Summary of Material Modifications (SMM)

The recent pandemic has seen new laws and regulations passed that affect Oak Ridge National Laboratory benefit plans. This document revises the "Information for All Medical Plans" section of the UT-Battelle, LLC, Your Retiree Benefits Summary Plan Description by adding the following new sections below. This Summary of Material Modifications should be retained with your other benefits information.

COVID-19 Testing - effective for testing incurred on or after 2/4/20 and before the end of the National Emergency
The Plan pays for Benefits for COVID-19 and SARS-CoV-2 diagnostic testing and the office visit associated with the testing without cost sharing (deductibles, coinsurance and copayments), for members and their covered dependents. This coverage includes the diagnostic test as well as items and services furnished to the Covered Person during the health care provider office visit, whether in-person or a telehealth visit, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such Covered Person for purposes of determining the need of such product. Covered services can be provided at a Physician's office, an Alternate Facility or a Hospital. There will also be a zero cost share for virtual visits related to the diagnosis of COVID-19.

Virtual Visits – effective March 1, 2020 – June 18, 2020
The medical plans covered all virtual visits that would otherwise be covered under the terms of the medical plan with no cost sharing. Any virtual visit that occurred on or after June 18, 2020 that is not related to the diagnosis of COVID-19 will be covered with applicable cost sharing under the terms of the plan.

COVID Treatment
ORNL retirees and their covered dependents will still have deductible, coinsurance and copayments to pay for the treatment of COVID-19.

Your Retiree Benefits Summary Plan Description is available to view or download at https://benefits.ornl.gov/retiree-book-of-benefits/.

If you have any questions about this SMM, you should contact the Benefits Plans Office by phone at 865-576-7766 or email ornlbenefits@ornl.gov.

Your Retiree Benefits Summary Plan Description

DISCOVER
your WORLD of benefits

OAK RIDGE
National Laboratory

Introduction

OAK RIDGE National Laboratory

ORNL BENEFITS
PO Box 2008, MS 6465
Oak Ridge, TN 37831-6465
(865) 576-7766 | ornlbenefits@ornl.gov

January 1, 2018

Dear Retiree/Spouse:

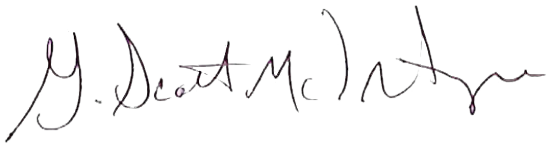
Your Retiree Benefits Summary Plan Description (SPD) outlines the benefits available to you as a retiree. Because of the many legal and plan design changes, the SPD has now been updated with current plan information.

The retiree SPD is available to view or download at http://benefits.ornl.gov/retiree-book-of-benefits/. You may also request a free CD or print copy by contacting ornlbenefits@ornl.gov.

Please discard the older versions of ***Your Book of Benefits*** issued as a three-ring binder or CD and refer to the most current Web-based edition.

If you have any questions or need assistance, you may access the ORNL Benefits website at https://ornl.sharepoint.com/sites/benefits/ or contact the ORNL Benefits Office at 865-576-7766.

Sincerely yours,



G. Scott McIntyre
Manager, Employee Benefits

This Notice applies only to UT-Battelle, LLC's group health plan and any health program that receives financial assistance from the Department of Health and Human Services

UT-Battelle, LLC (UT-Battelle) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

UT-Battelle does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- UT-Battelle:
  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Deborah Bowling, Civil Rights Coordinator, P.O. Box 2008, MS 6217, Oak Ridge, TN 37831-6217, Telephone - 865-574-9846.

If you believe that UT-Battelle has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Deborah Bowling, Civil Rights Coordinator, P.O. Box 2008, MS 6217, Oak Ridge, TN 37831-6217, Telephone - 865.574.9846, Fax - 865.574.4441, Email - bowlingdm@ornl.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Deborah Bowling, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Tagline Informing Individuals with Limited English Proficiency of Language Assistance Services

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.865.574.9846.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.865.574.9846 (رقم هاتف الصم والبكم: .

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.865.574.9846。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

1.865.574.9846.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1.865.574.9846 번으로 전화해 주십시오.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés

gratuitement. Appelez le 1.865.574.9846.

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.865.574.9846.

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.865.574.9846.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.865.574.9846.

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.865.574.9846.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1.865.574.9846 まで、お電話にてご連絡ください。

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.865.574.9846.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.865.574.9846 पर कॉल करें।

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.865.574.9846.

Persian (provided in Farsi language)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.865.574.9846 تماس بگیرید.

Contents

Contents (cont.)

Contents (cont.)

Contents (cont.)

Contents (cont.)

Contents (cont.)

Contents (cont.)

About Your Benefits

Your benefits have been designed to protect you and your family during your retirement years and to work with other sources of income to offer financial stability.

Highlights

Your Benefits …

… Offer Medical and Dental Coverage for You and Your Family

If you retired under the Pension Plan, you and your eligible dependents who are under age 65 may continue the coverage under the Medical and Dental Plans you had prior to retirement.

If you retired under the Pension Plan, and if you are age 65 or over *and* are enrolled in Medicare Part A and Part B **(but not Part D)**, you may enroll in the Over 65 Medicare Supplement Program. Upon reaching age 65, your spouse also may be eligible to participate in these plans.

… Allow You to Continue Your Life Insurance Coverage

You may continue or convert your life insurance during your retirement.

… Provide You With Retirement Income

Your Savings Plan and Pension Plan benefits work with your Social Security benefits and your personal savings to provide your retirement income.

The term “Company” refers to UT-Battelle, LLC. Other terms are defined in the “Glossary” chapter.

Eligibility and Cost

Determining Eligibility and Cost

At the time of your retirement, you made benefit elections and enrolled yourself and any eligible dependents in the appropriate plan(s), based on eligibility.

Your eligibility and cost for benefits in retirement are determined by your participation as an employee, your Company Service date, your years of Company service, your retirement date, your age, and whether you were a salaried employee or a bargaining unit employee.

For some benefits, the Company pays the full cost. For other benefits, you and the Company share the cost or you pay the full cost of coverage.

Eligibility and Cost (cont.)

Company Service Date prior to April 1, 2012

If your company service date is prior to April 1, 2012, you retired under the Company's Pension Plan, and you participated in the benefit plan immediately prior to your retirement, then your eligibility and cost are described below.

Benefit Plan	Eligible?	Cost
Medical (including Prescription Drugs and Vision Care) (for retirees under age 65)		
If you had at least 10 years of full-time service when you retired	Yes	Cost shared by you and the Company
If you had less than 10 years of full-time service when you retired	Yes	You pay full cost
Dental (for retirees under age 65)		
If you had at least 10 years of full-time service when you retired	Yes	Cost shared by you and the Company
If you had less than 10 years of full-time service when you retired	Yes	You pay full cost
Over 65 Medicare Supplement Program (for retirees over age 65)		
If you had at least 10 years of full-time service when you retired	Yes	Cost shared by you and the Company
If you had less than 10 years of full-time service when you retired	Yes	You pay full cost
Long-Term Care (for current plan participants)	Yes	You pay full cost
Basic Life Insurance	Limited (cost and eligibility are based on the chart in the Life Insurance chapter)	
Supplemental Life Insurance	Limited (cost and eligibility are based on the chart in the Life Insurance chapter)	
Pension Plan (participation will automatically continue until you die, or until your survivor dies if you have elected a form of payment that provides a survivor benefit; you are not required nor may you make participant contributions after retirement)	Yes	If you retired on or before January 1, 2013, the Company pays the full cost. Employee contributions began on January 1, 2013, for salaried employees and on October 1, 2013, for bargaining unit employees; these contributions are reflected as a non-taxable portion of your monthly pension payment.
Savings Plan (provided you have a deferred account balance, you may retain your account. However, you cannot make contributions to the Savings Plan after retirement)	Yes	NA

Eligibility and Cost (cont.)

Company Service Date on or after April 1, 2012

If your company service date is on or after April 1, 2012, you retired under the Company's Pension Plan, and you participated in the benefit plan immediately prior to your retirement, then your eligibility and cost are described below.

Benefit Plan	Eligible?	Cost
Medical (including Prescription Drugs and Vision Care) (for retirees under age 65)		
If you had at least 10 years of full-time service when you retired	Yes	You pay full cost
If you had less than 10 years of full-time service when you retired	No	NA
Dental (for retirees under age 65)		
If you had at least 10 years of full-time service when you retired	Yes	You pay full cost
If you had less than 10 years of full-time service when you retired	No	NA
Over 65 Medicare Supplement Program (for retirees over age 65)		
If you had at least 10 years of full-time service when you retired	Yes	You pay full cost
If you had less than 10 years of full-time service when you retired	No	NA
Basic Life Insurance	Coverage for salaried employees ends at retirement but may be converted (see the Life Insurance chapter). Coverage for Bargaining Unit employees is limited (Cost and eligibility are based on the chart in the Life Insurance chapter).	
Supplemental Life Insurance	Coverage ends at retirement but may be converted (see the Life Insurance chapter).	
Pension Plan (participation will automatically continue until you die, or until your survivor dies if you have elected a form of payment that provides a survivor benefit; you are not required nor may you make participant contributions after retirement)	Yes	If you retired on or before January 1, 2013, the Company pays the full cost. Employee contributions began on January 1, 2013, for salaried employees and on October 1, 2013, for bargaining unit employees; these contributions are reflected as a non-taxable portion of your monthly pension payment.
Savings Plan (provided you have a deferred account balance, you may retain your account. However, you cannot make contributions to the Savings Plan after retirement)	Yes	NA

Medical and Dental Plans Coverage Rules

Under Age 65 Medical (including Prescription Drug and Vision) and Dental Plans

The following rules apply to coverage under the Medical and/or Dental Plans:

- You must be covered in the plan for a spouse or child to be covered as your dependent.
- If you currently have active employer coverage from another source (such as coverage under your spouse's medical plan), you may later enroll in the Medical and/or Dental Plans if you lose coverage under that employer's plan. You must show proof of loss of coverage and enroll within 30 days of the date you lose coverage
- If your spouse is over age 65, your spouse (and other eligible dependents) may continue participating in the Medical and/or Dental Plans until you reach age 65. Your spouse must be enrolled in Medicare Part A and Part B **(but not Part D)**. Medicare will pay eligible medical expenses as primary payer for your spouse.

Over Age 65 Medical and Dental Plans

The following rules apply to coverage in the Over 65 Medicare Supplement Program:

- You must be enrolled in the Over 65 Medicare Supplement Program for a spouse or child to be covered under the company medical plans.
- You do not need to be enrolled in the Over 65 Medicare Supplement Program for a spouse or child to be covered under the company dental plans
    - Your spouse and other eligible dependents may continue participating in the under age 65 Medical Plan and the Dental Plan until your spouse reaches age 65.
- You—and your spouse, if also over age 65—must be enrolled in Medicare Part A and Part B, **but not Part D**.
- You must enroll in the Over 65 Medicare Supplement Program by the first day of the month of your 65th birthday, or if your birthday is on the first day of the month, you must enroll by the first day of the previous month (per Medicare rules).
- If you currently have active employer coverage from another source (such as coverage under your spouse's medical plan), you may enroll in the Over 65 Medicare Supplement Program if you lose coverage under that employer's plan. You must show proof of loss of coverage and enroll within 30 days of the date you lose coverage
- The plan provides an enhanced Part D Prescription Drug Plan administered by Express Scripts. If you enroll in another Medicare Part D prescription drug plan, you and your spouse will be dropped from the Over 65 Medicare Supplement Program and cannot re-enroll. If your spouse enrolls in another Medicare Part D prescription drug plan, your spouse will be dropped from the Over 65 Medicare Supplement Program and cannot re-enroll.
- If you are eligible, the Company shares in the cost of the Plan by providing a Health Reimbursement Arrangement (HRA). See Chapter 5 on the Medicare Supplement Program for more information.
- If you or your spouse cancels the Over 65 Medicare Supplement Program, you or your spouse cannot re-enroll later.
- Dental coverage and vision coverage are not available for retirees or spouses over age 65.

If you were *over age 65* at the time of retirement, enrollment information and guidelines for the Prescription Drug Plan and Over 65 Medicare Supplement Program were provided to you during retirement counseling.

If you retired *before age 65*, the ORNL Benefits Office will send you information and enrollment guidelines regarding the Over 65 Medicare Supplement Program approximately 3–4 months prior to your 65th birthday.

Eligibility for Dependents

Medical and Dental Eligibility for Your Dependents

In addition to the rules described previously, the following rules apply to eligibility for your dependents, including your spouse, dependent children, and your surviving spouse's dependents:

For your spouse:

- An eligible spouse can be enrolled in the retiree medical and dental plans under these limited circumstances:
  - At the time you retired and enrolled in the plans,
  - Within 30 days from the date of marriage, or
  - Within 30 days of losing active employer coverage elsewhere
- If you cancel coverage on yourself, coverage for your dependents will be cancelled.
- Surviving spouses on or after April 1, 2006, regardless of age, will be allowed to continue their current level of dental/medical coverage upon remarriage.
- A spouse who is also an active employee or retiree of ORNL has individual eligibility rights.

For your dependent children:

- Any newly acquired child (e.g., a stepchild) is eligible to be enrolled in the Medical and/or Dental Plan as long as the retiree or the surviving spouse enrolls the child within 30 days of a qualifying life event.
- If you or your spouse is enrolled in the under age 65 Medical Plan and/or the Dental Plan, the coverage may be continued for an unmarried child who is incapable of self-support due to a physical or mental handicap that began before he or she reached age 26, provided you submit proof of the child's disability to the insurance company within 30 days after the child reaches age 26. Additional proof of the child's continuing disability will be required periodically. Once you and your spouse both reach age 65, the child is no longer eligible for coverage.
- Your dependent children are no longer eligible for coverage when either of the following occurs:
  - When both you and your spouse reach age 65
  - When your dependent child turns age 26 (coverage will end at the end of the month of the child's 26th birthday), unless the child is incapable of self-support due to a physical or mental handicap that began before he or she reached age 26, as described above
- When your dependents are no longer eligible for health care coverage, they may be eligible to continue coverage for up to 36 months under COBRA. Refer to the "Administrative Information" chapter for information on COBRA.

The terms "Retiree," "Eligible Dependent," and "Child" are defined in the Glossary.

The following chart provides a snapshot of who is eligible for each benefit plan, providing the overall eligibility requirements are met.

Eligibility for Dependents (cont.)

Eligibility ... At a Glance			
Who Is Eligible	**Benefit Plan**		
	Medical (including Prescription Drug and Vision Care)	**Over 65 Medicare Supplement Program (including HRA and Prescription Drug)[1]**	**Dental**
Retiree under age 65	**X**		**X**
Retiree over age 65		**X**	
Spouse under age 65	**X**		**X**
Spouse over age 65[2]	**X**	**X**	**X**
Dependents, with retiree and/or spouse under age 65	**X**		**X**
Dependents, with retiree and spouse both over age 65	**COBRA**		**COBRA**

[1]Must be enrolled in Medicare Part A and Part B **but not a Part D** prescription drug plan.
[2]A spouse over age 65 must enroll in Medicare Part A and Part B to be his or her primary coverage; however, the spouse is allowed to remain in the Medical and Dental Plans until the retiree reaches age 65.

