

Medical Plans

All Employees...

.... may enroll for coverage in either the UnitedHealthcare Prime Select Plan or the UnitedHealthcare Consumer Choice with Health Saving Account (HSA) Plan. Both plans offer a national network of providers and the freedom to see a specialist without a referral. If there is no UnitedHealthcare network available, you may be eligible for coverage under the UnitedHealthcare Indemnity Plan.

Prescription drug and vision care benefits are included under each Medical Plan option.

- You are covered automatically for prescription drug benefits and vision care benefits when you enroll in a Medical Plan.
- Information on these benefits is provided in Chapter 3 (Prescription Drugs, administered by Express Scripts) and Chapter 4 (Vision Care, provided by Vision Service 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 a National Network for Both Salaried and Bargaining Unit Employees

If you have access to the UnitedHealthcare national network, you can enroll in either the UnitedHealthcare Prime Select Plan or the UnitedHealthcare Consumer Choice with HSA Plan. UnitedHealthcare has discretion to determine network availability.

... Provide Coverage Under the UnitedHealthcare Indemnity Plan for Employees Who Do Not Have Access to a UnitedHealthcare Network

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

... Let You Waive Coverage

You also may 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 in the “About Your Benefits” chapter.

... Provide Protection for Your Family

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

Whenever there is a conflict between the summary in this book and the applicable Certificate of Insurance, this book governs. You may request a copy of the certificate by following the steps outlined under the “Administrative Information” chapter 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” chapter.

Prime Select and Consumer Choice with HSA Medical Plans Overview

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How the Prime Select and Consumer Choice with HSA Medical Plans Work

National Network of Providers

Both the Prime Select and Consumer Choice with HSA Plans center on a national network of physicians, hospitals, and other health care providers who have agreed to provide care to patients at negotiated rates.

| Pick Your Path to Care | |
|---|--|
| ↓ | |
| When You Need Care | |
| ↓ ↓ | |
| Go In-Network | Go Out-of-Network |
| • You pay less | • You pay more |
| • There are no claim forms to file | • You file claims |
| • Preventive care is covered | • Preventive care is generally not covered |
| • Your primary care physician handles hospital precertification | • You handle hospital precertification |

Selecting a Physician

Under these plans, you are not required to select a primary care physician or obtain a referral from a primary care physician.

However, a primary care physician can help you by facilitating access to a specialist and by handling 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.

If you choose to select a primary care physician, the primary care physician you select for yourself may be different from the primary care physician you select for each of your dependents. You can change a primary care physician by calling UnitedHealthcare Member Services at the telephone number on your ID card.

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. See Chapter 4, "Vision Care," for more information.

Preventive Care

Preventive care, such as 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 recover fully. 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 provided at no cost to you. This care includes but is not limited to:

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

For a complete list of the preventive care services covered by the Plans, please contact UnitedHealthcare Member Services at the telephone number on your ID card.

How the Prime Select and Consumer Choice with HSA Medical Plans Work (cont.)

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the Plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or following procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myuhc.com or contact customer service at the phone number listed on the back of your ID card.

Coinsurance, Copayments, Deductibles, and Out-of-Pocket Maximum

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” are those expenses to be paid by you for certain covered services or products.
- “Deductibles” are separate from, and not reduced by, copayments. Deductible amounts are included in any out-of-pocket maximum.

For the Prime Select Plan

There is no deductible for in-network care, but a deductible applies for out-of-network care. The deductible applies separately to each covered family member; however, 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/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.

For the Consumer Choice with HSA Plan

The individual deductible must be met for employee-only coverage. For all other coverage levels, the family deductible must be met.

Out-of-Pocket Maximum is the most you must pay out of your pocket in a plan year for eligible health care expenses.

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:

- noncompliance penalties for not following precertification requirements
- charges above the Medicare-based Maximum Reimbursement Charge (MRC)
- care that is received but not covered by the plan.

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

How the Prime Select and Consumer Choice with HSA Medical Plans Work (cont.)

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.

Someone must contact your primary care physician or UnitedHealthcare 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/her directions.

“Emergency” and “Urgent Care” are defined in the Glossary.

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. UnitedHealthcare has a regular credentialing process to ensure the doctors in the network meet certain standards, such as:

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

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

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

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

If You Need Care While Traveling Outside Your Network Area

Under the UnitedHealthcare national network, there are very few areas of the United States without access to network providers. Should you need services while in an out-of-network area, you are covered for emergency care or urgent care on an in-network basis.

If you are traveling outside the United States, 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 also must submit proof of payment. Claims should be sent to the UnitedHealthcare 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.

Residing in Another Location

If you will be residing permanently outside the national network area, refer to the “UnitedHealthcare Indemnity Plan” section of this chapter and contact the ORNL Benefits Office for more information.

If You Are on an Off-Site Assignment for More Than 90 Days

Contact the ORNL Benefits Office for information.

How the Prime Select and Consumer Choice with HSA Medical Plans Work (cont.)

Out-of-Network Benefits

When you go out-of-network, you can use any physician or facility you like. If applicable, the Plan will process claims through the Shared Savings Program. If there is not a Shared Savings opportunity, fee negotiation may be applied. You will be responsible for the annual deductible and the coinsurance. If there is not a fee negotiation opportunity, then after you meet an annual deductible, the plan pays 140% of the Medicare-based MRC in your geographic area for similar services 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.

You are responsible to pay any amounts above the MRC. Amounts above the MRC do not apply to the 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 the MRC for the rest of that year.

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

If your physician recommends any nonemergency hospitalization or surgery, you are responsible for calling UnitedHealthcare 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%.

Medicare-Based Maximum Reimbursement Charge

Any charges above 140% of the Medicare-based MRC in your geographic area for similar services are not covered by the plan, and you will not be reimbursed for that amount. Also, the amounts above the MRC will not count toward the deductible or out-of-pocket maximum.

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 UnitedHealthcare Member Services at least 7 days, or as soon as possible, before you are admitted to the hospital or before you receive outpatient diagnostic testing or procedures. If you do not call, your benefit will be reduced by 20%.

When you call UnitedHealthcare 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.

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

Mental Health/Alcohol and Substance Abuse Treatment

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

How the Prime Select and Consumer Choice with HSA Medical Plans Work (cont.)

UnitedHealthcare Member Services

UnitedHealthcare Member Services is a customer service line staffed by experienced and courteous representatives trained to answer your questions and provide information about Medical Plan participation and benefits. UnitedHealthcare 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

As a UnitedHealthcare member, you have access to your benefit information through your own personalized UnitedHealthcare website—www.myuhc.com. There you can:

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

Contacting UnitedHealthcare

For UnitedHealthcare's Prime Select and Consumer Choice with HSA Plans:
1-844-234-7925

UnitedHealthcare Prime Select Plan

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How the UnitedHealthcare Prime Select Plan Works

In-Network Benefits

Under the Prime Select Plan, you may receive care from any provider you choose within the UnitedHealthcare national network. No referral is required to see a specialist. Preventive care is provided at no cost when you or your eligible dependents use an in-network provider.

You pay a copayment for certain in-network benefits and services, such as office visits, inpatient hospitalizations and surgeries, and emergency room visits. The Plan then pays 100% of the cost.

There is no in-network annual deductible. Your copayments and coinsurance do count toward the annual out-of-pocket maximum.

Out-of-network benefits are explained in the following section, “Summary of Benefits: UnitedHealthcare Prime Select Plan.”

Prescription Drug Benefits

Prescription Drug benefits are managed by Express Scripts. You may obtain up to a 30 day supply of your prescription at retail. A 90 day supply is available through the mail-order pharmacy.

You pay a copayment for generic drugs and coinsurance for brand name drugs. There are minimum and maximum limits on the coinsurance, which help protect you from the high cost of some drugs. If the cost of the drug is less than the minimum amount, you will pay the actual cost of the drug.

