official Plan Documents as well as the latest annual reports of plan operations and plan summaries are available for your review any time during normal working hours in the office of the Plan Administrator.

Upon written request to the Plan Administrator, at the address previously mentioned, copies of any of these documents will be furnished to a plan participant or beneficiary, generally within 30 days, at a nominal charge. In addition, once each year you will receive a copy of any required summary annual reports of the plans’ financial activities at no charge.

All statements made in this book are subject to the provisions and terms of the applicable Official Plan Document. In the event of a conflict between the Official Plan Documents and the summaries in this book, the Official Plan Documents are controlling, except in the event of a conflict between the Certificates and the summaries, in which case this book controls.

Claiming Benefits

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the plans, as described throughout this book. All forms required to take

any action under the plans are available through the ORNL Benefits Office. All completed forms must be submitted to the appropriate office, as described throughout this book.

Health Claims Review and Appeal Procedures

For information on review and appeal procedures for medical, prescription drug, or vision plan claims, see the Medical Plan chapter.

For information on review and appeal procedures for Dental Plan claims, see the Dental Plan chapter.

Other Claims Review and Appeal Procedures (non-Health and non-Disability claims)

Other Claims Appeal

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The plan also will recognize a court order giving a person authority to submit claims on your behalf. References to you in this section are intended to include references to a participant, an authorized representative, or a beneficiary who is entitled to a benefit under the plan.

2. a description of any additional information needed to complete the claim and an explanation of why such information is necessary,
3. a description of the plan’s claim review procedures and applicable time limits, and
4. a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (where applicable).

Notice of Adverse Benefit Determination for Other Claims

You will be notified of the plan’s benefit determination not later than 90 days after the plan’s receipt of the claim. The time period may be extended up to an additional 90 days due to circumstances outside the plan’s control. In that case, you will be notified of the extension before the end of the initial 90 day period.

Notification on Other Claim Decisions

If a claim for plan benefits is denied in whole or in part, you will receive written or electronic notification that will include:

1. the specific reasons for the denial with reference to the specific plan provisions on which the denial was based,

Other Claim Appeal of an Adverse Benefit Determination

To have your claim reconsidered, you must file an appeal of an adverse benefit determination for a claim. The appeal must be submitted in writing. You will have 60 days following receipt of an adverse benefit determination to appeal the decision. You will ordinarily be notified of the decision no later than 60 days *after the appeal is received*. If special circumstances require an extension of time of up to an additional 60 days, you will be notified of such extension during the 60 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

Other Claims Review and Appeal Procedures (non-Health and non-Disability claims) (cont.)

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You also may request that the plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Notification of Other Claims Decision on Appeal

If your appeal seeking reconsideration of the denied claim under the plan is again denied in whole or in part, you will receive written or electronic notification that will include:

1. the reasons for the decision, again with reference to the specific plan provisions on which that decision is based;
2. that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits; and
3. your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (where applicable).

Legal Process

Any legal process relating to a benefit plan should be directed to the plan's Agent for Service of Legal Process. Legal process also may be served upon the plan trustee (where applicable) or the Plan Administrator.

Agent for Service of Legal Process

UT-Battelle, LLC
General Counsel
1 Bethel Valley Road
Oak Ridge, TN 37831-6265

Plan Termination and Amendment

The Company expects and intends to continue the plans in your benefits program but reserves its right to terminate each of the plans, in whole or in part, without notice. The Company also reserves its right to amend each of the plans at any time.

The Company may also increase or decrease its contributions or the participants' contributions to the plans.

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may result in the transfer of plan assets and debts to another plan or may split a plan into two or more parts. If the Company does terminate or amend a plan, it may decide to set up a different plan

providing similar or identical benefits, but it is under no obligation to do so.

If the Pension Plan or Savings Plan is terminated, you will become vested immediately in your accrued retirement benefit under the Pension Plan or the entire value of your Savings Plan account, as applicable.

If a welfare plan is terminated, you will not have any further rights, other than the payment of benefits for covered losses or expenses incurred before the plan was terminated, and for covered Medical Plan expenses related to a total disability existing before the plan was terminated, which are incurred within 3 months after termination of the plan. The amount and form of any final benefit you or your beneficiary receives will depend on any insurance contract provisions affecting the plan and the Company's decisions.

Special Pension and Savings Provisions

There are a few special provisions that apply only to the Savings Plan and Pension Plan.

Assets Upon Termination

If the Savings Plan terminates, participants' accounts will be distributed after plan expenses are paid. The trustee will make account distributions as instructed by the plan administrator.

Any assets remaining in the Pension Plan after all liabilities to participants and beneficiaries are satisfied, and after all expenses are paid, will revert to the Company.