When You May Change Your Elections

When You May Change Your Elections

You can drop your medical, dental, or group life coverage at any time by notifying the ORNL Benefits Service Center. However, you must have a Qualifying Life Event to add coverage.

You may change most Savings Plan investments at any time by calling the Schwab Information Line.

Qualifying Life Events

An individual may make a mid-year election change to add coverage for a spouse or dependent in very limited circumstances when it is because of and consistent with a Qualifying Life Event. Retirees may add a new spouse or dependent child as a result of marriage or a new child as a result of birth, adoption or placement for adoption.

A rehired retiree who is participating in the plan may add a spouse or dependent who has a loss of other group health coverage, becomes eligible for assistance under Medicaid of CHIP, or losses eligibility for Medicaid or CHIP.

REMINDER: Enrollment must be completed within 30 calendar days of any marriage, birth, adoption or placement of adoption, or within 60 days of becoming eligible for premium assistance under Medicaid or CHIP or losing eligibility for Medicaid or CHIP.

Reference to a 30 day time limit in this book means calendar days. The period begins on the day of the event and ends 29 days thereafter. Holidays and weekends are included in the period.

Here are a few examples of election changes that are consistent with a Qualifying Life Event and plan eligibility rules:

With This Event	You Can Make These Changes	
You have a qualifying life event, such as: • Marriage • divorce or legal separation • birth or adoption • death • change in your spouse's employment status	Medical Plan Over 65 Medicare Supplement Program Dental Plan	If you were previously enrolled for coverage, you can add dependents (consistent with the family status change and subject to eligibility limits of each plan) or drop coverage for dependents
You experience a loss of other employer-provided medical or dental coverage	Medical Plan Over 65 Medicare Supplement Program Dental Plan	You can add coverage by providing proof of the coverage loss
You move outside a medical network	Medical Plan	Your coverage will be changed to the UHC Indemnity Plan
Benefit changes must be requested within 30 days of the qualifying life event by notifying the ORNL Benefits Service Center. All benefit changes are effective on the date of the event.		

How Changes Affect Your Benefits

Steps to Take If You Get Married

Notify the ORNL Benefits Office to update your retirement records if your name changes. In addition, make sure the ORNL Benefits Office knows of any address changes.

Notify the Social Security Administration of any name changes.

Change your benefit elections within 30 days of your marriage.

Update your life insurance beneficiary records by contacting the ORNL Benefits Service Center.

Update your Savings Plan beneficiary records by contacting the Savings Plan information line to request a beneficiary form. Keep in mind that if you have been married for at least 1 year and you want to designate someone other than your spouse as your beneficiary, you must have your spouse's written and notarized consent. Contact Schwab Retirement Services for more information.

Steps to Take If You Get Divorced

Notify the ORNL Benefits Office to update your retirement records if your name changes. Make sure the ORNL Benefits Office knows of any address changes.

Notify the Social Security Administration of any name changes.

You must change your benefit elections within 30 days of the date your divorce is final. A copy of the divorce decree is required when you drop coverage for your ex-spouse. You or your ex-spouse has 60 days to notify the ORNL Benefits Office to obtain COBRA benefits.

Refer to the "Administrative Information" chapter for more information.
Add your eligible dependents to your medical and dental coverage if a court establishes that you must provide coverage for dependent children and you are eligible for a plan that covers dependent children.

Update your life insurance beneficiary records by contacting the ORNL Benefits Service Center.

Update your Savings Plan beneficiary records by contacting the Savings Plan information line to request a beneficiary form.

Contact the ORNL Benefits Office if you think a court may issue a qualified domestic relations order (or "QDRO") granting your former spouse the right to receive any pension or savings benefits. You will be sent important information about the procedures and requirements for QDROs.

How Changes Affect Your Benefits (cont.)

Steps to Take If You Are Expecting or Adopting a Child

If You or Your Spouse is Pregnant …
Both men and women should contact the ORNL Benefits Office and ask about the steps you need to take and deadlines you need to meet to add your baby to your coverage. This will help you maximize your available benefits.

Schedule prenatal appointments.

Interview and choose a network pediatrician for your child to receive in-network benefits after your child is born. Well-child care and immunizations are covered only when you receive them from a network pediatrician. Your baby's first visit will be in the hospital after delivery, so consider choosing a pediatrician who has admitting privileges at your hospital to ensure that you receive in-network benefits for that visit.

For in-network coverage, your obstetrician/gynecologist will precertify your hospital or birthing center admission.

Present your medical ID card when you are admitted to the hospital or birthing center. You may have to pay your share of the hospital cost at admission.

For out-of-network coverage, you should call UnitedHealthcare to precertify your maternity admission. Refer to the back of your identification card for contact information.

If You Adopt a Child …
Interview and choose a pediatrician for your child from the provider directory to receive in-network benefits, including coverage for well-child care.

When Your Child Arrives

For Medical and Dental benefits: Enroll your newborn or newly adopted child within 30 days so your child's medical and dental expenses will be covered from the date of birth or adoption.

Complete your enrollment on the Benefits Enrollment website or call the ORNL Benefits Service Center at 1-800-211-3622.

You must provide a copy of the birth certificate or adoption papers when you enroll.

Steps to Take at Death

Upon your death, a family member should notify the ORNL Benefits Office. ORNL Benefits staff will assist your family members in completing the appropriate forms.

Steps to Take If You Lose a Spouse or Child

When you lose a spouse or child, you should notify the ORNL Benefits Office.

Change your medical and dental coverage within 30 days of the death, if coverage changes are appropriate.

Update your life insurance beneficiary records by contacting the ORNL Benefits Service Center.

Update your Savings Plan beneficiary records by contacting the Savings Plan information line to request a beneficiary form.

How Changes Affect Your Benefits (cont.)

Steps to Take If You or Your Spouse Is Admitted to a Long-Term Care Facility

When you or your spouse is admitted to a long-term care facility, contact the ORNL Benefits Office. Changes in your Medical or Prescription Drug Plan may be necessary.

What Happens to Your Benefits If You Die

Here is what happens to your benefits if you die:

Medical (Including Prescription Drug and Vision Care) and Dental
If your spouse is under age 65, he or she may continue medical coverage (including prescription drug and vision care) and/or dental coverage for himself or herself and other eligible dependents by paying the appropriate premiums.

Your spouse can continue this coverage until he or she reaches age 65. At age 65, your surviving spouse may transfer to the Over 65 Medicare Supplement Program, and your eligible dependents may continue their coverage through COBRA.

If, when you die, you do not have a spouse but have other eligible dependents, your eligible dependents may continue their coverage through COBRA.

Refer to the "Administrative Information" chapter for more information on COBRA.

Over 65 Medicare Supplement Program
If your spouse is age 65 or over, he or she may elect to remain in the plan, subject to plan qualifications and plan continuation.

Long-Term Care
Your spouse may continue his or her coverage by paying monthly premiums to the insurance company.

Life Insurance
Your beneficiary will receive a basic life insurance benefit and a supplemental life insurance benefit, depending on the coverage you were eligible for and elected.

Pension Plan
Your surviving spouse/beneficiary may receive a survivor benefit. The ORNL Benefits Office will contact your beneficiary to provide information about any plan benefits that may be payable.

Savings Plan
Your beneficiary will receive your full account balance in a lump sum. However, your spousal beneficiary may choose either a lump-sum payment or monthly installment payments over a 5 year period. Your spousal beneficiary may also elect to defer payment until the latest date permitted by the tax law.

When Coverage Begins

Your coverage will begin according to the chart on the following page, provided you meet the plan's eligibility requirements. With the exception of the Over 65 Medicare Supplement Program, any coverage you elect for your eligible dependents will begin on the same day your coverage begins. Over 65 Medicare Supplement Program coverage for your enrolled spouse will begin on the first of the month of your spouse's 65th birthday.

If you change your elections because of a qualifying life event, the changes will be effective on the date of the qualifying life event or as stated by individual plan rules, provided you contact the ORNL Benefits Service Center within 30 days of the event.

Benefit Plan	If You Are Eligible, Your Coverage Will Begin …
Medical (including Prescription Drugs and Vision Care)	**Retiree or spouse under age 65, retiree under age 65 with spouse over age 65:** If you had coverage immediately prior to retirement, coverage continues at retirement provided you elected to continue your coverage
Over 65 Medicare Supplement Program	**Retiree and spouse over age 65:** Coverage begins on your retirement date **Retiree under age 65:** Coverage begins the first day of the month of your 65th birthday. If your birthdate is the first day of the month, coverage begins on the first day of the previous month (per Medicare rules)
Dental MetLife or Delta Dental	**Retiree or spouse under age 65, retiree under age 65 with spouse over age 65:** If you had coverage immediately prior to retirement, coverage continues at retirement provided you elected to continue your coverage
Long-Term Care	**Retiree and spouse:** If you had coverage immediately prior to retirement, coverage continues at retirement provided you elected to continue your coverage
Basic Life Insurance	**Retiree only:** Coverage is based on your employment status and retirement date. See the Life Insurance chapter for the complete table of benefits
Supplemental Life Insurance	**Retiree only:** Coverage is based on your employment status and retirement date. See the Life Insurance chapter for the complete table of benefits
Savings Plan	**Retiree only:** Participation continues if you chose to defer receiving your account when you retired. You may not make contributions to the Savings Plan on or after your retirement date
Pension Plan	**Retiree only:** Plan benefits begin the first of the month after you retire unless you chose to defer your benefit. Employees who retire with less than full pension benefits can defer their benefit until they are eligible for a full benefit

When Coverage Ends

Coverage will end on the earliest of the following dates:

- the last day of the period for which your last contribution was made (if you fail to make any required contribution), except for the Savings and Pension Plans
- when you die

  or

- the date the plan is terminated.

If you have elected a joint and survivor form of payment, Pension Plan and Savings Plan benefit payments to your named survivor will continue after your death.

If you have not elected a joint and survivor form of payment:

- pension benefits will end the month of your death

  and

- Savings Plan benefits will be paid to your beneficiary.

Coverage for your dependents will end on the same day your coverage ends or on the day they are no longer considered eligible dependents, if earlier.

When your dependent child turns age 26, coverage for medical, dental, vision, and prescription drugs will end at the end of the month of their 26th birthday.

Your dependents may be eligible to extend medical (including prescription drugs and vision care) and dental coverage under COBRA when their coverage would otherwise end.

Administrative Information

See the “Administrative Information” chapter for more information about continuing coverage under COBRA.

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.

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 ...

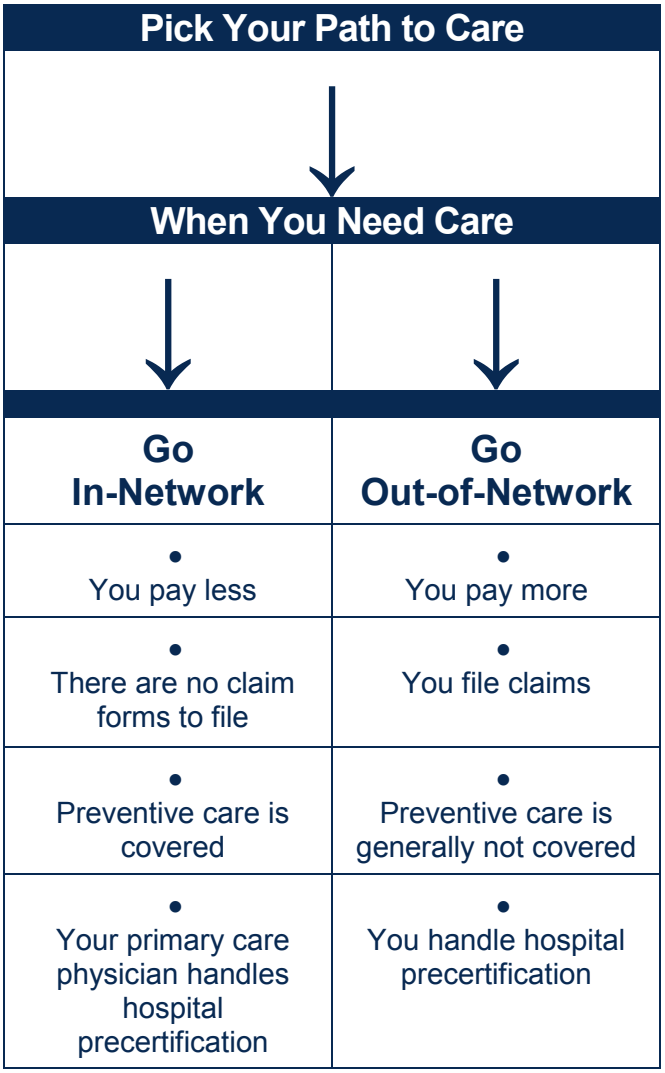
For more information about what happens to your Medical, Prescription Drug, and Vision coverage when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" chapter.

Prime Select and Consumer Choice with HSA Medical Plans Overview

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.



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.

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 negation 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

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	• 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: • 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 • Includes well-baby, well-child, well-woman, and adult preventive care • Includes routine immunizations	Plan pays 100%	Not covered
Preventive Screenings • 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 • Operating room, pharmacy, x-ray, laboratory services, and semiprivate room and board.	Plan pays 100% after $250 copay per admission *Hospital stays not deemed medically necessary will be disapproved.*	You pay 20% Plan pays 80% after the plan deductible is met *You must have all out-of-network inpatient hospitalizations and outpatient surgeries precertified through UnitedHealthcare. Failure to do so will result in denied claims.*
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 *All out-of-network outpatient surgeries must be precertified through UnitedHealthcare. Failure to do so will result in denied claims*

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 *20 days per calendar year for all conditions*	You pay 20% Plan pays 80% after the plan deductible is met *20 days per calendar year for all conditions*
	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.	
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% *Copay waived if admitted, then inpatient hospital charges would apply*	You pay a $75 copay, then Plan pays 100% *Out-of-network services are covered at the in-network rate*
Ambulance Services - Ground and Air Transport *Note: Non-emergency transportation requires prior authorization.*	Plan pays 100%	Plan pays 100% *Out-of-network services are covered at the in-network rate*
Urgent Care Facility *Out-of-network services are covered at the in-network rate*	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 • 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 • 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
	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.	
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	1. Physician's Office visit: Plan pays 100% after copay: • 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: • 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 • 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
	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.	
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 • 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

How the UnitedHealthcare Consumer Choice with HSA Plan Works

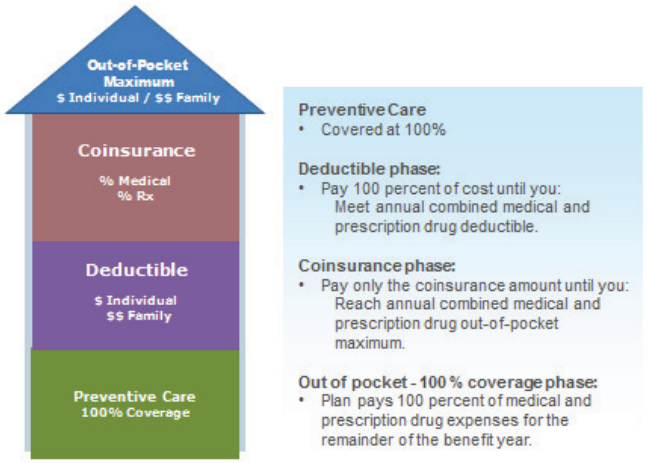
In-Network Benefits

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.