Preventive Care Drugs

Certain contraceptive items identified by the Plan as preventive care are covered in full and are not subject to copayments or coinsurance.

Vision Care

Vision benefits are included as part of your medical plan. Vision Services Plan (VSP) provides the Signature Choice plan, which includes coverage for exams, standard lenses, frames, and contact lenses.

Information on these benefits is provided in Chapter 3, “Prescription Drugs” (administered by Express Scripts) and Chapter 4, “Vision Care” (provided by VSP).

Summary of Benefits: UnitedHealthcare Prime Select Plan

| Plan Design Features | In-Network | Out-of-Network (Based on MRC*) |
|--|--|---|
| Annual Deductible | None | \$200/individual \$400/family (Medical only) Only out-of-network plan deductibles count. After each family member meets his/her individual plan deductible, the plan will pay his/her claims, less any coinsurance amount. After the family plan deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount. |
| Out-of-Pocket Annual Limit (includes Plan deductible)—In-network and out-of-network amounts are separate and do not cross-accumulate | Up to the maximum allowed by the IRS (includes Medical and Prescription Drugs) | Unlimited |
| Maximum Lifetime Benefit | Unlimited | Unlimited |
| Pre-Existing Condition Exclusion Period | N/A | N/A |
| Primary Care Physician (PCP) | Not Required | N/A |
| PCP Referral | Not Required | N/A |
| Provider Network | UnitedHealthcare National Network | N/A |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

| Physician Services | In-Network | Out-of-Network (Based on MRC*) |
|--|--|--|
| Office Visit | <ul style="list-style-type: none"> Primary Care Physician (PCP)—\$20 per visit Specialist—\$35 per visit | You pay 20% Plan pays 80% after the plan deductible is met |
| Surgery (in a physician's office) | Plan pays 100% after office visit copay: <ul style="list-style-type: none"> PCP: \$20 per visit Specialist: \$35 per visit | You pay 20% Plan pays 80% after the plan deductible is met |
| Allergy Treatment/Injections; Allergy Serum (dispensed by the physician in the office) | No charge for injections Copay applies for office services Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |

Summary of Benefits: UnitedHealthcare Prime Select Plan (cont.)

| Preventive Care | In-Network | Out-of-Network (Based on MRC*) |
|--|---|---|
| Preventive Health Services <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman, and adult preventive care Includes routine immunizations | Plan pays 100% | Not covered |
| Preventive Screenings <ul style="list-style-type: none"> Mammogram, Pap Smear and Maternity Screening | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Inpatient Hospital Services | In-Network | Out-of-Network (Based on MRC*) |
| Inpatient Services <ul style="list-style-type: none"> Operating room, pharmacy, x-ray, laboratory services, and semiprivate room and board. | Plan pays 100% after \$250 copay per admission <i>Hospital stays not deemed medically necessary will be disapproved.</i> | You pay 20% Plan pays 80% after the plan deductible is met <i>You must have all out-of-network inpatient hospitalizations and outpatient surgeries precertified through UnitedHealthcare. Failure to do so will result in denied claims.</i> |
| Physician and Surgeon Services in Hospital | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |

If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

| Outpatient Services | In-Network | Out-of-Network (Based on MRC*) |
|--|----------------|---|
| Outpatient Surgery— Outpatient Facility | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met <i>All out-of-network outpatient surgeries must be precertified through UnitedHealthcare. Failure to do so will result in denied claims</i> |

Summary of Benefits: UnitedHealthcare Prime Select Plan (cont.)

| Outpatient Services (cont.) | In-Network | Out-of-Network (Based on MRC*) |
|--|--|---|
| Outpatient Professional Services— Services performed by surgeons, radiologists, pathologists, and anesthesiologists | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Outpatient (short-term) Rehabilitation—Includes physical, speech, cardiac, cognitive, pulmonary, and occupational therapy | Plan pays 100% after copay: PCP: \$20 per visit Specialist: \$35 per visit <i>20 days per calendar year for all conditions</i> | You pay 20% Plan pays 80% after the plan deductible is met <i>20 days per calendar year for all conditions</i> |
| | <i>Day limits apply to both in- and out-of-network visits. Therapy days provided as part of an approved Home Health Care plan accumulate to the outpatient short-term rehab therapy maximum.</i> | |
| Chiropractic Care (when medically appropriate)— Limited to 25 days per year | Plan pays 100% after copay: PCP: \$20 per visit Specialist: \$35 per visit | Not covered |
| Lab and X-Ray | In-Network | Out-of-Network (Based on MRC*) |
| Outpatient Laboratory and Radiology Services received from 1. Outpatient hospital facility 2. Independent facility 3. Doctor's office 4. Advanced Radiology Services such as MRI, PET, MRA, CAT—must be precertified and preauthorized | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Prime Select Plan (cont.)

| Emergency and Urgent Care Services | In-Network | Out-of-Network (Based on MRC*) |
|--|--|--|
| Hospital Emergency Room Services— Includes radiology, pathology, and physician charges Payable for ER visits that meet UnitedHealthcare’s definition of an Emergency | You pay a \$75 copay, then Plan pays 100% <i>Copay waived if admitted, then inpatient hospital charges would apply</i> | You pay a \$75 copay, then Plan pays 100% <i>Out-of-network services are covered at the in-network rate</i> |
| Ambulance Services - Ground and Air Transport <i>Note: Non-emergency transportation requires prior authorization.</i> | Plan pays 100% | Plan pays 100% <i>Out-of-network services are covered at the in-network rate</i> |
| Urgent Care Facility <i>Out-of-network services are covered at the in-network rate</i> | You pay a \$25 copay, then Plan pays 100% | You pay a \$25 copay, then Plan pays 100% |
| Convenience Care | You pay a \$20 copay, then Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Other Health Care Services | In-Network | Out-of-Network (Based on MRC*) |
| Maternity Care Services— Covers maternity for employee and all dependents <ul style="list-style-type: none"> Initial visit to confirm pregnancy All subsequent routine prenatal visits, postnatal visits, and delivery Delivery (Inpatient Hospital, Birthing Center) | Plan pays 100% after copay for initial visit: PCP: You pay \$20 Specialist: You pay \$35 Delivery: \$250 copay per admission, then Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| 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, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], etc.) | Not covered | Not covered |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Prime Select Plan (cont.)

| Other Health Care Services (cont.) | In-Network | Out-of-Network (Based on MRC*) |
|---|---|--|
| Durable Medical Equipment—Unlimited calendar year maximum | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| External Prosthetic Appliance (EPA)—Unlimited calendar year maximum | Plan pays 100% after the EPA annual deductible is met The EPA annual deductible is \$200 per calendar year, both in- and out-of-network combined | You pay 20% Plan pays 80% after the EPA annual deductible and the plan deductibles are met |
| | <i>Benefits are available for Class III and Class IV Prosthetic devices. An evaluation by an orthopedic surgeon or a physical and rehabilitation physician are required, in addition to a prescription, to provide the clinical justification for advanced prosthetic devices and myoelectric limbs.</i> | |
| Hearing Aid Benefits | Not covered | Not covered |
| Organ Transplant Coverage: Inpatient Facility, Physician Services, and Travel Benefit | Inpatient: Covered at 100% at Center of Excellence; otherwise same as plan's inpatient hospital facility benefit (if facility is contracted with UnitedHealthcare for transplant services) Physician Services: Covered at 100% Travel maximum: \$10,000 per transplant (only available if using Center of Excellence facility) | Not covered |
| Dental Care—Limited to charges for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth | <ol style="list-style-type: none"> 1. Physician's Office visit: Plan pays 100% after copay: <ul style="list-style-type: none"> • PCP: \$20 • Specialist: \$35 2. Inpatient Facility: Plan pays 100% after \$250 copay per admission 3. Outpatient Facility and Physician Services: Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Prime Select Plan (cont.)