Pension Benefit Guaranty Corporation

Your pension benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

1. normal and early retirement benefits;
2. disability benefits if you become disabled before the plan terminates; and
3. certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- some or all benefit increases and new benefits-based plan provisions that have been in place for fewer than 5 years at the time the plan terminates
- benefits that are not vested because you have not worked long enough for the Company
- benefits for which you have not met all of the requirements at the time the plan terminates

- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age

and

- non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain benefits are not guaranteed, you still may receive some of those benefits from PBGC depending on how much money your plan has and on how much PBGC collects from employers.

For more information about PBGC and the benefits it guarantees, ask the plan administrator or contact:

**PBGC Technical Assistance Division
1200 K Street N.W.
Washington, D.C. 20005-4026**

Phone: 202-926-4000 (not a toll-free number)

Telephone text device/telecommunication device for the deaf (TTY/TDD) users: Call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000.

Additional information about PBGC's pension insurance program is available through PBGC's website, www.pbgc.gov.

Assignment or Alienation of Benefits

Except as required by applicable law (such as a qualified domestic relations order [QDRO]), benefits provided under the Pension Plan and Savings Plan are not subject to assignment, alienation, attachment, lien, garnishment, levy, pledge, bankruptcy, execution, or any other form of transfer.

Special Pension and Savings Provisions (cont.)

Qualified Domestic Relations Order

A QDRO is a legal judgment, decree, or order that recognizes the rights of another individual under the Savings Plan or Pension Plan with respect to child or other dependent support, alimony, or marital property rights.

In the event of a QDRO, benefits under the Pension Plan and Savings Plan may be payable to someone other than your designated beneficiary to satisfy a legal obligation you may have to a spouse, former spouse, child, or other dependent. Your Pension Plan or Savings Plan

benefits will be reduced by the benefits payable under the QDRO to someone else.

There are specific requirements which a domestic relations order must meet to be recognized by the Plan Administrator as a QDRO, as well as specific procedures regarding the amount and timing of payments. If you are affected by such an order, you will be notified by the ORNL Benefits Office. Participants and beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing QDROs.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is an order or judgment from a state court directing the Plan Administrator to cover a child for benefits under the health care plans. Coverage will be provided according to a valid order that is served on the Company or the Company's agent for service of legal process.

If you are affected by such an order, you and each child will be notified about further procedures to validate and implement the order. Participants and beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures for determining the validity of a QMCSO and administering a QMCSO.

Health Insurance Portability and Accountability Act (HIPAA)

This plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) with respect to protected health information (PHI). For purposes of the plan, PHI generally consists of individually identifiable information about you or

your dependents, including health and demographic information that relates to your or their eligibility for all group health benefits under the plan. Additional information about your rights under HIPAA is provided separately in a Notice of Privacy Practices.

Other Administrative Facts

UT-Battelle, LLC

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Pension Plan for Employees at ORNL	001	Defined Benefit	Calendar	Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Employee (as of 1/1/2013) and Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
Savings Plan for Employees at ORNL	002	Defined Contribution and 401(k) Plan	Calendar	Charles Schwab Retirement Plan Services Charles Schwab Trust Company serves as Trustee 12401 Research Blvd. 02-130 Austin, TX 78759	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust
Group Life Insurance	511	Welfare	Calendar	Metropolitan Life Insurance Company	Retiree and Company	Benefits are paid from an insurance contract
Health Benefits— <i>Under age 65 Retiree</i> (Medical, Dental, Vision)	510	Welfare	Calendar	UnitedHealthcare—Medical MetLife—Dental Delta Dental Plan of Ohio— Dental Vision Service Plan (VSP)— Vision Care	Retiree and Company	Benefits are paid (through a claims administrator) from retiree contributions and the general assets of the Company
Health Reimbursement Arrangement for Retirees of ORNL (Post-65 Plan)	510	Welfare	Calendar	OneExchange	Company	Benefits are paid (through a claims administrator) from the general assets of the Company

Other Administrative Facts (cont.)

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Prescription Drug Plan	510	Welfare	Calendar	Express Scripts	Retiree and Company	Benefits are paid (through a claims administrator, Express Scripts) from Retiree contributions and general assets of the Company
Long-Term Care Plan	511	Welfare	Calendar	MetLife	Retiree	Benefits are paid from an insurance contract

Your Rights Under COBRA

Your Qualified Beneficiaries covered under a group health plan (one of the Medical or Dental Plans) have the option to purchase a temporary continuation of health care coverages at full group rates, plus a 2% administrative charge, in certain instances when coverage would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Participation

If one of the events (such events are referred to as “Qualifying Events”) listed in the chart below causes an eligible dependent to lose coverage under one of the group health plans, the eligible dependent is a “Qualified Beneficiary” with respect to such group health plan.