Under age 65 retirees enrolled in Consumer Choice with HSA may make contributions to their HSA account directly with Optum Bank (assuming they are otherwise HSA eligible) and may be eligible to deduct such contributions on their federal income tax returns. Pension payroll deductions are not an option.

If you are no longer enrolled in the Consumer Choice with HSA Medical Plan, you may no longer make contributions to the HSA account, although funds in the account may be used to pay for eligible medical expenses.

When you turn age 65 and enroll in the Over 65 Medicare Supplement Program, you may no longer make contributions to the HSA account, although funds in the account may be used to pay for eligible medical expenses.

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 insurance 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*)*
Annual Deductible • 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.	Individual coverage: $1,500 All other coverage levels: $3,000 *(Includes Medical and Prescription Drugs)*	Individual coverage: $2,500 All other coverage levels:$5,000 *(Includes Medical and Prescription Drugs)*
	***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.*	
Out-of-Pocket Annual Maximum • 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.	Individual coverage: $2,500 All other coverage levels: $5,000 *(Includes Medical and Prescription Drugs)*	Individual coverage: $5,000 All other coverage levels: $10,000 *(Includes Medical and Prescription Drugs)*
	*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 • 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 • Includes well-baby, well-child, well-woman, and adult preventive care • Includes routine immunizations	Plan pays 100%	Not covered
Preventive Screenings • 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 *Hospital stays not deemed medically necessary will be disapproved.*	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met *You must have all out-of-network inpatient hospitalizations and outpatient surgeries precertified through UnitedHealthcare. Failure to do so will result in denied claims.*
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 *You must have all outpatient surgeries precertified through UnitedHealthcare. Failure to do so will result in denied claims.*
Outpatient Professional Services • 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: 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 • 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 *Out-of-network services are covered at the in-network rate*
Ambulance Services - Ground and Air Transport *Note: Non-emergency transportation requires prior authorization.*	You pay 10% Plan pays 90% after the plan deductible is met	You pay 10% Plan pays 90% after the plan deductible is met *Out-of-network services are covered at the in-network rate*
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 *Out-of-network services are covered at the in-network rate*
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 • 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 *(Based on MRC*)*
Infertility Treatment: • 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.)	You pay 10% Plan pays 90% after the plan deductible is met *$20,000 lifetime maximum in-network and out-of-network combined. Lifetime maximum does not apply to diagnostic and planning services.*	You pay 30% Plan pays 70% after the plan deductible is met *$20,000 lifetime maximum in-network and out-of-network combined. Lifetime maximum does not apply to diagnostic and planning services.*
Durable Medical Equipment—Unlimited calendar year maximum	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
External Prosthetic Appliance (EPA)—Unlimited calendar year maximum. Requires approval by Health Plan; limited coverage applies	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
	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	
Hearing Aid Benefits	You pay 10% Plan pays 90% after the plan deductible is met $750 maximum per 36 consecutive months; no maximum for children up to age 18	Not covered
Bariatric Surgery • Subject to medical necessity and clinical guidelines • Treatment of clinically severe obesity, as defined by the body mass index (BMI)	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
	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.	
Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorder by an eligible provider	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 (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	• 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 • 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 • 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.

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—includes 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 • Surgery performed in the physician's office • Allergy Treatment/Injections • Maternity office visits	Plan pays 80% of MRC* after deductible
• Allergy Serum (dispensed by the physician in the office)	Plan pays 80% with no deductible
Preventive Care	
Preventive Health Services • Includes well-baby, well-child, well-woman, and adult preventive care • Includes routine immunizations	Plan pays 100% of MRC*
Preventive Screenings • 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 • 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 • 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 • MRIs, MRAs, CAT Scans, and PET scans	Plan pays 80% of MRC* after deductible
Emergency and Urgent Care Services	
1. Emergency Room 2. Ambulance Services 3. Emergency Care at Doctor's Office 4. Physician Services in Emergency Room 5. Urgent Care Facility 6. Convenience Care	1. Plan pays 80% of MRC* after deductible 2. Plan pays 100% of MRC* 3. Plan pays 100% of MRC* 4. Plan pays 80% of MRC* after deductible 5. Plan pays 80% of MRC* after deductible 6. 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 • 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

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.

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

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, acupressure, 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), anorgasmy, 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

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.

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.

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.

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.

Prescription Drug Plan

Your Prescription Drug benefits are included as part of your Medical Plan coverage and are designed to help you manage the costs of drugs prescribed by your health care provider for you and your family.

Highlights

Your Prescription Drug Benefits ...

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

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

- Call Express Scripts at 1-866-749-0097 for assistance with locating a network pharmacy. This number is listed on your Express Scripts identification (ID) card.
- No claim form is required when you use a network pharmacy. When you fill a prescription at an out-of-network pharmacy or file a direct claim, you might have to pay the out-of-network deductible and then your co-pay or coinsurance of the approved cost for up to a 30 day supply of most Prescription Drugs.
- Call Accredo at 1-800-803-2523 for your Specialty Medications.

… Offer a Convenient Home Delivery Option

The home delivery option, designed for maintenance drugs, provides up to a 90 day supply of a drug. You will pay the required co-payment or coinsurance. You can have your doctor send a 90 day prescription to Express Scripts electronically, or new prescriptions can be ordered by mail by completing an order form and mailing it with your prescription.

Mail:	Express Scripts Health Solutions of Fort Worth PO Box 650322 Dallas, TX 75265-0322
Fax:	Your doctor may fax your prescription to Express Scripts. Have your doctor call 1-888-327-9791 for information on how to fax to Express Scripts.
Internet Refills:	www.Express-Scripts.com
Telephone Refills:	1-800-473-3455. Have your ID card and your refill bottle with the prescription information ready.

How the Prescription Drug Benefit Works

Prescription Drug Benefits

Prescription Drug benefits are managed by Express Scripts.

Your out-of-pocket costs are based on one of three tiers: generic, brand preferred, and brand non-preferred.

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

The preferred drug formulary includes over 1,800 drugs that may cost less than the non-preferred drugs that are not included in the formulary.

For short-term prescriptions such as antibiotics, you may fill up to a 30 day supply at a retail pharmacy. For long-term or maintenance drugs, use the Express Scripts mail-order pharmacy to get up to a 90 day supply and typically pay less for your prescription.

Quantity Limits

Some prescriptions are subject to additional supply limits based on Express Scripts Pharmacy & Therapeutics Committee's recommendation. The limit may restrict the amount dispensed per prescription order or the amount dispensed per month's supply.

Prior Authorization

Certain prescription drugs may require a prior authorization to receive the prescription or full quantity that your doctor prescribes. If your drug requires this step, your doctor may need to provide additional information to Express Scripts before the drug may be covered under your insurance plan. These programs ensure that members get the right drug in the right dosage at the right time. They also encourage appropriate drug use and drug selection and support the plan's provision of coverage.

Express Scripts criteria and rules are determined by an independent Pharmacy & Therapeutics Committee composed of nationally recognized medical and clinical pharmacy experts.

Step Therapy: The Right Medication at the Right Cost

This program is designed for people who have certain conditions, like high cholesterol, that require them to take medications regularly.

Step Therapy is all about value and about getting the most effective medication for your money. Most simply, that means getting a tried-and-true medication that has proven safe and effective for your condition and getting it at the lowest possible cost.

Member Pays the Difference

This program encourages members to select less expensive generic equivalents when available. If you choose to stay on the brand name drug, whether doctor or patient requested, you will pay for the difference between the gross costs of the brand name drug and the generic drug, in addition to the generic copayment/coinsurance. If there is a clinical reason why you cannot take the generic drug, there is an Express Scripts appeal process for approval to pay only the brand name coinsurance.

Retail Refill Allowance

This program encourages members to use the mail-order pharmacy for maintenance drugs. You may receive up to three fills of the same maintenance drug at retail before having to move to the mail-order pharmacy. If you continue to purchase the maintenance prescription at retail, you will pay the total cost of the prescription. These charges will not apply towards the deductible or out-of-pocket maximum.

Extended Payment Program

This program allows you to pay for your mail-order medications in 3 monthly installments, or payments. Enrollment in the Extended Payment Program requires a credit or debit card. Flexible spending account cards or any other forms of payment are not acceptable for this program.

If you order several prescriptions at the same time, you may not get all of your medications together with one invoice. Your credit or debit card will be charged only when each medication ships.

How the Prescription Drug Benefit Works (cont.)

Expedited shipping costs cannot be paid in installments. If you select expedited shipping for your order, the total shipping cost will be billed with your first payment.

You may disenroll from the Extended Payment Program at any time; however, any remaining balance under the program must be paid in full before your disenrollment can be completed.

Automatic Refills

This program gives you the peace of mind of knowing Express Scripts takes care of refilling your eligible prescriptions and sends your medicine to you before you run out.

Express Scripts reminds you about two weeks before it begins processing your refills. The reminder lets you make any updates to your delivery date, shipping address, or other details. If you prefer to see your full medicine name in your reminder, make sure you have your medication names turned on in your communication preference settings found in "My Account."

Because doctors write most long-term medicine prescriptions for one year only, Express Scripts also takes care of calling your doctor when it's time to renew your prescription. However, your doctor might change your dose or medicine at an annual checkup, so you can always contact Express Scripts if you need to let them know about any changes.

Certain drugs aren't eligible for automatic refills. Examples of medicine Express Scripts can't automatically refill include controlled substances, over-the-counter medicines, medicines used as needed for acute conditions, and specialty drugs used to treat complex conditions.

Specialty Medications

Express Scripts manages specialty medicine coverage through a pharmacy called Accredo. If your doctor prescribes a specialty medicine, call Accredo at 1-800-803-2523 to confirm your coverage and buy your medicine directly through Accredo.

You will pay the full retail cost for any specialty medicine you don't buy through Accredo. If you buy your specialty medicine at a retail pharmacy, you'll need to show your regular prescription plan ID card. The pharmacist will receive a message indicating the drug is not covered at a retail pharmacy, along with instructions for you to contact Accredo. If you complete the prescription fill at a retail pharmacy, you will be responsible for 100% of the pharmacy cost for that medicine—and it will not apply to your deductible and out-of-pocket maximum.

Copayment/Patient Assistance Programs and Accredo

If you qualify for a copayment/patient assistance for your specialty medication, the assistance from these programs is not applied toward your deductible or your out-of-pocket maximum. Only your actual out-of-pocket expenses will apply towards your deductible and out-of-pocket maximum accumulators.

Example under Prime Select:

Cost of medication	$3500
Copayment Assistance	$2500
Copayment	$200
Plan Pays	$800
Applied to Out-of-Pocket	$200

Example under Consumer Choice
Assumes the Deductible has not been met:

Cost of medication	$3500
Copayment Assistance	$2500
Deductible	$1000
Plan Pays	$0
Applied to Out-of-Pocket	$1000

Preventive Care Drugs

The Affordable Care Act requires non-grandfathered plans to cover certain preventive items and services at a zero dollar cost share to their members. Express Scripts has developed a standard list of the required preventive medications having an "A" or "B" rating based on the recommendations of the US Preventive Services Task Force (USPSTF). These items and services are covered at no cost to the member by ensuring that no deductible or other cost sharing is applied.

How the Prescription Drug Benefit Works (cont.)

The list is subject to change based on USPSTF recommendations. Drug categories required to be covered by the USPSTF include:

- Aspirin
- Oral Fluoride
- Folic Acid
- Immunizations
- Tobacco Cessation
- Vitamin D
- Bowel Preps
- Breast Cancer Prevention
- Contraceptives
- Statins

Infertility Drug Coverage

Infertility drugs are not covered under the Prime Select health insurance plan.

Administrative Information

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

What happens to your benefits when ...

For more information about what happens to your Prescription Drug benefits when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

Summary of Benefits

Prescription Drugs, Provided by Express Scripts				
Covered Services	**Consumer Choice with HSA In-Network**	**Prime Select In-Network**	**Consumer Choice with HSA Out-of-Network**	**Prime Select Out-of-Network**
Retail Prescription Drugs (Up to a 30 day supply)	Member pays 100% until meets overall plan deductible of $1,500 individual/$3,000 all other coverage levels Then 20% coinsurance Generic: 20% (minimum $10/ maximum $75) after deductible Preferred Brand: 20% (minimum $25/maximum $150) after deductible Non-Preferred Brand: 20% (minimum $40/maximum $250) after deductible If actual cost is under the minimum, you pay actual cost	Generic: $5 co-pay Preferred Brand: 30% coinsurance (minimum $20/maximum $100) Non-preferred Brand: 30% coinsurance (minimum $40/ maximum $200) If actual cost is under the minimum, you pay actual cost	50% after plan deductible is met	80% after $200 pharmacy deductible
Mail Order—Home Delivery (Up to a 90 day supply)	Member pays 100% until meets overall plan deductible of $1,500 individual/$3,000 all other coverage levels Then 20% coinsurance Generic: 20% (minimum $20/ maximum $150) after deductible Preferred Brand: 20% (minimum $60/maximum $300) after deductible Non-Preferred Brand: 20% (minimum $100/maximum $500) after deductible Specialty Medications: 20% (minimum $60/maximum $300) after deductible If actual cost is under the minimum, you pay actual cost	Generic: $12 co-pay Preferred Brand: 30% coinsurance (minimum $50/maximum $200) Non-preferred Brand: 30% coinsurance (minimum $100/ maximum $400) Specialty Medications: 30% coinsurance (minimum $50/maximum $200) If actual cost is under the minimum, you pay actual cost	Not covered	Not covered

Summary of Benefits (cont.)

Examples of Prescription Drug costs		
CONSUMER CHOICE with HSA: Retail Brand Preferred Coinsurance Examples		
Drug Cost	**20% Coinsurance**	**Member Pays**
$60	$12	$25 (minimum payment)
$150	$30	$30 (20% of covered cost)
$800	$160	$150 (maximum payment)
PRIME SELECT: Retail Brand Preferred Coinsurance Examples		
Drug Cost	**30% Coinsurance**	**Member Pays**
$60	$18	$20 (minimum payment)
$150	$45	$45 (30% of covered cost)
$400	$120	$100 (maximum payment)

Other Important Information

Prescription Drug Claims Review and Appeal Procedures

Claims and appeal for benefit coverage claims

Urgent Care Claims (Expedited Reviews)

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don't provide the needed information within the 48 hour period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 800-753-2851.