| Other Health Care Services (cont.) | In-Network | Out-of-Network (Based on MRC*) |
|---|--|--|
| Temporomandibular Joint (TMJ) Disorder (surgical and nonsurgical treatment)— Excludes appliances and orthodontic treatment. Subject to medical necessity | 1. Physician's Office visit: Plan pays 100% after copay for visit: <ul style="list-style-type: none"> • PCP: \$20 • Specialist: \$35 2. Inpatient Facility: Plan pays 100% after \$250 copay per admission 3. Outpatient Facility and Physician Services: Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Bariatric Surgery <ul style="list-style-type: none"> • Subject to medical necessity and clinical guidelines • Treatment of clinically severe obesity, as defined by the body mass index (BMI) | Office visit copay: PCP: \$20 Specialist: \$35 Inpatient facility: \$250 copay per admission, then Plan pays 100% Outpatient: Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| <i>The plan will not cover non-cancerous skin tag removal. The plan will cover rhinoplasty, breast reductions, varicose veins, and blepharoplasty surgery (removal of excessive eyelid tissue) if medically necessary. Authorization is required.</i> | | |
| Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorder by an eligible provider | Plan pays 100% after copay: PCP: \$20 per visit Specialist: \$35 per visit | You pay 20% Plan pays 80% after the plan deductible is met |
| Gender Dysphoria | Office visit copay: PCP: \$20 Specialist: \$35 Inpatient facility: \$250 copay per admission, then Plan pays 100% Outpatient: Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| myuhc.com, Healthy Pregnancy Program, 24 Hour Nurse Line, (Advocate4me.com) | Yes | NA |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Prime Select Plan (cont.)

| Mental Health and Substance Abuse Services | In-Network | Out-of-Network (Based on MRC*) |
|---|---|--|
| Inpatient Mental Health Services, UnitedHealthcare Behavioral Health Network—Unlimited days per calendar year | You pay \$250 copay per admission, then Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Outpatient Mental Health Services—Unlimited visits per calendar year <ul style="list-style-type: none"> This includes individual, group therapy mental health, and intensive outpatient mental health | Plan pays 100% after copayment per visit: PCP visit: \$20 Specialist visit: \$35 | You pay 20% Plan pays 80% after the plan deductible is met |
| Inpatient Substance Abuse—Unlimited days per calendar year | You pay \$250 copay per admission, then Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Outpatient Substance Abuse—Unlimited visits per calendar year This includes individual and intensive outpatient substance abuse treatment | Plan pays 100% after copayment per visit: PCP visit : \$20 Specialist visit: \$35 | You pay 20% Plan pays 80% after the plan deductible is met |
| Other Health Care Facilities | In-Network | Out-of-Network (Based on MRC*) |
| Home Health Care Skilled visits only—60 days per calendar year, in-network and out-of-network combined | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Skilled Nursing Facility—60 days per calendar year, in-network and out-of-network combined | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Hospice Care (inpatient and outpatient) | Plan pays 100% | You pay 20% Plan pays 80% after the plan deductible is met |
| Prescription Drugs and Vision Care | | |
| Prescription Drugs, administered by Express Scripts—see chapter 3 | | |
| Vision Care, provided by Vision Service Plan (VSP)—see chapter 4 | | |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

UnitedHealthcare Consumer Choice with HSA Plan

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How the UnitedHealthcare Consumer Choice with HSA Plan Works

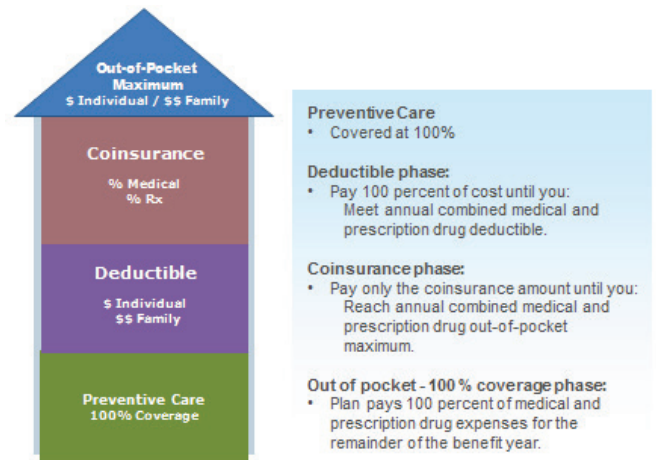
In-Network Benefits

The Consumer Choice with HSA Plan is a high-deductible or consumer-driven plan, designed to give you choice and control over how you spend your health care dollars.

Under the Consumer Choice with HSA Plan, you may receive care from any provider you choose within the UnitedHealthcare national network. No referral is required to see a specialist. The Consumer Choice with HSA plan is made up of several connected levels or phases, including preventive care, an annual deductible, coinsurance, and an out-of-pocket maximum.

- **Phase 1—Preventive Care:** includes 100% coverage for preventive care such as annual physicals and age-appropriate screenings. These services are provided at no cost to you when you use an in-network provider.
- **Phase 2—Deductible:** includes all other services, including physician visits and prescription drugs, which are subject to the deductible. You are responsible for 100% of the cost until you reach the individual or family deductible limit.
- **Phase 3—Coinsurance:** Once you meet the deductible, you share in the cost of services by paying coinsurance for medical services and for prescription drugs.
- **Phase 4—Out-of-Pocket Maximum:** Once the out-of-pocket maximum is met, the plan pays 100% for eligible covered medical and prescription drug expenses. The annual deductible and your coinsurance payments are included in the out-of-pocket maximum.

Important note: The individual deductible and out-of-pocket maximum apply to those enrolled in the plan with individual coverage only. All other coverage levels must meet the family deductible and out-of-pocket maximum amounts.



Prescription Drug Benefits

Prescription Drug benefits are administered by Express Scripts. You may obtain up to a 30 day supply of your prescription at retail. A 90 day supply is available through the mail-order pharmacy.

You pay 100% of all prescription drug benefits until you meet your deductible. After you meet your deductible, you pay coinsurance for generic and brand name drugs. There are minimum and maximum limits on the coinsurance which help protect you from the high cost of some drugs. If the cost of the drug is less than the minimum amount, you will pay the actual cost of the drug.

Preventive Care Drugs

Certain contraceptive items identified by the Plan as preventive care are covered in full and are not subject to deductible limits or coinsurance.

Vision Care

Vision benefits are included as part of your medical plan. Vision Services Plan (VSP) provides the Signature Choice plan, which includes coverage for exams, standard lenses, frames, and contact lenses.

Information on these benefits is provided in Chapter 3 (Prescription Drugs, administered by Express Scripts) and Chapter 4 (Vision Care, provided by Vision Service Plan).

How the UnitedHealthcare Consumer Choice with HSA Plan Works (cont.)

Health Savings Account (HSA)

If you are enrolled in the Consumer Choice with HSA Plan, you will open a Health Savings Account because this Plan is intended to be a federally qualified high deductible health plan. To be eligible to contribute to an HSA, you cannot be covered by Medicare or any other individual or group health plan that is not a federally qualified high deductible health plan.

Special Note for employees age 65 and over

If you apply for Social Security, you should stop all contributions to your HSA up to 6 months before you collect Social Security. When you apply for Social Security, Medicare Part A will be retroactive for up to 6 months (as long as you were eligible for Medicare during those 6 months). If you do not stop contributing to the HSA 6 months before you apply for Social Security, you may incur a tax penalty.

Out-of-network benefits are explained in the following section, “Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan.”