Each Qualified Beneficiary independently may elect to continue coverage under such group plan. Covered retirees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of their eligible dependents.

If you adopt or have a child while covered by COBRA, that child is also a Qualified Beneficiary entitled to COBRA coverage if the applicable plan provides coverage to dependents.

Continued coverage is available for a maximum of 36 months as outlined in the chart below.

Your Rights Under COBRA (cont.)

COBRA Continuation Period		
Qualifying Event (if accompanied by a loss of coverage)	Maximum Continuation Period	
	Spouse	Child
You die	36 months*	36 months*
You and your spouse legally separate or divorce	36 months	36 months
Your child no longer qualifies as an eligible dependent	N/A	36 months

*If your dependent is eligible for extended coverage under the Medical Plan, as described in the "Medical Plan" chapter, the maximum COBRA period will be reduced by the length of that extended coverage.

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to a plan sponsor, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a Qualified

Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and other eligible dependents also will become Qualified Beneficiaries if bankruptcy results in their loss of coverage under the group health plan.

Choosing COBRA

Here are some things to keep in mind about COBRA continuation:

You and your Qualified Beneficiaries have 60 days after your COBRA notice to elect continued participation. You will have an additional 45 day period to pay any make-up contributions you missed from the first day of the COBRA coverage.

- If COBRA is elected, the coverage previously in effect generally will be continued. Coverage will be effective as of the date of the Qualifying Event, unless you waive COBRA coverage and subsequently revoke your waiver within the 60 day election period. In that case, your election coverage begins on the date you revoke your waiver.
- You may change coverage if you experience a Qualifying Event, as described in the "About Your Benefits" chapter.

Your Rights Under COBRA (cont.)

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

- For medical and dental coverage, premiums are based on the full group rate per covered person set at the beginning of the year, plus 2% to cover administrative costs.
- If you are disabled under the Social Security definition of disability, COBRA premiums for months 19 through 29 reflect the full group cost per person, plus 2%.

Under the HRA plan, your spouse is entitled to the level of coverage under the Plan in effect immediately preceding the Qualifying Event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of active Participants (subject to any restrictions applicable to active Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, your spouse must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from PBGC (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get an advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage.

If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTY/TTD callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at <http://webapps.dol.gov/elaws/ebsa/health/employer/C19.htm>.

Notification

If your dependents lose coverage due to divorce, legal separation, or loss of dependent status, you (or a family member) must notify the ORNL Benefits Office within 60 days of the event so that COBRA can be offered and your election rights can be mailed to you. Also, to extend coverage beyond 18 months because of disability, notice of the Social Security Administration's determination must be provided within 60 days after you receive that determination and before the end of the initial 18 month period.

The ORNL Benefits Service Center will notify you by mail of your COBRA election rights. You will receive instructions on how to continue your health care benefits under COBRA.

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

- a person who was covered under COBRA becomes covered under another group health plan not offered by the Company (providing the other plan does not have pre-existing condition limitations affecting the covered person; if the other plan has such limitations, COBRA coverage will end when those limitations expire)
- your eligible dependent becomes entitled to Medicare after COBRA is elected
- the first required premium is not paid within 45 days, or any subsequent premium is not paid within 30 days of the due date
or
- the Company's group health plans are terminated.

Questions concerning your COBRA continuation coverage rights should be addressed to the Plan Administrator.

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Social Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Your Rights Under ERISA

As a participant in any of the Company's benefit Plans described in this book, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Plan Administrator's office, and at other specified worksites, all Plan documents—including pertinent insurance contracts, trust agreements, collective bargaining agreements, annual reports, and other documents filed with the Internal Revenue Service or the US Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security
- Obtain copies of all plan documents and other plan information, including insurance contracts, collective bargaining agreements, copies of the latest annual report, and updated summary plan description, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary annual report of the plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse, or eligible dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation of coverage, and when your COBRA continuation of coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants as well as beneficiaries. No one, including your employer, your union, or any other person, may fire you, or otherwise discriminate against you in any way, to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

Your Rights Under ERISA (cont.)

In order to file suit in a state or federal court concerning: (i) a claim for a benefit; (ii) the qualified status of a domestic relations order or medical child support order; or (iii) your service credit, you must file suit within 1 year of the date of the final determination by the Plan Administrator which is the basis of your suit. If you do not file suit within this time period, the Plan Administrator's final determination will be binding and cannot be challenged by you in court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory, or contact:

**Division of Technical Assistance and
Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210**

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.