Other Important Information (cont.)

In addition, you also may have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo, or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Other Prescription Drug Claims (Pre-Service and Post-Service)

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. A post-service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45 day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45 day period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you are not satisfied with the decision on your claim (or if your claim is deemed denied), you have the right to appeal as described below.

Appeals Procedure

The plan has a two-step appeals procedure for coverage decisions. If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered "deemed" denied because missing information was not submitted in a timely manner), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

Level-One Appeal

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims.

Other Important Information (cont.)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not submitted in a timely manner) if your situation is urgent. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call 1-800-753-2851 or fax the request to 1-888-235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim.

If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond before issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life, health, or ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or if you do not agree with the determination of the external review organization, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes; and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings, which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

Level-Two Appeal

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second-level appeal. A second-level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second-level appeal, provide in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts,
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

Other Important Information (cont.)

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; and a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second-level appeal; and the right to present evidence and testimony as part of your appeal.

You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If new information is received and considered or relied upon in the review of your second-level appeal, such information will be provided to you together with an opportunity to respond before issuance to any final adverse determination of this appeal. The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under ERISA, you have the right to bring a civil action under ERISA Section 502(a).

In addition, for cases involving medical judgment or rescission, if your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under ERISA, you have the right to an independent review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedure

The right to an independent external review is available only for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal before, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.) Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Other Important Information (cont.)

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision.

If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review, and you have the right to bring civil action under ERISA Section 502(a).

Urgent External Review

Once you have submitted your urgent external review request, your claim will be reviewed immediately to determine if you are eligible for an urgent external review. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will be reviewed immediately to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a).

Direct Reimbursement Claims and Appeals

Your plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase. The claim will be processed based on your plan benefit.

To request reimbursement, send your claim to:

Express Scripts
PO Box 14711
Lexington, KY 40512

You will be notified of the decision within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

If your claim does not provide sufficient information for the claim to be processed, you will be notified that more information is needed within 30 days of receipt of the claim. If your claim provides sufficient information to determine the last day that your plan allows you to submit the claim for reimbursement (i.e., plan's stale date), then you will be notified that more information is needed and you will have until that date to submit the missing information. If you do not submit the information by the required date, your claim is deemed denied and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your claim is missing information, and without the information, the claim's stale date cannot be determined, your claim will be denied and you have the right to appeal the decision as described below.

Other Important Information (cont.)

If your claim is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim.

If you are not satisfied with the decision on your claim or if your claim is deemed denied, you have the right to appeal this decision. See below for appeal instructions.

Appeals Procedure

To appeal a denied claim or a claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal, including missing information

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; the plan provisions on which the decision is based; a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes; and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings, which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If you are not satisfied with the decision made on the appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second-level appeal. A second-level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second-level appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the

plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable external review processes; and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second-level appeal; and the right to present evidence and testimony as part of your appeal.

You also have the right to request the diagnosis code and treatment code and their corresponding meanings, which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim). If new information is received and considered or relied upon in the review of your second-level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under ERISA, you may have the right to an independent review by an external review organization if the case involves medical judgment or rescission. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedures

The right to an independent external review is available only for claims involving medical judgment or rescission. You can request an external review by an IRO as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.) Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA Section 502(a).

Vision Care

Your Vision Care benefits are designed to provide you and your family with coverage for routine eye care.

Highlights

Your Benefits …

… Provide Vision Care Regardless of the Medical Plan You Select

Vision Care benefits provided by Vision Service Plan (VSP) are the same under each Medical Plan option. You are covered automatically for vision benefits when you enroll in a Medical Plan.

… Offer Coverage for Both You and Your Eligible Dependents

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

How Vision Service Plan Works

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

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 the Summary of Benefits for a summary of the co-payments, deductibles, coinsurance, and related limits under the plan.

Administrative Information

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

What happens to your benefits when ...

For more information about what happens to your Vision Care benefits when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

Summary of Benefits

Provided by VSP through the VSP Choice Network		
Covered Services	**In-Network**	**Out-of-Network**
Vision Services	No charge for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal, or polycarbonate (for dependent children) Frames allowance of up to $120 plus 20% off excess of $120 every 24 months; **OR** Contact lens every 12 months covered up to $120 allowance; allowance applies to cost of contacts. Contact lens exam (evaluation and fitting fee) subject to nor more than $60 patient copay.	Allowance of up to: • Exam: $45 • Single vision: $30 • Bifocals: $50 • Trifocals: $65 • Frames: $70 **OR** • Elective contacts: $105
Lens Enhancements	20–25% discount on lens enhancements and upgrades	
Additional Discounts	20% discount on additional prescription glasses and sunglasses including lens enhancements from any VSP provider within 12 months of your last eye exam. Laser vision correction services at reduced cost through VSP network doctors and contracted laser surgery centers	

Necessary Contact Lenses

Necessary contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are required for Covered Person to be eligible for necessary contact lenses.

- In-Network Provider Benefit—Professional fees and materials covered in full
- Out-of-Network Provider Benefit—Professional fees and materials covered up to $210

Low Vision Benefit

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

- In-Network Provider Benefit—Supplementary testing covered in full
- Out-of-Network Provider Benefit—Supplementary testing covered up to $125
- In-Network Provider Benefit—Supplemental care aids covered 75% of cost
- Out-of-Network Provider Benefit—Supplemental care aids covered 75% of cost

Benefit maximum available is $1,000 every two years.

Out-of-Network Provider Benefit

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and co-payment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% co-payment feature.

Summary of Benefits (cont.)

Diabetic Eyecare Benefit

The VSP Diabetic Eyecare Program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration including medical follow-up exams, visual fields and acuity tests, specialized screenings and diagnostic tests, diagnostic imaging of the retina and optic nerve, and retinal screening for eligible members with diabetes. The program provides secondary coverage to your medical plan's primary coverage for non-surgical medical eye conditions at participating VSP Providers. Members can self-refer, visit their VSP Provider as often as needed, and pay a $20 copay for services.

TruHearing Hearing Aid Discount Program

VSP members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too. Contact TruHearing at 877-396-7194 and mention that you are a VSP member. They will schedule an appointment with a local provider. For more information, contact TruHearing or visit their website at truhearing.com/vsp.

Other Important Information

Vision Services Claims Review and Appeal Procedures

Your Provider Submits a Claim

You pay your provider any applicable co-pays, taxes, and any amount over the coverage allotment. Your provider then submits a claim to VSP, and VSP pays the provider directly for your services and eyewear. Not all providers will submit a claim to VSP; ask the provider before you receive services.

Out-of-Network Claims Procedures

When you see a provider other than a VSP doctor, you must submit a claim to VSP for reimbursement. You have 6 months from the date of service to submit a claim for reimbursement. There are two ways to submit a claim to VSP.

Submitting a Claim

You can submit a claim online by logging on to www.vsp.com and clicking on "file a claim to request reimbursement" on the home page. Complete the form, scan receipts, and submit the claim.

Pay the provider in full for services and eyewear received, including taxes. Submit your receipt with an itemized list of services and eyewear using the VSP Member Reimbursement Form. VSP then reimburses you the allotted amount based on your coverage. Log on to www.vsp.com to access the form. For questions about submitting a claim, contact Member Services or call VSP at 800-877-7195.

Mail the completed claim, including form and receipts, to:

VSP
PO Box 385018
Birmingham, AL 35238-5018

Claim Denial Appeals

If, under the terms of this plan, a claim is denied in whole or in part, a request may be submitted to VSP by the Covered Person or Covered Person's authorized representative for a full review of the denial. The Covered Person may designate any person, including his/her provider, as the authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Other Important Information (cont.)

Initial Appeal

The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP enrollee's name, the VSP enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services, and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person also may submit written comments or supporting documentation concerning the claim to assist in VSP's review. Mail the appeal to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

Denied Claims for Services Rendered: within 30 calendar days after receipt of a request for an appeal from the Covered Person.

Second-Level Appeal

If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second-level appeal. Within 60 calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies

When the Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or Group should advise the Covered Person to contact the US Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of the Employee Retirement Income Security Act of 1974 [Section 502(a)(1)(B)] [29 U.S.C. 1132(a)(l)(B)], the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

Time of Action

No action in law or in equity shall be brought to recover on the plan prior to the Covered Person exhausting his grievance rights as described above and/or prior to the expiration of 60 days after the claim and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of 6 years from the last date that the claim and any applicable invoices may be submitted to VSP, in accordance with the terms of this plan.

Over 65 Medicare Supplement Program

If you have Medicare Part A and Part B coverage and you do not have other Part D prescription drug coverage, the Over 65 Medicare Supplement Program is available to you. This program provides an additional level of protection for hospital and medical expenses after Medicare pays.

The program includes prescription drug coverage and a Health Reimbursement Arrangement. An outside vendor, Via Benefits, also makes Medicare Supplement Plans through a Medicare Exchange available to retirees of the Company.

Highlights

Your Over 65 Medicare Supplement Program Benefits …

… Are Available to Retirees and Eligible Spouses Who are at Least Age 65 and are Covered Under Medicare Part A and Part B, *but not Other Part D*.

… Provide Prescription Drug Coverage that Exceeds the Level of Coverage Provided by Medicare Part D

… Provide Assistance with the Cost of Health Care Expenses through a Health Reimbursement Arrangement (HRA)

What happens to your benefits when ...

For more information about what happens to your Over 65 Medicare Supplement Program coverage when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

How the Over 65 Medicare Supplement Program Works

Via Benefits, an outside vendor that is not affiliated with the Company, offers a Medicare Exchange to assist retirees with selecting individual health coverage in the Medicare market. The Company only makes this exchange available to retirees and in no way sponsors or promotes the individual plans sold on the Via Benefits Medicare Exchange. A licensed benefit advisor with Via Benefits is available to help you evaluate options and enroll in individual coverage that fits your health, dental, and vision needs. Cost is dependent on the plan(s) you select. You will pay premiums directly to the insurance provider(s).

When you enroll in a Medicare supplement plan through Via Benefits, the Company will provide a comprehensive group prescription drug plan so you will not experience a gap—known as the "donut hole"—in drug coverage that is part of Medicare Part D plans.

In addition, if eligible, the Company will assist with the cost of health care expenses by providing benefit dollars through a Health Reimbursement Arrangement (HRA) that can be used to reimburse health care expenses, including insurance premiums and other eligible out-of-pocket health care expenses.

Medicare Part A and Part B benefits are primary to any of the individual plans that you may choose in the Via Benefits Medicare Exchange for Medicare-eligible retirees and their eligible dependents. This means Medicare pays benefits first. Then the individual plan you purchased may pay eligible expenses that are more than the amount payable for the same medical expenses under Medicare Part A or Part B.

You must enroll when first eligible, and maintain coverage, under both Medicare Part A and Part B to be eligible for coverage in this program.

If you enroll in a Medicare Part D prescription drug plan other than the ORNL Prescription Drug Plan, your Health Reimbursement Arrangement and prescription drug coverage under this program will be cancelled, and you cannot re-enroll later. These eligibility rules apply to retirees and to eligible spouses of retirees.

If you or your spouse cancels coverage or loses coverage for any reason (including enrolling in Medicare Part D), there is no future opportunity to re-enroll in this plan.

In order for a spouse to participate in this plan, the retiree must participate. A surviving spouse may be able to participate in the plan if enrolled or eligible to enroll prior to the retiree's death.

You must elect coverage when you are first eligible. If you do not, or if you elect and later cancel coverage, neither you nor your spouse can later enroll or re-enroll.

More information about Eligibility is found in the chapter titled "About Your Benefits."

Your Prescription Drug Benefits ...

… Provides Comprehensive Drug Coverage

Your plan combines coverage through the Medicare Part D program with Company-provided additional coverage. This added coverage lowers the cost you pay for your prescriptions and provides coverage for drugs that are not on the Medicare Part D formulary.

… Allows You the Flexibility to Use a Network Pharmacy or any Pharmacy You Choose

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

- Call Express Scripts at 1-877-701-9946 for assistance with locating a network pharmacy. This number is listed on your Express Scripts ID card.

… Offers a Convenient Home Delivery Option

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

- *Mail to:* Express Scripts
  PO Box 30493
  Tampa, FL 33633-0561
- *Fax:* Have your doctor call 1-888-327-9791 for information on how to fax to Express Scripts.
- *Internet Refills:* www.express-scripts.com
- *Telephone Refills:* 1-877-701-9946
  - Have your ID card and refill bottle with the prescription information ready.

ORNL Prescription Drug Plan, Administered by Express Scripts

You may have to pay an additional income-related adjustment if you meet certain income criteria as determined by Centers for Medicare & Medicaid Services (CMS). See www.CMS.gov for more information.

Deductible stage	• You pay a $150 yearly deductible for prescriptions filled at retail pharmacies. • Prescriptions filled by mail are not subject to a deductible. • After you pay your yearly retail-only deductible, you will pay the following:		
Tier Name	**Retail Final Cost-Share (31 day supply)**	**Retail Final Cost-Share (90 day supply)**	**Mail-Order Final Cost-Share (90 day supply)**
Tier 1: Generic Drugs	20% coinsurance $10 minimum	20% coinsurance $30 minimum	$15 copayment
Tier 2: Preferred Brand Drugs	30% coinsurance $10 minimum	30% coinsurance $30 minimum	$35 copayment
Tier 3: Non-Preferred Brand Drugs	30% coinsurance $10 minimum	30% coinsurance $30 minimum	$35 copayment

Health Reimbursement Arrangement

The purpose of the HRA Plan is to reimburse Participants for Eligible Medical Expenses which are not otherwise reimbursed by any other plan or program.

An HRA Account is a bookkeeping account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Company's general assets.

HRA Account and Benefit Credits

A joint HRA Account will be established for the eligible retiree and eligible spouse. Benefit credits will be credited to your HRA account by the Company at the beginning of each Plan Year. You will receive an HRA credit each Plan Year that you are a Participant. You also will receive an additional HRA credit each Plan Year that your spouse is a Participant. The amount of the HRA credit is determined by the Company.

If an eligible retiree and/or spouse becomes eligible to participate in the HRA Plan after the beginning of a Plan Year, the individual's HRA credit will be prorated based on the number of months that the individual is a Participant in the HRA Plan.

At any time, the Participant may receive reimbursement for eligible medical expenses up to the amount in his or her HRA Account. The account will be reduced by the amount of any eligible medical expenses for which you are reimbursed under the HRA Plan.

Note that the law does not permit Participants to make any contributions to their HRA Accounts. If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years.