Administrative Information

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

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan

| Plan Design Features | In-Network | Out-of-Network (Based on MRC*) |
|--|---|--|
| <p>Annual Deductible</p> <ul style="list-style-type: none"> In-network deductibles do not count toward out-of-network deductibles, and vice versa. All family members contribute toward the family plan deductible. The plan cannot pay an individual's claims until the total family plan deductible has been met, even if he or she has met the individual plan deductible. This plan includes a combined Medical/Prescription plan deductible. Retail and home delivery pharmacy costs contribute to the plan deductible. Once the combined Medical/ Prescription plan deductible has been met, pharmacy will be paid at the defined pharmacy levels. | <p>Individual coverage: \$1,500 All other coverage levels: \$3,000 <i>(Includes Medical and Prescription Drugs)</i></p> | <p>Individual coverage: \$2,500 All other coverage levels: \$5,000 <i>(Includes Medical and Prescription Drugs)</i></p> |
| <p>Out-of-Pocket Annual Maximum</p> <ul style="list-style-type: none"> In-network, out-of-pocket limits do not count toward out-of-network, out-of-pocket limits, and vice versa. Plan deductibles contribute toward your out-of-pocket maximum. Mental health and substance abuse services contribute toward your out-of-pocket maximum. All family members contribute toward the family out-of-pocket maximum. The plan cannot pay an individual's covered expenses at 100% until the total family out-of-pocket maximum has been reached. This plan includes a combined Medical/Prescription out-of-pocket maximum. Retail and home delivery pharmacy costs contribute to the out-of-pocket maximum. | <p>Individual coverage: \$2,500 All other coverage levels: \$5,000 <i>(Includes Medical and Prescription Drugs)</i></p> | <p>Individual coverage: \$5,000 All other coverage levels: \$10,000 <i>(Includes Medical and Prescription Drugs)</i></p> |

Coinsurance is the portion of covered health care costs for which an insured person has a financial responsibility, usually according to a fixed percentage. For example, 90%/10% plan coinsurance means the plan pays 90% of your covered costs (such as costs for physician and surgeon services in a hospital), and you are responsible for paying the remaining 10% after you meet the deductible. Coinsurance amounts apply to your out-of-pocket maximum.

The **Out-of-Pocket maximum** is the most you will pay during the calendar year, based on your coverage level. Once you meet the maximum, the plan pays 100% of your covered costs. Plan deductibles, copayments, and coinsurance contribute toward your out-of-pocket maximum. In-network and out-of-network amounts are separate and do not cross-accumulate.

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

| Plan Design Features (cont.) | In-Network | Out-of-Network (Based on MRC*) |
|--|--|--|
| Maximum Lifetime Benefit | Unlimited | Unlimited |
| Pre-Existing Condition Exclusion Period | N/A | N/A |
| Primary Care Physician (PCP) | Not Required | N/A |
| PCP Referral | Not Required | N/A |
| Provider Network | UnitedHealthcare Choice Plus Network | N/A |
| Physician Services | In-Network | Out-of-Network (Based on MRC*) |
| Office Visit <ul style="list-style-type: none"> PCP Specialist | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Surgery (in a physician's office) | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Allergy Treatment / Injections Allergy Serum (dispensed by the physician in the office) | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Preventive Care | In-Network | Out-of-Network (Based on MRC*) |
| Preventive Health Services <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman, and adult preventive care Includes routine immunizations | Plan pays 100% | Not covered |
| Preventive Screenings <ul style="list-style-type: none"> Mammogram, Pap Smear, and Maternity Screening | Plan pays 100% | You pay 30% Plan pays 70% after the plan deductible is met |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

| Inpatient Hospital Services | In-Network | Out-of-Network (Based on MRC*) |
|--|--|---|
| Inpatient Services: Operating room, pharmacy, x-ray, and laboratory services; semi-private room and board <i>Hospital stays not deemed medically necessary will be disapproved.</i> | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met <i>You must have all out-of-network inpatient hospitalizations and outpatient surgeries precertified through UnitedHealthcare. Failure to do so will result in denied claims.</i> |
| Physician and Surgeon Services in Hospital | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Outpatient Services | In-Network | Out-of-Network (Based on MRC*) |
| Outpatient Surgery— Outpatient Facility | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met <i>You must have all outpatient surgeries precertified through UnitedHealthcare. Failure to do so will result in denied claims.</i> |
| Outpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists, and anesthesiologists | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Outpatient (short-term) Rehabilitation—Includes physical, speech, cardiac, cognitive, pulmonary, and occupational therapy | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| | 180 days per calendar year in-network and out-of-network combined. Therapy days provided as part of an approved Home Health Care plan accumulate to the outpatient short-term rehab therapy maximum. | |
| Chiropractic Care (when medically appropriate)—limited to 25 days per year | You pay 10% Plan pays 90% after the plan deductible is met | Not covered |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

| Lab and X-Ray | In-Network | Out-of-Network (Based on MRC*) |
|--|--|---|
| Outpatient Laboratory and Radiology Services received from: <ol style="list-style-type: none"> 1. Outpatient hospital facility 2. Independent facility 3. Doctor's office 4. Advanced Radiology Services such as MRI, PET, MRA, CAT—must be precertified and preauthorized | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Emergency and Urgent Care Services | In-Network | Out-of-Network (Based on MRC*) |
| Hospital Emergency Room Services <ul style="list-style-type: none"> • Includes radiology, pathology, and physician charges | You pay 10% Plan pays 90% after the plan deductible is met | You pay 10% Plan pays 90% after the plan deductible is met <i>Out-of-network services are covered at the in-network rate</i> |
| Ambulance Services - Ground and Air Transport <i>Note: Non-emergency transportation requires prior authorization.</i> | You pay 10% Plan pays 90% after the plan deductible is met | You pay 10% Plan pays 90% after the plan deductible is met <i>Out-of-network services are covered at the in-network rate</i> |
| Urgent Care Facility | You pay 10% Plan pays 90% after the plan deductible is met | You pay 10% Plan pays 90% after the plan deductible is met <i>Out-of-network services are covered at the in-network rate</i> |
| Convenience Care | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Other Health Care Services | In-Network | Out-of-Network (Based on MRC*) |
| Maternity Care Services Covers maternity for employee and all dependents <ul style="list-style-type: none"> • Initial visit to confirm pregnancy • All subsequent routine prenatal visits, postnatal visits, and delivery Delivery (Inpatient Hospital, Birthing Center) | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

| Other Health Care Services | In-Network | Out-of-Network |
|--|--|--|
| <p>Infertility Treatment:</p> <ul style="list-style-type: none"> Physician office visit, test, counseling <p>Surgical Treatment—includes procedures for correction of infertility (in vitro fertilization, artificial insemination, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], etc.)</p> | <p>You pay 10% Plan pays 90% after the plan deductible is met</p> <p><i>\$20,000 lifetime maximum in-network and out-of-network combined. Lifetime maximum does not apply to diagnostic and planning services.</i></p> | <p>You pay 30% Plan pays 70% after the plan deductible is met</p> <p><i>\$20,000 lifetime maximum in-network and out-of-network combined. Lifetime maximum does not apply to diagnostic and planning services.</i></p> |
| <p>Durable Medical Equipment— Unlimited calendar year maximum</p> | <p>You pay 10% Plan pays 90% after the plan deductible is met</p> | <p>You pay 30% Plan pays 70% after the plan deductible is met</p> |
| <p>External Prosthetic Appliance (EPA)—Unlimited calendar year maximum. Requires approval by Health Plan; limited coverage applies</p> | <p>You pay 10% Plan pays 90% after the plan deductible is met</p> <p><i>Benefits are available for Class III and Class IV Prosthetic devices. An evaluation by an orthopedic surgeon or a physical and rehabilitation physician are required, in addition to a prescription, to provide the clinical justification for advanced prosthetic devices and myoelectric limbs</i></p> | <p>You pay 30% Plan pays 70% after the plan deductible is met</p> |
| <p>Hearing Aid Benefits</p> | <p>You pay 10% Plan pays 90% after the plan deductible is met</p> <p><i>\$750 maximum per 36 consecutive months; no maximum for children up to age 18</i></p> | <p>Not covered</p> |
| <p>Bariatric Surgery</p> <ul style="list-style-type: none"> Subject to medical necessity and clinical guidelines Treatment of clinically severe obesity, as defined by the body mass index (BMI) | <p>You pay 10% Plan pays 90% after the plan deductible is met</p> <p><i>The plan will not cover non-cancerous skin tag removal. The plan will cover rhinoplasty, breast reductions, varicose veins, and blepharoplasty surgery (removal of excessive eyelid tissue) if medically necessary. Authorization is required.</i></p> | <p>You pay 30% Plan pays 70% after the plan deductible is met</p> |
| <p>Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorder by an eligible provider</p> | <p>You pay 10% Plan pays 90% after the plan deductible is met</p> | <p>You pay 30% Plan pays 70% after the plan deductible is met</p> |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