Casual Retiree

If you become a Casual Retiree, access to your HRA will be suspended during the period that you have Casual Retiree status. Furthermore, your spouse, if applicable, will not be able to access the account. Neither you nor your spouse will be reimbursed for any eligible expenses incurred during the time that you are a Casual Retiree. Access to your HRA will be reinstated when you return to full Retiree status. You will not receive any benefit credits for the period that you are a Casual Retiree. In the year that you return to full Retiree status, benefit credits will be prorated for the remainder of the Plan Year as of the date you return to Retiree status, unless you already received a full credit for that year from being a full Retiree as of the first of the Plan Year. Even upon reinstatement, you will not be able to submit reimbursements for eligible expenses incurred while you were a Casual Retiree.

Taxation

Reimbursements for eligible medical expenses paid by the HRA Plan generally are excludable from the Participant's taxable income. However, the Company cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Eligible Medical Expenses

An "eligible medical expense" is an expense incurred by you or your covered spouse for medical care, as that term is defined in IRC Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease). Some common examples of eligible medical expenses include:

- Medications (in reasonable quantities), but only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin;
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision, or long-term care insurance.

Health Reimbursement Arrangement (cont.)

For more information about what items are and are not eligible medical expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." Be careful in relying on this publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account. If you need more information regarding whether an expense is an eligible medical expense under the Plan, contact the Third Party Administrator.

Some examples of common items that are *not* eligible medical expenses include the following:

- Babysitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

Only eligible medical expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only eligible medical expenses incurred while your spouse is a Participant in the Plan may be reimbursed from the HRA Account.

Eligible medical expenses are "incurred" when the medical care is provided, not when you or your Spouse is billed, is charged, or pays for the expense. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may *not* be reimbursed from an HRA Account:

- Expenses incurred for qualified long-term care services;
- Expenses incurred *prior to the date* that you became a Participant in the HRA Plan;
- Expenses incurred *after the date* that you cease to be a Participant in the HRA Plan; and
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

What Happens Upon Your Death

If you die with no spouse who is a Participant, your HRA Account is immediately forfeited upon death, but your estate or representatives may submit claims for eligible medical expenses incurred by you before your death. Claims must be submitted within 180 days of your death. If you die with a spouse who is a Participant, your HRA Account shall continue, and your spouse can continue to submit his or her eligible medical expenses for reimbursement after your death.

At the later of the eligible retiree's or spouse's death, the HRA Account is immediately forfeited, but the deceased eligible retiree's or spouse's estate or representatives may submit claims for eligible medical expenses incurred by the eligible retiree or spouse before his or her death. Claims must be submitted within 180 days of his or her death.

Continuation of Coverage

Your covered spouse may continue HRA coverage for a limited time after that date he or she would otherwise lose coverage because of a divorce from the participant. Refer to COBRA in the "Administrative Information" chapter.

Other Important Information

Prescription Drug Claims Review and Appeal Procedures

Claims and appeal for benefit coverage claims

Urgent Care Claims (Expedited Reviews)

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 800-753-2851. In addition, you also may have the right to request a written translation of your letter if 10 % or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo, or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Other Prescription Drug Claims (Pre-Service and Post-Service)

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. A post-service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45 day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

Other Important Information (cont.)

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that may be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Appeals Procedure

The plan has a two-step appeals procedure for coverage decisions. If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered "deemed" denied because missing information was not submitted in a timely manner), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

Level-One Appeal

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims.

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not submitted in a timely manner) if your situation is urgent. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call 1-800-753-2851 or fax the request to 1-888-235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim.

If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond before issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

Other Important Information (cont.)

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or if you do not agree with the determination of the external review organization, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes; and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings, which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim

Level-Two Appeal

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician).

To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any considered by the plan in relation to your appeal; the plan provisions on which the decision is based; and a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal; and the right to present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond before issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

Other Important Information (cont.)

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to bring a civil action under ERISA Section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under ERISA, you have the right to an independent review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and also are described below.

External Review Procedure

The right to an independent external review is available only for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions) generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal before, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.)

Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within one business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO also will be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and that you have the right to bring civil action under ERISA Section 502(a).

Other Important Information (cont.)

Urgent External Review

Once you have submitted your urgent external review request, your claim will be reviewed immediately to determine if you are eligible for an urgent external review. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will be reviewed immediately to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a).

Direct Reimbursement Claims and Appeals

Your plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase. The claim will be processed based on your plan benefit. To request reimbursement, send your claim to:

Express Scripts
PO Box 14711
Lexington, KY 40512

You will be notified of the decision within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

If your claim does not provide sufficient information for the claim to be processed, you will be notified that more information is needed within 30 days of receipt of the claim. If your claim provides sufficient information to determine the last day that your plan allows you to submit the claim for reimbursement (i.e., plan's stale date), then you will be notified that more information is needed, and you will have until that date to submit the missing information. If you do not submit the information by the required date, your claim is deemed denied, and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your claim is missing information, and without the information the claim's stale date cannot be determined, your claim will be denied, and you will have the right to appeal the decision as described below

If your claim is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim.

If you are not satisfied with the decision on your claim or if your claim is deemed denied, you have the right to appeal this decision. See below for appeal instructions.

Appeals Procedure

To appeal a denied claim or a claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal including missing information

Other Important Information (cont.)

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If you are not satisfied with the decision made on the appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable external review processes; and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal; and the right to present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or if your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you may have the right to an independent review by an external review organization if the case involves medical judgment or rescission. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and also are described below.

Other Important Information (cont.)

External Review Procedures

The right to an independent external review is available only for claims involving medical judgment or rescission. You can request an external review by an IRO as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.) Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and that you have the right to bring civil action under ERISA Section 502(a).

HRA Claims Procedures

Only medical care expenses that have not been or will not be reimbursed by any other source may be considered eligible medical expenses (to the extent all other conditions for eligible medical expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to the HRA Plan for reimbursement.

You may use your HRA account for automatic reimbursement of your Medicare supplement premium payments. Contact Via Benefits to set up this option.

Via Benefits is the Claims Administrator for the HRA. You may submit claims for reimbursement online, by fax, or through the mail. When you submit a claim, you must provide supporting documents such as a copy of your insurance premium bill and an “explanation of benefits” or “EOB,” or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from Via Benefits. Your claim is deemed filed when it is received by Via Benefits.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by Via Benefits.

Other Important Information (cont.)

If it is later determined that you or your spouse received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your spouse will be required to refund the overpayment or erroneous reimbursement to the Company.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after Via Benefits receives your claim. If Via Benefits determines that an extension of this time period is necessary due to matters beyond the control of the Plan, they will notify you within the initial 30 day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the HRA provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the HRA's appeal procedures and the time limits applicable to such procedures;
- a description of your right to request all documentation relevant to your claim; and
- a statement of your right to bring an external review and/or civil action under ERISA Section 502(a) following a denied appeal.

Appeals Procedure

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of Via Benefits, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by Via Benefits.

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law. You must submit a written request for external review to the Plan Administrator within 4 months of the notice of the internal appeal determination. You may submit additional information that you think is important for review.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Medicare Supplement Plan Claims

Any plans you purchase from the Via Benefits Medicare Exchange are individual insurance policies. The Company has no involvement in the claims or appeals process for these individual plans. Please contact your insurance carrier to determine how and when you must submit claims or make an appeal.

Dental Plans

You have two Dental Plans to choose from—the Metropolitan Life Insurance Plan (MetLife) and the Delta Dental Plan of Ohio (Delta Dental). You may elect either plan, but not both.

The Dental Plans pay benefits to you and your covered dependents for a wide range of dental services and supplies, including preventive, diagnostic, restorative, prosthodontic, and orthodontic care.

Highlights

Your Dental Plans …

... Encourage Preventive Care

The Dental Plans promote regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings, and X-rays, at 100% of reasonable and customary charges with no deductible.

... Offer Protection for More Extensive Treatment

Oral surgery and restorative and prosthodontic services are covered after you meet the annual deductible.

... Provide Orthodontic Benefits for Your Children

Coverage for orthodontic treatment is available for your eligible dependent children under age 26.

What Happens to Your Benefits When ...

For more information about eligibility and what happens to your dental benefits when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

For more information about coverage you and your eligible dependents may be eligible to continue in certain cases when coverage would otherwise end, refer to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in the “Administrative Information” chapter.

Some Facts to Remember About Your Dental Plans ...

- Dependents in military service are not eligible for dental coverage.
- Dental coverage may not be converted to individual coverage.
- This information is a summary of the dental benefits under the plans. Should there be a conflict between the summary and the group contract, the group contract will control.
- A predetermination of benefits is recommended for costs that are expected to exceed $100.

Administrative Information

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

MetLife Dental Plan

MetLife Dental Plan

How the MetLife Dental Plan Works

You select and schedule an appointment with the provider of your choice. You are not required to use a network provider. There is a difference in how network providers and non-network providers bill for their services.

Network Provider

MetLife has a Preferred Dentist Program (PDP Plus) network. Participating dentists agree to accept a discounted fee schedule as full payment for covered service. You will not be billed for any covered charges that are greater than the contracted fee schedule if you use a PDP provider.

Non-Network Provider

If you use a provider that is not part of the contracted PDP Plus network, the plan pays benefits toward covered dental expenses on the basis of “reasonable and customary charges.”

If you incur charges that exceed what is considered reasonable and customary, the plan covers the reasonable and customary charge, and you are responsible for paying the balance. Charges beyond reasonable and customary will not count toward the deductible.

Briefly, the plan covers four types of dental services:

- Type A—Preventive and diagnostic services
- Type B—Oral surgery and restorative services
- Type C—Prosthodontic services
- Type D—Orthodontic services

The plan pays different benefits for each of these types of coverage—with one annual deductible required for Type B and Type C services only.

Annual Deductible

You and each covered dependent must satisfy a $50 individual deductible each calendar year before benefits become payable toward Type B (oral surgery and restorative) services and Type C (prosthodontic) services covered by the plan. The deductible does not apply to Type A (preventive and diagnostic) or Type D (orthodontic) services.

Maximum Benefits

The plan pays up to a maximum of $1,500 per year for each covered person for Type A, Type B, and Type C expenses combined. For Type D (orthodontic) services, there is a separate lifetime maximum of $1,500 in benefits for each covered person.

MetLife Dental Plan

Summary of Benefits

Refer to the "Covered Expenses" section, provided on the following page, for details.

Services Covered	Amount of Coverage Per Member*
Calendar Year Maximum	$1,500
Lifetime Orthodontic Maximum	$1,500
Lifetime Maximum	NA
Annual Deductible (applies to Type B and Type C services)	$50 per member

Services Covered	Amount of Coverage Per Member*
TYPE A—Preventive and Diagnostic Services	Covered 100%
• Oral Examinations	Two in a calendar year
• Prophylaxis (cleanings)	Two in a calendar year
• Periodontal Maintenance	If approved, treatment is covered in addition to routine oral exams
• Full Mouth X-rays	Once every 24 months
• Bite-wing X-rays	Two in a calendar year
• Fluoride	Under age 19, two in a calendar year
• Space Maintainers	No age limit
TYPE B—Oral Surgery and Restorative Services • Restorative (fillings, including composites on posterior teeth • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics • Endodontics (root canal therapy)	Covered 80% after deductible
• Sealants	Covered 80% after deductible, under age 16; chewing surfaces for permanent first and second molars only—one benefit per tooth
TYPE C—Prosthodontic Services	Covered 50% after deductible
• Crowns, Inlays, and Onlays (includes porcelain crowns on molar teeth) • Bridges, Partial Dentures, and Full Dentures	Covered once every 60 months, no age limit
• Implants (Subject to Benefit Consultant Review)	Covered once every 60 months per tooth

MetLife Dental Plan

Summary of Benefits (cont.)

Refer to the "Covered Expenses" section, provided on the following page, for details.

Services Covered	Amount of Coverage Per Member*
TYPE D—Orthodontic Services for dependents up to age 26: • Braces, surgical repositioning to correct malocclusion, surgical extractions, x-rays, retention checking	$300 initial payment and $49.50 for each month following (paid quarterly) up to the lifetime orthodontic maximum

*Reasonable and customary charges apply for non-network providers. The PDP network fee schedule applies for PDP providers.

Covered Expenses

Type A—Preventive and Diagnostic Services

The Dental Plan pays 100% of covered expenses for Type A (preventive and diagnostic) services, with no deductible required.

Covered expenses for preventive and diagnostic services include reasonable and customary charges for:

- oral examinations (two in a calendar year)
- cleaning and scaling of teeth (two in a calendar year)
- bitewing x-rays (two in a calendar year)
- full mouth x-rays (one set every 24 months)
- topical fluoride applications for children under age 19 (two in a calendar year)
- space maintainers
- emergency treatment

Type B—Oral Surgery and Restorative Services

After the deductible has been satisfied, the plan pays 80% of covered expenses for Type B (oral surgery and restorative) services.

Covered expenses for oral surgery and restorative services include reasonable and customary charges for:

- amalgam fillings
- composite fillings on teeth
- treatment of gum disease (periodontics)
- endodontic treatment, including root canal services
- extractions (except in connection with orthodontic treatment)
- oral surgery
- general anesthesia when determined necessary under the plan's dental provisions
- repair or re-cementing of crowns, inlays, onlays, dentures, or bridgework

Type C—Prosthodontic Services

After the deductible has been satisfied, the plan pays 50% of covered expenses for Type C (prosthodontic) services.

Covered expenses for prosthodontic services include reasonable and customary charges for:

- inlays, onlays, crowns (including porcelain crowns on molar teeth), and gold fillings
- fixed bridgework installed for the first time to replace missing natural teeth, including inlays and crowns as abutments, but excluding periodontal splinting, once in 60 months

MetLife Dental Plan

Covered Expenses (cont.)

- full or partial dentures installed for the first time to replace missing natural teeth and adjacent structures and any adjustments required during the 6 month period following installation, once in 60 months
- implants—once in 60 months per tooth, subject to benefit consultant review
- replacement or modifications of dentures or bridgework if required:
  - to replace one or more teeth extracted after the existing denture or bridgework was installed
  - to replace an existing appliance which is at least 60 months old and cannot be made serviceable
  - to replace a temporary denture that cannot be made permanent and has been in place 12 months or less.

Type D—Orthodontic Services

No deductible applies to Type D covered expenses.

All covered children through age 25 are eligible to receive benefits for orthodontic services. At age 26, all coverage under the plan ends, even if a course of orthodontic treatment is ongoing.

The plan payment for covered expenses (initial and monthly) is based on a schedule. This schedule is available from the ORNL Benefits Office.

Covered expenses for orthodontic services include charges for:

- braces
- surgical repositioning of the jaw, facial bones, and/or teeth to correct malocclusion
- surgical extractions
- x-rays
- retention checking

Predetermination of Benefits

When you or your covered eligible dependents require dental care and treatment, you should discuss in advance with your dentist what needs to be done and how much it will cost. If treatment is expected to cost $100 or more, you should ask your dentist to file for predetermination of benefits. This helps you avoid surprises by letting you know how much is payable for the proposed treatment before it begins.