| Other Health Care Services (cont.) | In-Network | Out-of-Network (Based on MRC*) |
|--|--|--|
| Gender Dysphoria | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| myuhc.com, Healthy Pregnancy Program, 24 Hour Nurse Line, Advocate4me.com) | Yes | NA |
| Organ Transplant Coverage— Inpatient Facility, Travel Benefit | <ul style="list-style-type: none"> • Inpatient covered at 100% at Center of Excellence after plan deductible is met; otherwise covered 90% after plan deductible is met (if facility is contracted with UnitedHealthcare for transplant services) • Physician Services: Covered at 100% at Center of Excellence after plan deductible is met; otherwise 90% after plan deductible is met • Travel maximum \$10,000 per transplant (only available if using Center of Excellence facility) | You pay 30% Plan pays 70% after the plan deductible is met |
| Dental Care—Limited to charges for a continuous course of dental treatment started within 6 months of injury to sound, natural teeth <ul style="list-style-type: none"> • Physician’s Office visit • Inpatient Facility • Outpatient Facility • Physician’s Services | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Temporomandibular Joint Disorder (TMJ) (surgical and non-surgical treatment)—Excludes appliances and orthodontic treatment; subject to medical necessity <ul style="list-style-type: none"> • Physician’s Office visit • Inpatient Facility • Outpatient Facility • Physician’s Services | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

| Mental Health and Substance Abuse Services | In-Network | Out-of-Network (Based on MRC*) |
|--|--|--|
| Inpatient Mental Health Services, UnitedHealthcare Behavioral Health Network—Unlimited days per calendar year | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Outpatient Mental Health Services—Unlimited visits per calendar year • Includes individual, group therapy mental health, and intensive outpatient mental health | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Inpatient Substance Abuse—Unlimited days per calendar year | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Outpatient Substance Abuse—Unlimited visits per calendar year • Includes individual and intensive outpatient substance abuse treatment | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Other Health Care Facilities | In-Network | Out-of-Network (Based on MRC*) |
| Home Health Care skilled visits only | You pay 10% Plan pays 90% after the plan deductible is met Unlimited days per calendar year, in-network | You pay 30% Plan pays 70% after the plan deductible is met 60 days per calendar year out-of-network, reduced by any in-network days |
| Skilled Nursing Facility—60 days per calendar year, in-network and out-of-network combined | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |
| Hospice Care (inpatient and outpatient) | You pay 10% Plan pays 90% after the plan deductible is met | You pay 30% Plan pays 70% after the plan deductible is met |

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Consumer Choice with HSA Plan (cont.)

Prescription Drugs and Vision Care

Prescription Drugs, administered by Express Scripts—see Chapter 3

Vision Care, provided by Vision Service Plan (VSP)—see Chapter 4

UnitedHealthcare Indemnity Plan

If you do not have access to UnitedHealthcare's national network but you are otherwise eligible for the Medical Plan, you may be covered under the UnitedHealthcare Indemnity Plan.

| For more information on ... | See Page ... |
|---|--------------|
| How the UnitedHealthcare Indemnity Plan Works | 2—32 |
| Summary of Benefits | 2—34 |

How the UnitedHealthcare 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 the Medicare-based Maximum Reimbursement Charge (MRC) 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 the MRC 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 UnitedHealthcare Member Services.

You must also call UnitedHealthcare 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.

Medicare-Based Maximum Reimbursement Charge (MRC)

All Indemnity Plan benefit payments are subject to the MRC. Any charges above the MRC 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.

“Medicare-Based Maximum Reimbursement 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, 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/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 UnitedHealthcare

For questions on eligibility,
UnitedHealthcare Indemnity Plan
benefits, claims, or precertification:
1-844-234-7925

How the UnitedHealthcare Indemnity Plan Works (cont.)

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 the Medicare-based Maximum Reimbursement Charge (MRC)
- care that is received but is 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 MRC for a second surgical opinion, with no deductible. If additional opinions are necessary, they will be covered at 80% of the MRC.

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 the MRC for the tests, after you meet the deductible.

Mental Health/Substance Abuse Treatment

After you meet the deductible, the Indemnity Plan pays 80% of the MRC for mental health/substance abuse treatment, up to the limits described in the chart on the following pages. Inpatient care must be precertified by calling 844-234-7925.

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

Administrative Information

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

Summary of Benefits: UnitedHealthcare Indemnity Plan

Plan Design Features

| | |
|--|--------------------------------------|
| Annual Deductible Amount for injury, illness, or maternity | \$400 Individual \$800 Family |
| Out-of-Pocket Annual Limit—including Medical, Prescription Drugs, and deductible | Up to the maximum allowed by the IRS |
| Pre-Existing Conditions Limitations | N/A |
| Maximum Lifetime Benefit | Unlimited |
| Network of Providers | N/A |
| Primary Care Physician (PCP) | N/A |
| PCP Referral | N/A |

Physician Services

| | |
|--|--|
| Physician Office Visit—Primary Care Physician or Specialist <ul style="list-style-type: none"> Surgery performed in the physician's office Allergy Treatment/Injections Maternity office visits | Plan pays 80% of MRC* after deductible |
| <ul style="list-style-type: none"> Allergy Serum (dispensed by the physician in the office) | Plan pays 80% with no deductible |

Preventive Care

| | |
|--|------------------------|
| Preventive Health Services <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman, and adult preventive care Includes routine immunizations | Plan pays 100% of MRC* |
| Preventive Screenings <ul style="list-style-type: none"> Mammogram, Pap Smear, and Maternity Screening | Plan pays 100% of MRC* |

Inpatient Hospital Services

| | |
|---|--|
| Inpatient Services: semi-private room, operating room, x-ray, and laboratory services | Plan pays 80% of MRC* after deductible |
| Physician and Surgeon Services in Hospital | Plan pays 80% of MRC* after deductible |

Outpatient Services

| | |
|---|--|
| Outpatient Services <ul style="list-style-type: none"> Outpatient surgery Outpatient professional services—surgeon, radiologist, pathologist, anesthesiologist X-ray and laboratory services | Plan pays 80% of MRC* after deductible |
|---|--|

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Indemnity Plan (cont.)

Outpatient Services (cont.)

| | |
|---|--|
| Outpatient short-term rehabilitation <ul style="list-style-type: none"> Includes cardiac, physical, speech, and occupational therapy | Plan pays 80% of MRC* after deductible Contract year maximum is unlimited |
|---|--|

| | |
|-------------------|---|
| Chiropractic Care | Plan pays 80% of MRC* after deductible; 25 day limit per year |
|-------------------|---|

Lab and X-Ray

| | |
|---|--|
| Laboratory and X-ray <ul style="list-style-type: none"> MRIs, MRAs, CAT Scans, and PET scans | Plan pays 80% of MRC* after deductible |
|---|--|

Emergency and Urgent Care Services

| | |
|---|--|
| <ol style="list-style-type: none"> Emergency Room Ambulance Services Emergency Care at Doctor's Office Physician Services in Emergency Room Urgent Care Facility Convenience Care | <ol style="list-style-type: none"> Plan pays 80% of MRC* after deductible Plan pays 100% of MRC* Plan pays 100% of MRC* Plan pays 80% of MRC* after deductible Plan pays 80% of MRC* after deductible Plan pays 80% of MRC* after deductible |
|---|--|

Other Health Care Services

| | |
|---------------------|--|
| Maternity—Inpatient | Plan pays 80% of MRC* after deductible |
|---------------------|--|

| | |
|--|--|
| Maternity Delivery (physician charges) | Plan pays 80% of MRC* after deductible |
|--|--|

| | |
|-----------------------|--|
| Infertility Treatment | Limited coverage <ul style="list-style-type: none"> Artificial insemination lifetime maximum: Three attempts per menstrual cycle with a maximum of eight cycles per lifetime (total attempts allowed is 24) In vitro fertilization, gamete and zygote intrafallopian transfers (GIFT, ZIFT) lifetime maximums: four attempts |
|-----------------------|--|

| | |
|---------------------------|--|
| Durable Medical Equipment | Plan pays 80% of MRC* after deductible |
|---------------------------|--|

| | |
|---|--|
| External Prosthetic Appliances—Requires approval by Health Plan | Plan pays 80% of MRC* after deductible |
|---|--|

| | |
|---------------------------|---|
| Organ Transplant Coverage | Plan pays 80% of MRC* after deductible Travel services maximum when transplant procedure is performed at a Center of Excellence Facility: \$10,000 per transplant |
|---------------------------|---|

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Summary of Benefits: UnitedHealthcare Indemnity Plan (cont.)

Other Health Care Services (cont.)

| | |
|---|---|
| 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 deductible |
| Temporomandibular Joint Disorder (TMJ) (surgical and non-surgical treatment) | Plan pays 80% of MRC* after deductible |
| Bariatric Surgery | Plan pays 80% of MRC* after deductible; limitations may apply |
| Hearing Aid Benefits | Not Covered |
| Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorder by an eligible provider | Plan pays 80% of MRC* after deductible |
| Gender Dysphoria | Plan pays 80% of MRC* after deductible; limitations may apply |
| myuhc.com, Healthy Pregnancy Program, 24 Hour Nurse Line, (Advocate4me.com) | Covered |

Other Health Care Facilities

| | |
|---|--|
| Skilled Nursing Facility, Rehabilitation Hospital, and Sub-Acute Facilities | Plan pays 80% of MRC after deductible Up to 60 days confinement per calendar year maximum |
| Home Health Care (skilled visits only) | Plan pays 100% of MRC*, no deductible Up to 60 days per calendar year maximum |
| Hospice Care—inpatient and outpatient | Plan pays 80% of MRC* after deductible |

Mental Health and Substance Abuse Services

| | |
|----------------------------|--|
| Inpatient Mental Health | Plan pays 80% of MRC* after deductible |
| Outpatient Mental Health | Plan pays 80% of MRC* after deductible |
| Inpatient Substance Abuse | Plan pays 80% of MRC* after deductible |
| Outpatient Substance Abuse | Plan pays 80% of MRC* after deductible |

Prescription Drugs and Vision Care

Prescription Drugs, administered by Express Scripts—see Chapter 3

Vision Care, provided by Vision Service Plan (VSP)—see Chapter 4

* If the Shared Savings Program or fee negotiation cannot be applied, claims will be based on 140% of the Medicare-based Maximum Reimbursable Charge (MRC) in your geographic area for similar services.

Information for All Medical Plans

| For more information on ... | See Page ... |
|-----------------------------------|--------------|
| Information for All Medical Plans | 2—38 |
| Other Important Information | 2—45 |

Information for all Medical Plans

Certification Requirements

Under each of the 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.

If you are using an in-network physician for care, the in-network physician is responsible for contacting UnitedHealthcare 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 UnitedHealthcare Indemnity Plan, you are responsible for requesting certification. If you do not obtain approval through certification, penalties will apply.

Contacting UnitedHealthcare

For certification:
1-844-234-7925

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 otherwise would be payable under this plan for the charges listed below will not include:

- hospital charges for bed and board and for treatment listed above for which PAC was performed, but which are charged 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 UnitedHealthcare 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.)

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 freestanding surgical facility, another 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 test or procedures.

Outpatient Certification is performed through a utilization review program by a Review Organization with which UnitedHealthcare has contracted. Outpatient Certification should be requested only 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 outpatient diagnostic testing or procedures for which Outpatient Certification was performed but which were not certified as medically necessary tests or procedures.

In any case, 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, MRI, MRA, or PET scans
- hysterectomy

Prior Authorization/Preauthorized

For the UnitedHealthcare Plans, the term "Prior Authorization" refers to the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, 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 other participating health care facility
- residential treatment
- outpatient facility services
- advanced radiological imaging
- nonemergency ambulance requested by the member

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.

Contacting UnitedHealthcare

For precertification:
1-844-234-7925

Information for all Medical Plans (cont.)

Expenses Not Covered

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

- expenses for supplies, care, treatment, or surgery that are not medically necessary
- 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
- 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 an injury or a sickness connected to military-service
- expenses for or in connection with an injury or sickness due to war, declared or undeclared
- charges 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
- expenses for or in connection with experimental, investigational, or unproven services (as defined and determined by UnitedHealthcare)
- cosmetic surgery and therapies (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, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy, and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions
- expenses 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 freestanding surgical facility or the outpatient department of a hospital in connection with surgery
- unless otherwise covered by the plan, expenses for medical and surgical services (initial and repeat) 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
- 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), anorgasmia, 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 disabilities

Information for all Medical Plans (cont.)

Expenses Not Covered (cont.)

- consumable medical supplies other than ostomy supplies and urinary catheters, except as provided by the plan
- 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
- 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, 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 Vision Care Plan; see Chapter 4 for more information), 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—limited to treating nausea caused for hyperemesis of pregnancy,

- nausea or vomiting following chemotherapy, and postoperative dental pain relief
- 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.
- membership costs or fees associated with health clubs and weight loss programs
- dental implants for any condition
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three visits per calendar year for both pre- and post-genetic testing.

Information for all Medical Plans (cont.)

Expenses Not Covered (cont.)

- 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
- 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 and nutritional formulae for enteral feedings regardless of diagnosis
- 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
- charges which would not have been made if the person had no insurance
- the extent that charges are more than the Medicare-based MRC
- expenses incurred outside the United States, unless you or your eligible dependent is a US resident and the charges are incurred while traveling on business or for pleasure
- the extent of the exclusions imposed by any certification requirement in this plan.

Filing Claims

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

To file a claim for out-of-network treatment under the Medical Plans or for any treatment under the Indemnity Plan, you must complete a claim form

and send it to UnitedHealthcare 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 sent to you for a payment you have made. Otherwise, it will be sent to the provider.

You can 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 UnitedHealthcare 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, UnitedHealthcare determines how benefits from all such plans will be coordinated. The Company follows a maintenance of benefits method to ensure that the total combined payment from all sources is never more than the total charge for the services. Whenever another group plan is primary, the Company plan will pay only the difference between the benefits paid by the primary plan and what would have been paid had this plan been primary.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Information for all Medical Plans (cont.)

Plan

Any of the following that provides benefits or services for medical care or treatment:

1. Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
2. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
3. Medical benefits coverage of group, group-type, and individual automobile contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan also may recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable, and customary service or expense, including deductibles, coinsurance, or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit. Examples of expenses or services that

are not Allowable Expenses include, but are not limited to, the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. If you are confined to a private room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
3. If you are covered by two or more Plans that provide services or supplies on the basis of Medicare-based MRC fees, any amount in excess of the highest MRC fee is not an Allowable Expense.
4. If you are covered by one Plan that provides services or supplies on the basis of Medicare-based MRC fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
5. If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Information for all Medical Plans (cont.)