Here is how it works:

- Your dentist submits the proposed course of treatment to MetLife by itemizing services and charges on a regular claim form.
- MetLife then determines the amount the plan will pay and informs you and your dentist by sending each of you a “Notice of Benefits Allowable” statement.
- You are free to pursue any treatment; however, the plan may pay only for the treatment that is indicated on the “Notice of Benefits Allowable.”

Whether or not you request predetermination of benefits, MetLife will pay the claim based on whatever information it has about your treatment.

MetLife Dental Plan

Alternative Course of Treatment

If, according to generally accepted professional standards of dental practice, there is more than one suitable procedure for the treatment of a dental condition, the plan will pay benefits for the least expensive procedure that can be used for the effective treatment of that condition. MetLife determines the benefit reimbursement amount when alternative courses of treatment are available.

If you and your dentist elect to use a more expensive procedure or material than the one determined by MetLife to be appropriate, you will be required to pay the difference between the dentist's bill and the costs covered by the plan.

Exclusions

The MetLife Dental Plan does not cover certain expenses, including but not limited to charges for:

- services provided before plan coverage becomes effective
- services other than those specifically covered by the plan
- services and supplies that are not provided by a legally licensed dentist or physician (or a licensed hygienist for the scaling or cleaning of teeth and topical application of fluoride under the dentist's supervision)
- services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- replacement of a lost, missing, or stolen prosthetic device
- services covered by any Workers' Compensation laws or employer's liability laws, or services which an employer is required by law to furnish in whole or in part
- services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer
- services or supplies for which a covered person would not legally have to pay if there were no coverage
- services or supplies which do not meet accepted standards of dental practices, including charges for services or supplies which are unnecessary or experimental in nature
- services or supplies received as a result of dental disease, defect, or injury due to an act of war, whether declared or not
- dental services or supplies that are payable by any government
- any duplicate prosthetic devices or sealants (material, other than fluorides, painted on the grooves of the teeth in an attempt to prevent future decay), oral hygiene, and dietary instruction
- plaque control programs
- periodontal splinting
- myofunctional therapy

Expenses incurred for any of the services or supplies listed above may not be used to satisfy your deductible.

MetLife Dental Plan

Extended Dental Care Benefits

If your coverage ends because your employment terminates, you retire, or you lose eligibility, benefits for covered expenses incurred before your plan terminates remain payable under the plan.

If you are undergoing a course of treatment when your coverage ends, benefits are payable for most covered charges related to that treatment and incurred up to 30 days after your plan terminates.

Exceptions to this 30 day extension include treatment involving:

- prosthetic devices—impressions and tooth preparation must be completed before coverage ends, and the device must be installed or delivered within 2 calendar months following the end of coverage
- crowns—tooth preparation must be completed before the coverage ends and the crowns installed within 2 calendar months following the end of coverage
- root canal therapy—the tooth must be opened before coverage ends and treatment completed within 2 calendar months following the end of coverage
- orthodontia—not extended under any circumstance

Treatment in Progress

The plan does not cover treatment received before your insurance becomes effective. However, if a course of treatment is started before the effective date and completed after the effective date, part of the cost may be covered. MetLife will determine whether a portion of the dentist's fee can be allocated to treatment received after the effective date and covered under the plan.

Claiming Benefits

Your dentist will usually file a claim whenever you and your covered eligible dependents incur covered dental expenses. Claims must be filed no later than 90 days after the plan year in which the services were rendered

If you need to file a claim, you may obtain a claim form from the MetLife website. Completed forms should be mailed to MetLife at the address listed on the form.

MetLife will send an explanation of payment with the benefit check. If you have authorized MetLife to pay your dentist directly, the dentist will receive an explanation of payment with the check, and you will receive a copy of the explanation if your claim was not paid in full.

MetLife Dental Plan

Coordination of Benefits

The Dental Plan has a Coordination of Benefits (COB) provision that is designed to prevent duplication of payments when a person can collect benefits from more than one employer group Dental Plan.

Under this provision, when coverage is provided by both the Company and another employer group plan, you can receive up to 100% of your covered expenses from both plans, but no more than that.

Other Company Benefits

If you have an accidental injury, seek recommended care through your Medical Plan's primary care physician to receive in-network benefits. Treatment of injuries to your natural teeth by a dentist, physician, or surgeon is covered under your medical coverage as long as services are provided within 12 months of the accident.

File your medical claim with your Medical Plan. A claim must be filed no later than 90 days after the plan year in which services were rendered.

Dental benefits payable under a Company Medical Plan will reduce your benefits otherwise payable under the Dental Plan. After you receive notice of payment from the Medical Plan, you should submit the notice of payment to MetLife.

Claims Review and Appeal Procedures

Initial Determination

After you submit a claim for Dental Insurance benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a 30 day period from the date you submitted your claim, except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination.

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline, or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge.

MetLife Dental Plan

Claims Review and Appeal Procedures (cont.)

Appeals Procedure

If MetLife denies your claim, you may take two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of employee
- Name of the plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination.

The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim.

If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days of MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criterion or indicate that such rule, protocol, guideline, or other criterion was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim.

Delta Dental Plan

Delta Dental Plan

How the Delta Dental Plan Works

Eligibility and Enrollment
The general eligibility and enrollment provisions can be found in the chapter titled “About Your Benefits.”

A subscriber or dependent who drops coverage but still meets all eligibility requirements of the plan may re-enroll during the first Open Enrollment period after having been out of the plan for 12 consecutive months.

For further definitions of Eligible Employees, Eligible Dependents, and Child(ren), refer to the “Glossary” and “About Your Benefits” chapters.

Choosing a Dentist
Delta Dental has contracted with Participating Dentists in two networks: Delta Dental PPO and Delta Dental Premier. These dentists are independent contractors who have agreed to accept certain fees for the services they provide to you. Dentists who have not contracted with Delta Dental are referred to as “Nonparticipating Dentists.”

Although you are free to choose any dentist, your out-of-pocket expenses are likely to be lowest if you choose a dentist in the Delta Dental PPO network. This is because PPO dentists have agreed to accept fees that are typically lower than those that Delta Dental Premier or Nonparticipating Dentists will accept. But if you don’t choose a Delta Dental PPO dentist, you can still save money if you go to a dentist who participates in Delta Dental Premier. Therefore, before receiving dental treatment, you should always verify if your dentist participates in one of these networks by calling the dentist’s office, calling Delta Dental’s Customer Service department at (800) 524-0149, or checking the online dentist directories at www.deltadentaloh.com.

Participating vs. Nonparticipating
PPO Dentists are paid based on Delta Dental’s PPO fee schedule, and Premier Dentists are paid based on Delta Dental’s maximum approved fees. Participating providers agree to accept these fees, with no balance billing, as payment in full. You will be responsible only for any applicable copayments and deductibles. If you go to a Nonparticipating Dentist, you will be responsible for the difference between Delta Dental’s payment and the amount that the Nonparticipating Dentist charges, in addition to your copayment and deductible.

The Nonparticipating Dentist may require that you pay the full amount up front, and you may have to fill out and file your own claim forms. Delta Dental will send reimbursement to you, and you will be responsible for making full payment to the Nonparticipating Dentist.

PPO fee schedule amounts and maximum approved fees are based on fees charged in your geographic area.

Annual Deductible
You and each covered dependent must satisfy a $50 individual deductible each calendar year before benefits become payable toward Class II (basic) services and Class III (major) services covered by the plan. There is no deductible for Class I (diagnostic and preventive) services or Class IV (orthodontic) services.

Maximum Benefits
The plan pays up to a maximum of $1,500 per year for each covered person for all services except cephalometric film, photos, diagnostic casts, and orthodontics. For cephalometric film, photos, diagnostic casts and orthodontics, there is a separate lifetime maximum of $1,500 for each covered person.

Emergency Dental Care
If you require emergency dental care, you may seek services from any dentist. Your out-of-pocket expenses likely will be less if you choose a Participating Dentist.

Delta Dental Plan

How the Delta Dental Plan Works (cont.)

Limitations
All time limitations are measured from the last date of service in the Delta Dental claims system and include service through other Delta Dental plans.

Types of Dental Services
The Delta Dental plan pays different benefits for each of the types of coverage—with an annual deductible required for Class II and Class III services only.

- Class I: Preventive and diagnostic benefits
- Class II: Basic services
- Class III: Major services
- Class IV: Orthodontic services

Summary of Benefits

Refer to the "Schedule of Benefits" section on the following pages for details.

Services Covered	Amount of Coverage
Calendar Year Maximum (excludes diagnostic casts, cephalometric film, photos, and orthodontics)	$1,500
Lifetime Orthodontic Maximum	$1,500
Lifetime Maximum	NA
Annual Deductible (applies to Class II and Class III services only)	$50
Services Covered	**Amount of Coverage**
CLASS I—Preventive and Diagnostic Services *Note: Members with certain high-risk medical conditions, such as diabetes, heart conditions, and high-risk pregnancies, may be eligible for additional prophylaxes (cleanings) or fluoride treatment*	Covered 100%
• Oral Examinations	Two in a calendar year
• Prophylaxis (cleanings)—includes periodontal maintenance	Two in a calendar year
• Full Mouth X-rays	Once every 3 years
• Bite-wing X-rays	Two in a calendar year
• Fluoride	Two in a calendar year, under age 19
• Space Maintainers	Under age 14
CLASS II—Basic Services: • Restorative (fillings, including composites on posterior teeth) • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics • Endodontics (root canal therapy) • Emergency palliative treatment	Covered 80% after deductible
• Sealants	Covered 80% after deductible, under age 16, once per tooth per lifetime. Chewing surfaces for permanent first and second molars only. The surface must be free from decay and restorations.

Delta Dental Plan

Summary of Benefits (cont.)

Refer to the "Schedule of Benefits" section on the following pages for details.

Services Covered	Amount of Coverage
CLASS III—Major Services (no age limit for bridges, partial dentures, or full dentures)	Covered 50% after deductible
• Crowns, Inlays, and Onlays (includes porcelain crowns on molar teeth)	Porcelain, gold, or veneer crowns for children under age 12 are not a benefit
• Bridges, Partial Dentures, and Full Dentures	Fixed bridges or cast partials for children under age 16 are not a benefit
• Implants	Covered 50% after deductible, once every 60 months per tooth
CLASS IV— Orthodontic Services: for dependents up to age 26 (services, treatment, and procedures to correct malposed teeth, including braces)	Covered 50% up to the lifetime orthodontic maximum

Schedule of Benefits

Class I—Preventive and Diagnostic Services

- Preventive—prophylaxis (cleaning), topical application of fluoride, and space maintainers
- Diagnostic—oral examination and x-rays to aid the dentist in planning required dental treatment

Class II—Basic Services

- Oral Surgery—extractions and other surgical procedures (including pre- and postoperative care)
- General Anesthesia and Intravenous Sedation—only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions
- Endodontia—treatment of the dental pulp (root canal procedures)
- Periodontia—treatment of the gums and bones that surround the tooth
- Denture Repairs—services to repair complete or partial dentures
- Basic Restorations—amalgams (silver fillings), composites (white fillings), and prefabricated stainless steel crown restorations for the treatment of decay
- Sealants—resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth
- Occlusal guards (TMJ appliances are excluded)

Class III—Major Services

- Cast Restorations—Crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations
- Prosthodonics—Procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges
- Complete or Partial Denture Reline—Chair-side or laboratory procedure to improve the fit of the appliance to the tissue (gums)
- Complete or Partial Denture Rebase—Laboratory replacement of the acrylic base of the appliance
- Implants and implant-related services are payable once per tooth in any 5 year period

Delta Dental Plan

Schedule of Benefits (cont.)

Class IV—Orthodontic Services

Delta Dental will pay benefits for procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a benefit.

Orthodontic Payment Method

- The initial payment (initial banding fee) made by Delta Dental for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
- Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment and lifetime maximum.

Predetermination of Benefits

When a proposed treatment plan will cost more than $200, it is recommended that the dentist submit it to Delta Dental for predetermination. You may have your dentist send Delta Dental a claim form detailing the projected treatment, and Delta Dental will give an estimate of the benefits to be paid. This will let you know approximately how much the work will cost and what your share of the costs will be.

A predetermination is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums. It is important to note that Delta Dental never dictates treatment—only payment. Delta Dental's payment can be applied toward the treatment the dentist and patient choose.

Optional Services

If you select a more expensive service than is customarily provided or for which Delta Dental does not determine a valid dental need is shown, Delta Dental will make an allowance based on the fee for the customarily provided service.

This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the subscriber's coverage. The dentist and subscriber or dependent should decide the course of treatment.

Delta Dental Plan

Exclusions and Limitations

Delta Dental will make no payment for the following services unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the following services will be the responsibility of the Subscriber (though the Subscriber's payment obligation may be satisfied by insurance or some other arrangement for which the Subscriber is eligible). ***This is a partial listing; please see your Dental Care Certificate for all exclusions and limitations. The Certificate was mailed to your home address when you enrolled. Contact Delta Dental for additional copies.***

Limitations and Exclusions on Preventive and Diagnostic Benefits

a) Two oral exams and cleanings, to include periodontal maintenance procedures, in any 12 month period. Members with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

b) Full mouth x-rays are covered once within 3 years, unless special need is shown.

c) Two sets of bite-wing x-rays in a 12 month period

d) Topical application of fluoride for members up to 19 years of age

e) Adult prophylaxis for members under 14 years of age is not allowed.

f) Space maintainers for members age 14 and older are not allowed.

Limitations and Exclusions on Basic Benefits

a) Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.

b) Payment for root canal treatment includes charges for x-rays and temporary restorations. Root canal treatment is limited to once in a 24 month period of the original root canal treatment by the same dentist or dental office.

c) Payment for periodontal surgery shall include charges for 3 months of postoperative care and any surgical re-entry for a 3 year period. Root planning, curettage, and osseous surgery are not a benefit for members under 14 years of age.

d) The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not a benefit.

e) The replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within a 24-month period of the initial placement is not a benefit.

f) The replacement of a stainless steel crown on a permanent tooth by the same dentist or dental office within a 60 month period of the initial placement is not a benefit.

g) Gold foil restorations are an Optional Service.

h) metal inlays are Optional Services.

i) A sealant is a benefit only on the unrestored, decay-free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars. Sealants are only a benefit on members under 16 years of age. Only one benefit will be allowed for each tooth within a lifetime.

j) Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

Delta Dental Plan

Exclusions and Limitations (cont.)