Shared Savings Program

The Shared Savings Program provides access to discounts from non-Network Physicians who participate in the program. UnitedHealthCare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthCare might negotiate lower Eligible Expenses for Non-Network Benefits, the Deductible and Coinsurance will stay the same as described in the Summary of Benefits. When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to out-of-network Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a dependent shall be the Secondary Plan;
2. If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
3. If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
 - a. first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - b. then, the Plan of the parent with custody of the child;
 - c. then, the Plan of the spouse of the parent with custody of the child;

- d. then, the Plan of the parent not having custody of the child, and
 - e. finally, the Plan of the spouse of the parent not having custody of the child.
4. The Plan that covers you as an active employee (or as that employee's dependent) shall be the Primary Plan, and the Plan that covers you as laid-off or retired employee (or as that employee's dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
 5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
 6. If one of the Plans that cover you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary. When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

Information for all Medical Plans (cont.)

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you.

UnitedHealthcare will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period. As each

claim is submitted, UnitedHealthcare will determine the following:

1. UnitedHealthcare's obligation to provide services and supplies under this policy;
2. whether a benefit reserve has been recorded for you; and
3. whether there are any unpaid Allowable Expenses during the Claims Determination Period.

Other Important Information

Recovery of Excess Benefits

If UnitedHealthcare pays charges for benefits that should have been paid by the Primary Plan, or if UnitedHealthcare pays charges in excess of those for which we are obligated to provide under the Policy, UnitedHealthcare will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

UnitedHealthcare will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, health care plan, or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

UnitedHealthcare, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received

within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibility

Benefits also will 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's 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.

Other Important Information (cont.)

The Medical Plan reduces its benefits for you (or 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 actually is 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 of whether 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. Claims are processed using Medicare billed charges as the allowed amount and the total charges less Medicare coinsurance (80%) as the paid amount.

Right to Reimbursement (Subrogation)

Under the Employee Retirement Income Security Act of 1974 (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 inform the Plan Administrator in a timely manner 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 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.

Other Important Information (cont.)

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 also shall 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.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers, under federal law, generally may not 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, under federal law, may not 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 also is 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 covered under this plan and before age 65, your spouse and eligible dependents may elect to continue medical coverage until your spouse reaches age 65. When your spouse turns age 65, he or she may enroll in the Over 65 Medicare Supplement Program, and your eligible dependents may continue coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Continuation of Medical Coverage via COBRA

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

Other Important Information (cont.)

Coverage for Reconstructive Surgery Following Mastectomy

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

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

This coverage will be subject to the same deductibles, copayments, and coinsurance as any other benefit under the plan.

Medical Claims Review and Appeal Procedures

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 with respect to a claim or appeal for benefits. The plan also will recognize a court order giving a person authority to submit claims on your behalf. In the case of a medical claim involving urgent care, a health care professional with knowledge of your condition may act as your authorized representative, unless you have designated a different authorized representative. References to you in this section are intended to include references to your authorized representative.

If your claim for benefits is denied, you cannot bring a lawsuit to recover benefits under the plan unless you have exercised, in a timely manner, all appeal rights available to you under the plan’s administrative claims procedures for a denied claim and your appeal(s) seeking benefits have been denied by the plan. In most instances, you may not initiate a legal action against the plan until you have completed the Level-One and Level-Two appeal processes.

If your appeal is expedited, there is no need to complete the Level-Two process before bringing legal action. Further, any such lawsuit may not be filed after 1 year from the date the final decision on appeals is issued. If you do not file suit within this period, the final determination of your appeal will be binding and cannot be challenged by you in court.

Urgent Health Care Claims

If the plan requires advance approval of a service, supply, or procedure before a benefit will be payable, and if the plan or your physician determines it is an Urgent Care Claim, you will be notified of the decision as soon as possible, but not later than 72 hours after the claim is received unless you fail to provide sufficient information for the plan to make a decision.

“Urgent Care” means services received for a sudden illness, injury, or condition that is not an emergency condition but that requires immediate outpatient medical care that cannot be postponed.

An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person’s health or ability to regain maximum function; this includes a condition that, in the opinion of a physician with knowledge of your medical condition, would subject a person to severe pain that could not be managed adequately without prompt treatment. The determination of whether a claim is an Urgent Care Claim will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine or by a physician with knowledge of your medical condition who determines the claim involves urgent care.

If there is not sufficient information to decide the claim, you will be notified of the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision as soon as possible, but not later than 48 hours after the end of that additional time period (or after receipt of the specified information, if earlier).

Other Important Information (cont.)

Other Health Claims (Preservice and Post-Service)

If the plan requires you to obtain advance approval of a service, supply, or procedure before a benefit will be payable, a request for advance approval is considered a preservice claim. You will be notified of the decision as soon as possible, but not later than 15 days after receipt of the preservice claim.

For other health claims (post-service claims), you will be notified of the decision as soon as possible but not later than 30 days after receipt of the claim.

For a preservice or a post-service claim, these time periods may be extended up to an additional 15 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 15 or 30 day period.

For example, the period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For preservice claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a plan representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing preservice claims, you will be notified of the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

For preservice claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a plan representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing preservice claims, you will be notified of the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Appeals Procedure

The plan has a two-step appeals procedure for coverage decisions (except for those appeals related to a rescission of coverage). To initiate an appeal, you must submit a request for an appeal in writing to UnitedHealthcare within 180 days of receipt of a denial notice. You should state the reason why you believe your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask UnitedHealthcare to register your appeal by telephone. Call or write UnitedHealthcare at the toll-free number on your benefit identification card, explanation of benefits, or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

For Level-One appeals, UnitedHealthcare will respond in writing with a decision within 15 calendar days after it receives an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after it receives an appeal for a post-service coverage determination. If more time or information is needed to make the determination, UnitedHealthcare will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request the appeal process be expedited if

- (a) the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or
- (b) your appeal involves nonauthorization of an admission or continuing inpatient hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Level-One appeal would be detrimental to your medical condition.

Other Important Information (cont.)

UnitedHealthcare's physician reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, UnitedHealthcare will respond orally with a decision within 72 hours, followed up in writing.

Level-Two Appeal

If you are dissatisfied with the Level-One appeal decision, you may request a second review. To initiate a Level-Two appeal, follow the same process required for a Level-One appeal.

Requests for a Level-Two appeal regarding the medical necessity or clinical appropriateness of your issue will be conducted by a committee, which consists of one or more people not involved in the prior decision. The committee will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by UnitedHealthcare's physician reviewer. You may present your situation to the committee in person or by conference call.

For required preservice and concurrent care coverage determinations, the committee review will be completed within 15 calendar days; for post-service claims, the committee review will be completed within 30 calendar days.

If more time or information is needed to make the determination, UnitedHealthcare will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon, or generated by UnitedHealthcare in connection with the Level-Two appeal, UnitedHealthcare will provide this information to you as soon as possible and sufficiently in advance of the committee's decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered on appeal, UnitedHealthcare will provide the rationale to you as soon as possible and sufficiently in advance of the Committee's decision so that you will have an opportunity to respond.

If the committee does not approve the requested coverage, you will be notified in writing of the committee's decision within 5 business days after the committee meeting, and within the committee review time frames above, if the committee does not approve the requested coverage.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your physician, would cause you severe pain that cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient hospital stay. UnitedHealthcare's physician reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, UnitedHealthcare will respond orally with a decision within 72 hours, followed up in writing.

Rescission Appeal Procedures

The Company has the authority to rescind benefit coverage from participants in certain circumstances. A rescission of coverage that is initiated by the Company instead of by the filing of a claim may be appealed through a modified form of the plan's appeals procedures ("rescission appeal procedures"). Just as in the claims procedures, either yourself or an authorized representative may file the appeal, and you cannot bring a lawsuit to recover benefits under the plan unless you have exercised, in a timely manner, all appeal rights available to you under the plan's rescission appeal procedures and your appeal has been denied by the plan.