Limitations and Exclusions on Major Benefits

a) Replacement of crowns or cast restorations received in the previous 5 years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown buildup, impression, temporary restoration, and any re-cementation by the same dentist within a 12 month period.

b) A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.

c) Procedures for purely cosmetic reasons are not benefits.

d) Porcelain, gold, or veneer crowns for children under 12 years of age are not a benefit.

e) Specialized implant surgical techniques are excluded.

f) Replacement of any fixed bridges, or partial or complete dentures, that the member received in the previous 5 years is not a benefit.

g) Payment for a complete or partial denture shall include charges for any necessary adjustment within a 6 month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a 3 year period and includes all adjustments required for 6 months after delivery.

h) Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.

i) Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit.

j) A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.

k) Temporary partial dentures are a benefit only when upper anterior teeth are missing.

Limitations and Exclusions on Orthodontic Benefits

a) Orthodontic benefits are limited to eligible dependent children to age 26.

b) Delta Dental shall make regular payments for orthodontic benefits.

c) If orthodontic treatment began prior to enrolling in this plan, Delta Dental will begin benefits with the first payment due the orthodontist after the subscriber or covered eligible dependent becomes eligible.

d) Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.

e) Benefits are not paid to repair or replace any orthodontic appliance received.

f) Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under Preventive and Diagnostic or Basic Benefits.

Delta Dental Plan

General Provisions

This is a partial listing; please see your Dental Care Certificate for all exclusions and limitations. The Certificate was mailed to your home address when you enrolled. Contact Delta Dental for copies.

a) Claims: Participating Dentists (PPO and Premier) will file your claim with Delta Dental. If you need a claim form for services provided by a Nonparticipating Dentist, you can print one from Delta Dental's website. Delta Dental will make no payment for services if a claim for those services has not been received by Delta Dental within 1 year following the date the services were completed.

b) Emergency Dental Care: If you require emergency dental care, you may seek services from any dentist. Your out-of-pocket expenses will likely be less if you choose a Participating Dentist (PPO or Premier).

c) Subrogation and Right of Reimbursement: This provision applies when Delta Dental pays benefits for personal injuries and you have a right to recover damages from another.

d) Reimbursement: If you or your eligible dependent recovers damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under the Plan.

e) Actions: No action on a legal claim arising out of or related to this Plan will be brought until the claims review and appeal process has been exhausted and 30 days after notice of the legal claim has been given to Delta Dental. A summary of the Claims Review and Appeal Procedures can be found in the chapter titled "Administrative Information." In addition, no action can be brought more than 3 years after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.

f) Coordination of Benefits: Coordination of Benefits (COB) is used to pay health care expenses when you are covered by more than one plan. Delta Dental follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective of coordination of benefits is to make sure the combined payments of the plans are no more than your actual bills.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following rules that applies:

1. Employee
   - The plan that covers you as an employee (neither laid off nor retired) is always primary.

2. Children (parents divorced or separated)
   - If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.
   - If a court decree gives joint custody and does not mention health care, Delta Dental follows the birthday rule.
   - If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

3. Children and the Birthday Rule
   - When your children's health care expenses are involved, Delta Dental follows the "birthday rule." Under this rule, the plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" that says the father's plan is always primary), Delta Dental will follow the rules of that plan.

4. Other situations
   - For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

Delta Dental Plan

Extended Dental Care Benefits

Coverage for any subscriber or eligible dependent terminates when he/she no longer is eligible for benefits as a member of the group.

Specific state or federal laws or group polices may allow an extension of benefits for a limited time.

Claims Review and Appeal Procedures

If you believe that Delta Dental has not paid a claim properly, you should first attempt to resolve the problem by contacting Delta Dental.

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate.

If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a copayment to satisfy the balance, you also may treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you can take the following steps:

First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly. You also may mail your inquiry to:

Delta Dental
Customer Service Department
PO Box 9089
Farmington Hills, MI 48333-9089

When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Appeals Procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
PO Box 30416
Lansing, MI 48909-7916

You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and you also must indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

Delta Dental Plan

Claims Review and Appeal Procedures (cont.)

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will:

a) inform you of the specific reason(s) for the denial;

b) list the pertinent Plan provision(s) on which the denial is based;

c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed;

d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge;

e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part); and

f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure, or if Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within 1 year of the date on which you receive notice of the final denial of your claim.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling (614) 644-2673 or (800) 686-1526. You may also write to:

Consumer Services Division
Ohio Department of Insurance
50 W. Town St., Third Floor, Suite 300
Columbus, OH, 43215

Long-Term Care

Long-Term Care Insurance can help you or an eligible family member pay for costly Long-Term Care assistance when you can no longer function independently.

Highlights

Your Long-Term Care Insurance Benefits …

This plan closed to new enrollments effective 4/30/2011. Plan participants enrolled in coverage before this date may continue to be enrolled in the plan. MetLife's long-term care insurance coverage is guaranteed renewable. This means that as long as your premiums are paid on time, coverage cannot be cancelled.

What happens to your benefits when ...

For more information about what happens to your long-term care insurance benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" chapter.

About Long-Term Care Benefits

The long-term care insurance plan sponsored by the Company can help you or an eligible family member pay for costly long-term care assistance when you can no longer function independently.

Long-term care can be as simple as having help in your home with the activities of daily living or as complex as the constant supervision provided by a health care professional in a nursing home.

Long-term care is different from acute medical care, which treats temporary conditions from which you are expected to recover, such as broken bones or a heart attack. Most long-term care services are not covered by other Company medical benefit plans for retirees or by Medicare.

This summary reviews the long-term care insurance benefits offered under the plan, including important information about eligibility, coordination of benefits, continuation of coverage, and other plan features.

The plan is governed by the certificate of insurance, which is an insurance contract between MetLife and the insured. (In the event of any conflict between the certificate and this summary, the certificate of insurance will govern.)

The Company reserves the right to end or change the benefit program at any time within the terms of the group policy. These changes may affect the benefits provided or the contribution required from participants.

How the Plan Works

Eligibility

The plan closed to new enrollments effective 4/30/2011. Plan participants enrolled in coverage before this date may continue to be enrolled in the plan.

Premium Payments

You pay the full cost of your coverage. The cost of your coverage depends on the daily benefit and lifetime benefit you chose, and your age as of the time your coverage began.

You will pay MetLife directly. You may be billed quarterly, semiannually, or annually, or you may have monthly deductions taken directly from your checking account. You will have a 31 day grace period. If you do not pay within that grace period, your coverage will be canceled as of the last day of the month in which you paid your last contributions.

… Changes in Premiums

Your premiums are based on your age as of the time your coverage became effective. Except for changes in premium rates for all enrollees, which may occur from time to time, your premiums remain the same as you get older. If you increase your coverage, your contributions for the additional coverage will be based on your age at the time the change is effective.

… No Premiums While Benefits are Paid

You will not be required to pay premiums during any period in which you are receiving benefits. Premiums are waived as of the first day of the month following the date you fulfill the waiting period and begin receiving benefits. Your premiums will resume as of the first of the month on or after the date your eligibility for benefits ceases. If you die while covered by the plan, all or a portion of your premiums may be returned to your estate.

If you die before age 65, your estate will receive the contributions you paid up until the date of your death, less any benefits you had received.

If you die after age 65, your estate will receive the contributions you paid up to age 65, less any benefits you had received. This amount will be reduced by approximately 20% each year after age 65. There will be no return of premium if death occurs after age 70.

Note: Due to state insurance regulations, this feature is not available to residents of Washington. Residents of this state will have an enhanced transition expense services benefit instead of this feature.

How the Plan Works (cont.)

… If You Stop Paying Premiums

If you stop paying premiums, your coverage will terminate if you have paid premiums for less than 3 years.

If you pay premiums for 3 years or more and then stop, you will still have some coverage. This non-forfeiture feature allows you to maintain some coverage even if you choose to cancel your coverage. The feature provides the full daily benefit with a total lifetime benefit based on the greater of the total paid contributions amount or 30 times the daily benefit in effect immediately prior to the non-forfeiture date.

When Benefits are Paid

Once enrolled in the plan, if you think you need benefits, you or your designated representative may call MetLife at 1-800-GET-MET8 (1-800-438-6388) to initiate the benefit authorization process. A nurse at MetLife will review your situation with you, your doctor, or other care provider to determine the extent to which you are unable to perform, without substantial assistance from another individual, the following activities of daily living:

- bathing
- dressing
- transferring (moving between a bed and a chair, for example)
- toileting
- continence
- eating

If you are certified by a licensed health care practitioner (e.g., your doctor or a nurse) as being unable to perform at least two of these activities of daily living for a period of 90 days, or if you require substantial supervision to protect yourself from threats to your health and safety due to a severe cognitive impairment, MetLife will authorize plan benefits.

MetLife will notify you as to your authorization for benefits within 10 working days after receiving the necessary information. If you are not authorized for benefits, MetLife will explain the reasons for the denial and instruct you how to appeal the decision.

Waiting Period

Because this is long-term care insurance, payments begin after you have established a need for extended care. You must satisfy a waiting period of 90 days. Any day paid by your group medical plan or by Medicare will count as a waiting period day. During this waiting period, you will pay for services covered by the plan. Once the waiting period is over, you will then begin to receive benefit payments for covered services. You will not have to fulfill another waiting period unless you have gone for more than 180 days without being eligible for benefits.

What the Plan Pays

After you satisfy the waiting period, the plan pays benefits up to a daily benefit amount. The daily benefit is the maximum amount of reimbursement that you can receive for each day you are eligible for benefits. There is a daily benefit for nursing home care and respite care services and another daily benefit for home care services and assisted living facilities. The total lifetime benefit is the maximum amount of benefits you can receive from the plan.

You choose one of three nursing home daily benefit amounts. The nursing home daily benefit amount you choose will determine your home care daily benefit amount and your total lifetime benefit.

If you choose this nursing home daily benefit	Your home care/assisted living daily benefit will be	Your total lifetime benefit will be
$100	$ 60	$182,500
$150	$ 90	$273,750
$200	$120	$365,000

When the total amount of benefits you have received equals your total lifetime maximum amount, your coverage ends.

How the Plan Works (cont.)

Coordination of Benefits

Long-term care benefits will be reduced by the dollar amount payable by any of the following, to the extent that the combination of your benefit and amounts payable or amounts which would be payable by any of the following exceeds 100% of the actual charge for the covered expenses:

- any federal, state, or other government health care plan or law (except Medicaid or Medicare)
- any state or federal Workers' Compensation law
- any employer's liability or occupational disease law
- any motor vehicle no-fault law
- any other plan which any employer contributes to or sponsors.

Concurrent Review

While you receive covered services, MetLife reviews your condition to determine whether the authorization for benefits can be continued. This review may require that MetLife examine your medical records or request additional information from your doctor or other care provider. You and your doctor will be notified if MetLife made a determination to change your benefit eligibility.

Changing Your Selections

The plan permits you to increase or decrease your daily benefit amounts. You must apply to MetLife, which will notify you if the change is approved, what your change in premium will be, and when the change becomes effective.

Inflation Increases

At least once every 3 years, you can increase your daily benefit amount by a specified dollar amount to protect against inflation. You may make this change without providing a statement of health as long as you have accepted this offer at least once during the last two consecutive offerings.

Reinstatement

If your coverage ends because you fail to pay the required premium, your coverage may be reinstated within 12 months of the date coverage ended if you submit all past due contributions with proof of good health to MetLife.

However, if you can prove that you didn't pay your premium due to a cognitive impairment or loss of functional capacity, you can request reinstatement within 5 months of the date coverage ended by paying all past due premiums. In this situation, you will not have to submit proof of good health to have your coverage reinstated.

Covered Services

Initial Care Planning Visit

You are covered for one initial care planning visit from a care advisor, a long-term care professional who can help you explore issues and aid your decision-making. The care advisor helps you:

- determine what type of care is necessary
- identify options and resources, including providers, available in your area (but the choice of providers is always yours)
- develop an ongoing care plan for your consideration.

The plan covers the full cost of the initial visit if you use a designated care advisor. However, if there is no care advisor in your area, the plan also pays the cost of the initial visit to any professional long-term care advisor, up to $250.

Nursing Home Care

Benefits are paid toward the cost of care provided in a licensed skilled nursing facility or intermediate care facility, including:

- room and board
- custodial care services.

It also includes hospice care services received in an inpatient hospice.

If you are hospitalized while receiving benefits and you are required to pay ongoing room and board charges to guarantee a bed in the nursing home, assisted living facility, or hospice facility when you are discharged, the plan will cover those charges for up to 21 days per calendar year.

Covered Services (cont.)

Assisted Living Facility Services

The plan will pay 100% of the cost, up to the maximum daily benefit shown in the Benefits Schedule (as shown in the Certificate of Coverage provided by MetLife) for the plan option you have chosen, for the following qualified long-term care services provided in an assisted living facility:

- room and board accommodations
- nursing care, maintenance or personal care, therapy services, and hospice care provided by a formal caregiver
- bed reservation charges for up to 21 days per calendar year. The bed reservation shall not exceed the benefit payable if you had been confined in the assisted living facility on that day.

Home Care Services

Sometimes, care can be provided best at home rather than in a nursing home. The plan covers nursing care and custodial care services provided:

- by a licensed home health care agency
- by a licensed nurse
- by a licensed adult day care center.

The plan also covers:

- care advisory services provided by a licensed care management organization which are received after the initial care planning visit
- hospice care services received at home
- homemaker services provided by a licensed home health care agency which include light housekeeping, meal preparation, and shopping
- services provided by a licensed physical therapist, licensed speech therapist, licensed respiratory therapist, or licensed occupational therapist through a home health care agency.

Respite Care Services

Respite care includes covered nursing home or home care services which temporarily substitute for regular home services. Up to 30 days per calendar year are covered under the respite care benefit.

Transition Benefit

The plan will pay 100% of the charges incurred, up to five times the daily benefit amount selected, for expenses incurred while chronically ill for items that were required to provide qualified services during and after the waiting period. Such expenses may include personal emergency response systems or durable medical equipment. However, the plan will not pay for home modifications that would otherwise qualify as covered expenses if they would increase the value of your home.

Claiming Benefits Once You Are Authorized

To be reimbursed for your authorized covered services, you must file a claim with MetLife within 90 days after the end of the calendar year in which you receive the covered services.

To File a Claim

You will receive a claim form with your authorization letter.

When you have received covered services, complete the form and mail it to MetLife at the address printed on the form.

You will receive payments from MetLife after the waiting period, unless you have asked for your provider to be paid directly by filling out an area of the claim form for assigning benefits to your provider.

Once the waiting period has been satisfied, as you submit claims, benefit payments will be made within 10 working days of the receipt of all necessary information by MetLife.

If any premiums are owed to MetLife at the time you submit your claim, the amount you owe will be subtracted from the benefit payment for which you are eligible.