To initiate an appeal, you must submit a request in writing to the Plan Administrator within 180 days of the receipt of a notice of rescission of coverage. You should state the reason why you believe your appeal should be approved and include any information supporting your appeal. Your appeal will be reviewed and the decision made by the Plan Administrator.

Other Important Information (cont.)

The Plan Administrator will respond in writing with a decision within 30 calendar days of receiving your appeal for a rescission. This time period may be extended up to an additional 15 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 30 day period.

The modified rescission appeal procedures will have one level of review.

Independent Review Procedure

If you are not fully satisfied with the decision of the final appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by the Company or UnitedHealthcare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. The plan will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of the Level-Two appeal review denial. To request a review of a rescission, you must notify the Plan Administrator within 180 days of your receipt of the appeal review denial. The Plan Administrator or UnitedHealthcare will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by the physician reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a denied claim or a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal as well as an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment, or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

Relevant Information

Relevant information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

On-Site Medical Services: Occupational Medical Division

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Introduction

The ORNL Occupational Medical Division (“ORNL Medical”) manages ORNL’s occupational medical program to help provide for the safety and health of workers at ORNL facilities through the delivery of medical and other occupational health-related services by qualified personnel who possess appropriate licensing, certification, and training. The scope and nature of these medical services rendered are based on regulatory requirements for occupational medical monitoring and surveillance necessary to support the diverse research and

operational activities of ORNL. All components of the occupational medical program are evaluated and prioritized with respect to regulatory compliance, their impact on our workers’ health and safety at the site, and their benefit/effectiveness in relation to cost to help contain health care expenditures and to allocate funds in the most judicious manner. 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.

Eligibility

You are eligible to receive occupational medical services from ORNL Medical 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 or a Casual Employee working on an ad hoc or intermittent basis. Casual Retirees are not eligible to participate receive occupational medical services.

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 Summary Plan Description.

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

Enrollment

Benefits and programs that are offered through ORNL Medical are provided as long as you are an eligible employee.

Cost of Services

There is no cost to you when you access any of the services available through ORNL Medical.

Services Provided

Employee fitness for duty is a foremost objective of ORNL Medical's occupational medical program, and the performance of health evaluations is essential to the process. ORNL Medical provides job-required evaluations, including evaluations for preplacement (health status and fitness for duty), medical surveillance (jobs involving specific physical, chemical, or biological hazards), qualification (job assignments with specific medical qualifications standards), return to work (ensure that the employee may return to work without undue health risk to self or others), job transfer (determine whether the employee's health status and fitness for the newly assigned duties can be performed in a safe and reliable manner), and termination (health status review).

ORNL Medical also provides occupational medical services for all UT-Battelle employees with an on-the-job illness or injury (including x-ray services), physical therapy, and emergency services. ORNL Medical is available to provide emergency response (stabilization) medical services to anyone at the ORNL main campus.

For every UT-Battelle employee, ORNL Medical is responsible to provide or ensure the assessment of all on-the-job injury/illnesses as well as the documentation of injury and follow-up treatment, including all referrals to board-certified specialists as needed.

Accessing Services

ORNL Medical is open Monday through Friday, 7:00 a.m. to 4:30 p.m. The telephone number is 574-7431, email address is medical@ornl.gov, and website is

<https://portal09.ornl.gov/sites/hrd/onsitemed/medical.html>. If you need care after hours, call 911 (land line only) or the Laboratory Shift Supervisor (LSS) at 576-4LSS or 574-6606.

How Changes Affect Your Benefits

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

Claims and Appeal Procedures

Claims for services will be processed by ORNL Medical. If you disagree with the outcome of a claim or feel you have been denied a service you are eligible to receive from the Health Services Division, you may file an appeal.

For appeal procedures, see "Claims Review and Appeals" in the "Administrative Information" chapter. In addition, the collective bargaining agreement contains information related to the resolution of disputes for hourly employees.

On-Site Medical Services: The WellOne Clinic

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Introduction

The WellOne Clinic 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. This will reduce absenteeism, enhance productivity, and prolong the employee's productive years. The WellOne Clinic is a self-insured, self-administered

workplace-based medical services facility that provides outpatient health care to those with 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.

Eligibility

You are eligible to receive benefits and services from the WellOne Clinic if you are authorized to

access ORNL facilities. No enrollment is necessary for employees.

Cost of Services

The WellOne Clinic is a freestanding clinic operated on site to bring you convenient access to health and wellness services with new benefits for continuing treatment, management, and prevention. Just like visits to an external primary care provider, visits to the WellOne Clinic do incur costs. The services are offered at competitive, affordable rates that vary according to insurance plans. WellOne

accepts most insurance plans. Please check with your carrier to determine network status.

At WellOne Clinic, no payments are made at the time of service. All services are billable to insurance plans or directly to you if you are not insured. All patients, regardless of insurance status, will be billed for services, including office visits.

Services Provided

The WellOne Clinic provides care and services for non-occupational illness and injury. The ORNL Occupational Medical Division provides care for occupational injuries (please see that section of this Summary for additional details).

The WellOne Clinic provides a variety of primary and acute care services. In many ways, the WellOne Clinic can act as your primary care physician relationship. The specific services provided by the Clinic are listed below.

Primary Care Services

Primary care identifies health risks, manages chronic or episodic conditions, and offers preventive screening and physicals. The WellOne Clinic provides a number of wellness and preventive care services, including:

- Annual physical exams,
- Preoperative exams,
- Health care screenings,
- Well-woman exams (including breast exams and pap smears),
- Well-man exams,

Services Provided (cont.)

- Biometric (wellness) screenings,
- Blood pressure screenings,
- Cholesterol screenings,
- Complete health screenings,
- Diabetes screenings,
- HPV and STD screenings,
- Smoking cessation, and
- Flu vaccinations and allergy shots.

The WellOne Clinic also provides ongoing treatment and care for the following health conditions:

- Allergies,
- Asthma,
- Chronic obstructive pulmonary disease (COPD),
- Depression and/or anxiety,
- Diabetes,
- Gastroesophageal reflux disease (GERD),
- Heart disease,

- High blood pressure, and
- High cholesterol.

Acute Care Services

Acute care addresses non-work-related urgent care needs for illness, minor injury, and minor surgical procedures. The WellOne Clinic provides treatment for the following minor illnesses and injuries:

- Colds, flu, and other viral illnesses;
- Bronchitis, pneumonia, and asthma;
- Ear, throat, and sinus infections;
- Poison ivy and other rashes;
- Nausea, vomiting, diarrhea, and dehydration;
- Fractures, sprains, strains, and dislocations;
- Minor surgical procedures and stitches;
- Cuts, scrapes, and splinters;
- Urinary tract infections; and
- Other medical services such as non-work-related immunizations, EKGs, and medical evaluations.

Accessing Services

The WellOne Clinic, located in Building 4500-North, Room I-112, is open Monday through Friday, 8 a.m.–4:30 p.m. Their telephone number is (865) 574-WELL or (865) 574-9355.

If you need care after hours or if you have an emergency, call 911 (land line only) or the Laboratory Shift Supervisor (LSS) at 576-4LSS or 574-6606.

How Changes Affect Your Benefits

If your access to ORNL is terminated, you will no longer have access to the WellOne Clinic.

Claims and Appeal Procedures

Claims for services will be processed by the WellOne Clinic. If you disagree with the outcome of a claim or feel you have been denied a service you are eligible to receive from the WellOne Clinic, you may file an appeal. For appeal procedures, see

“Claims Review and Appeals” in the “Administrative Information” chapter. In addition, the collective bargaining agreement contains information related to the resolution of disputes for hourly employees.