If a claim is denied, you have 60 days to appeal the decision by writing to MetLife at the following address:

MetLife Long-term Care
PO Box 937
Westport, CT 06880

What The Plan Does Not Cover

This plan does not provide benefits for the following:

- Care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a physician for an injury or sickness.
- Any service or supply received outside the United States or its territories.
- Illness, treatment, or medical condition arising out of:
  - war or act of war (whether declared or undeclared)
  - participation in a felony, riot, or insurrection
  - service in the armed forces or auxiliary units
  - attempted suicide (while sane or insane) or intentionally self-inflicted injury
  - aviation (this applies only to non-fare paying passengers).
- Treatment provided in a government facility, unless otherwise required by law.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital which is licensed as a nursing home or hospice.
- Any service provided by your immediate family, unless the service is a covered service from an informal caregiver.
- Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be reimbursable but for the application of a deductible, coinsurance, or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payer under applicable law.
- Services for which no charge is normally made in the absence of insurance.

When Coverage Ends

Your coverage under the plan ends on the earliest of the following:

- when you reach your total lifetime limit
- at your death
- on the last day of the month your cancellation notice is received by MetLife (you may be eligible for coverage under the non-forfeiture feature as previously described)
- if you fail to pay your premiums within 35 days after MetLife sends a written notice of termination of your coverage as stated in the grace period (you may be eligible for coverage under the non-forfeiture feature as previously described)
- the date the group policy ends, subject to the provisions in "Continuation Coverage"
- the date your employment with the group policyholder terminates, subject to the provisions in "Continuation Coverage"
- if you are an eligible employee or eligible family member of an eligible employee, the date the eligible employee's employment with the group policyholder terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff, or similar circumstances, subject to the provisions in "Continuation Coverage."

In the event this group long-term care insurance policy ends, you have the option of continuing your coverage at the same rate by making payments directly to MetLife.

Continuation Coverage

You have the right to continue coverage even if your coverage ends, except as stated below. This is called "Continuation Coverage," and it requires that you pay contributions to MetLife directly when they are due. You will be provided Continuation Coverage automatically unless you or your representative notifies MetLife that you do not want it.

Continuation Coverage is not available to the following categories of persons:

Category 1: Your coverage ends because you failed to make any required payment or contribution when due or you notified MetLife that you want to end your coverage;

or

Category 2: You have already received benefits that count toward your total lifetime benefit that are equal to your total lifetime benefit;

or

Category 3: The group policy terminates and coverage is replaced (within 31 days after termination) by other group coverage that:

- is effective on the day following termination of coverage and provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy;

  and

- calculates premium based on your age at inception of coverage under the group policy.

or

Category 4: Your employment with the Company terminates or, if you are an eligible family member of an eligible employee, that eligible employee's employment with the Company terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff, or similar circumstances, and coverage is replaced (within 31 days after termination) by other group coverage that:

- is effective on the day following your termination of coverage

  and

- provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy

  and

- calculates premium based on your age at inception of coverage under the group policy.

MetLife may, in its discretion, offer Continuation Coverage to all persons in Categories 3 and/or 4. In this event, you will be notified in writing of MetLife's offer.

When Coverage Ends (cont.)

Certificate of Insurance

In case of conflict among the terms contained in this Summary Plan Description and the Certificate of Insurance, the Certificate of Insurance will govern.

Administrative Information

Information about the administration of your long-term care insurance can be found in the chapter titled “Administrative Information.”

Life Insurance

Your Life Insurance benefits are designed to provide financial security for your survivors in the event of your death.

For Salaried Employees: **These benefits apply to retirees who were hired prior to 4/1/2012.**

If you were hired on or after 4/1/2012, you had the right to convert Life Insurance to individual policies at the time of your retirement.

For Bargaining Unit Employees: **These benefits apply to retirees regardless of hire date.**

Highlights

Your Benefits …

… Provide Security for Your Family Through Basic Life Coverage

Your basic life insurance coverage pays a benefit to your beneficiary in case of your death from any cause.

… Offer the Opportunity for Added Protection Through Supplemental Coverage

You may be eligible for supplemental life insurance, based on when you retired. Supplemental life insurance coverage provides greater security for your beneficiary in case of your death from any cause.

What happens to your benefits when ...

For more information about what happens to your life insurance benefits when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

Basic Life Insurance (for Bargaining Unit Employees and Salaried Employees hired prior to 4/1/2012)

While you were actively employed, basic life insurance coverage of two times your pay was available on an optional contributory basis. If you have basic life insurance coverage at retirement, the plan pays benefits to your beneficiary in the event of your death from any cause while you are insured.

If You Retired Before Age 65

If you retired before age 65, were eligible for an immediate pension benefit, and had basic life insurance coverage for at least 1 year immediately preceding retirement, you had these options:

- continue your full basic life insurance amount until the end of the month preceding your 65th birthday by continuing to make your regular premium payments

  or

- take the reduced basic life insurance amount (as described under "Reduced Coverage Amount") immediately at no cost to you.

The reduced policy can be elected at retirement or any time after retirement until the month preceding your 65th birthday.

When you reach age 65, your life insurance will be automatically reduced the first of the month of your 65th birthday.

If You Retired at Age 65 or After

If you retired at age 65 or after, a reduced amount of basic life insurance coverage will continue for the rest of your life provided you had basic life insurance coverage for at least 1 year immediately preceding retirement. This reduced coverage currently is provided at no cost to you.

Reduced Coverage Amount

If you had basic life insurance coverage for at least 1 year but less than 5 years immediately preceding your retirement, your reduced insurance will be $625.

If you had basic life insurance coverage for at least 5 years immediately preceding your retirement, the amount of your reduced insurance is determined by the date on which you retired, as described in the following table.

The balance between your reduced amount and the original amount can be converted to an individual policy within 31 days from the date benefits were reduced. Refer to "Conversion Privileges" at the end of this section for more information.

The term "Pay" is defined in the Glossary.

Basic Life Insurance (cont.)

Reduced Basic Life Insurance Amount at age 65		
If you had basic life insurance for *at least 1 year but fewer than 5 years* before retirement, your total benefit is $625 **If you had basic life insurance for *at least 5 years* before retirement, you are eligible for benefits according to this table**		
Employee category	**Retirement date**	**Reduced life insurance will be the greater of:**
Salaried	**Retired on or after 1/1/1973**	• 1% of basic life just before retirement multiplied by years of service (including any fraction of a year), plus $500, with a minimum of $2,500 and a maximum of $10,000 **or** • 25% of basic life insurance just before retirement, up to a maximum of $10,000 **or** • 20% of basic life insurance just before retirement
Hourly	**Retired on or after 11/1/1977 but before 6/1/1980**	• 1% of basic life just before retirement multiplied by years of service (including any fraction of a year), plus $500, with a minimum of $2,500 and a maximum of $10,000 **or** • 25% of basic life insurance just before retirement, up to a maximum of $10,000 **or** • 20% of basic life insurance just before retirement
	Retired on or after 6/1/1980 but before 7/1/1996	• 1% of basic life just before retirement multiplied by years of service (including any fraction of a year), plus $500, with a minimum of $2,500 and a maximum of $10,000 **or** • 25% of basic life insurance just before retirement, up to a maximum of $10,000
	Retired on or after 7/1/1996 (or later, depending on when contract was ratified)	• 1% of basic life just before retirement multiplied by years of service (including any fraction of a year), plus $500, with a minimum of $2,500 and a maximum of $10,000 **or** • 25% of basic life insurance just before retirement, up to a maximum of $10,000 **or** • 20% of basic life insurance just before retirement

Supplemental Life Insurance

While you were an active employee, supplemental life insurance coverage of at least one times your pay was available on an optional contributory basis.

The following table explains eligibility and life insurance benefit amounts for retirees.

Supplemental Life Insurance		
Retirees may be eligible for supplemental life insurance, depending on retirement date		
Employee category	**Retirement date**	**Supplemental Life Insurance Benefit**
Salaried	**Retired on or after 1/1/1973 but before 4/1/1990**	Supplemental life insurance ended at retirement or at age 65, based on your decision at retirement.
	Retired on or after 4/1/1990 but before 2/1/2001	• If you had supplemental life insurance for at least 1 year but fewer than 5 years before retirement, your total benefit is $312 • If you had supplemental life insurance for at least 5 years immediately preceding retirement, your reduced supplemental life insurance benefit will be the greater of: ○ 1% of supplemental life just before retirement multiplied by years of service (including any fraction of a year), plus $250, up to a maximum of $5,000 **or** ○ Minimum of $1,250 or 12.5% of supplemental life just before retirement, up to a maximum of $5,000 **or** ○ 10% of supplemental life just before retirement
	Retired on or after 2/1/2001	Supplemental life insurance ended at retirement
Hourly	**Retired on or after 11/1/1977 but before 4/1/1990**	Supplemental life insurance ended at retirement or at age 65, based on your decision at retirement.
	Retired on or after 4/1/1990 but before 7/1/1996	• If you had supplemental life insurance for at least 1 year but fewer than 5 years before retirement, your total benefit is $312 • If you had supplemental life insurance for at least 5 years immediately preceding retirement, your reduced supplemental life insurance benefit will be the greater of: ○ 1% of supplemental life just before retirement multiplied by years of service (including any fraction of a year), plus $250, up to a maximum of $5,000 **or** ○ Minimum of $1,250 or 12.5% of supplemental life just before retirement, up to a maximum of $5,000
	Retired on or after 7/1/1996 but before 8/1/2001	• If you had supplemental life insurance for at least 1 year but fewer than 5 years before retirement, your total benefit is $312 • If you had supplemental life insurance for at least 5 years immediately preceding retirement, your reduced supplemental life insurance benefit will be the greater of: ○ 1% of supplemental life just before retirement multiplied by years of service (including any fraction of a year), plus $250, up to a maximum of $5,000 **or** ○ Minimum of $1,250 or 12.5% of supplemental life just before retirement, up to a maximum of $5,000 **or** ○ 10% of supplemental life just before retirement
	Retired on or after 8/1/2001	Supplemental life ends at retirement

Other Important Information

Naming Your Beneficiary

You may name anyone as your beneficiary, and you may change your beneficiary designation at any time at the ORNL Benefits Service Center website or by phone at 1-800-211-3622. The beneficiary you name for basic life insurance benefits will automatically be your beneficiary for supplemental life, unless you elect otherwise in writing.

If you do not designate a beneficiary, basic and supplemental life insurance benefits will be paid to the first survivor among the following beneficiaries:

- your spouse
- your child or children
- your mother or father
- your sisters or brothers

If you do not have any living beneficiaries, insurance benefits will be paid to your estate.

Tax Consequences

Under current tax law, employer-paid insurance coverage in excess of $50,000 may result in additional taxable income for federal income and FICA tax purposes. This additional taxable income, called imputed income, is reported on your W-2 earnings statement as “other income.”

Payment of Benefits

Basic and Supplemental Life death proceeds over $5,000 are deposited into a Total Control Account (TCA), a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty, by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account and not a checking, savings, or money market account.

When Coverage Ends

Basic life insurance and supplemental life insurance coverages end on the earliest of the following dates:

- the last day of the month for which your last contribution was made if you fail to make any required contribution
- when you are no longer eligible
- when you die
- the date the plan is terminated.

If you should die within the 30 day period after your coverage terminates, basic life insurance and supplemental life insurance benefits will be paid.

Accelerated Benefit Option

If you are diagnosed with a terminal illness with 6 months or less to live and have at least $10,000 of basic life or supplemental life insurance, you may make a one-time request to receive a portion of your life insurance benefit before you die. You must furnish satisfactory proof of your illness to the insurance company before any benefits can be paid.

You may receive up to 50% of the amount of your basic and supplemental life insurance coverage, with a maximum living benefit of $250,000 of your basic life insurance coverage and $250,000 of your supplemental life insurance coverage. Benefits will be paid in a lump sum.

Living benefit payments may be taxable and may affect your eligibility for certain government benefits, such as Medicaid. In addition, the amount of benefits payable to your beneficiary upon your death will be reduced by the amount of the living benefit that you receive.

If you wish to apply for a living benefit, please contact the ORNL Benefits Office for information.

Conversion and Portability

Conversion Privileges

Within 31 days after your basic life insurance and supplemental life insurance coverages reduce or terminate, you may convert all or part of these coverages to an individual whole life insurance policy without taking a medical examination. The cost for individual coverage will be based on the insurance company's regular premium rates for the type and amount of insurance available to you through the conversion privilege.

Portability

Although your costs may differ from what you are currently paying, the cost to continue your supplemental life coverage under the portability option is generally less expensive than converting to an individual life insurance policy. When you elect to continue coverage under the portability option, you won't lose the valuable features of the Total Control Account or the Accelerated Benefits Option (ABO).

Within 31 days after your supplemental life insurance coverage terminates or reduces, you may port all of the coverage to a term life policy without taking a medical examination. The cost for the ported coverage will be based on your age and will increase incrementally as you get older.

The portable coverage reduces at age 70 and terminates at age 80. (You may convert the ported coverage when the benefit reduces at age 70 and when it terminates at age 80.)

The minimum amount of coverage that you can port is $20,000. The maximum amount you can port is the lesser of the amount of supplemental life coverage you had at the time your group supplemental life benefits ended or $1,000,000. Once you select a coverage amount, you may only decrease coverage in the future; you cannot increase the amount.

If Your Benefits Terminate

If your supplemental life benefits terminate, you will be sent a notice of group life insurance portability and conversion privileges from MetLife within 30 days of losing of coverage. If you do not receive this notice, contact the ORNL Benefits Service Center

NOTE: The employee may not continue group coverage under portability AND convert the coverage to an individual policy. Benefits may either be ported in full, converted in full, or a combination of the two. The total amount of coverage converted and/or ported cannot exceed the amount of insurance that was in effect prior to coverage termination. If you are electing portable coverage and it is reduced or ends due to age, new conversion rights may be triggered.

Administrative Information

Information about the administration of your life insurance benefits can be found in the chapter titled "Administrative Information."

Pension Plan

The Pension Plan helps build financial security and provides a dependable source of income throughout your retirement years, based on your earnings and length of service with the Company.

Highlights

The Pension Plan …

… Provides a Benefit Which Adds to Your Other Retirement Income

The income you receive from the Pension Plan adds to any Social Security benefits, savings program benefits, or other retirement income you are eligible to receive.

… Offers Financial Security to Your Family in Case of Your Death

If you choose a survivor payment option, the Pension Plan will pay a benefit to your spouse, dependent child, or dependent parent after your death.

What happens to your pension benefits when …

For more information about what happens to your pension benefits when certain changes occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

Receiving Benefit Payments

If You are Receiving Benefit Payments

If you are now receiving monthly checks from the Pension Plan, your benefits will continue based on the payment option that you chose. You may not change this option.

If Your Benefit Has Not Started

If you retired before age 65, you may elect to start your benefit at any time, with a 30 day notice to the ORNL Benefits Office.

If you have retired, your plan benefits will begin no later than the first of the month after you reach age 70½.

Pension Benefit Amount

The amount of your pension benefit is determined when you retire based on the plan's formula (and your earnings and service) in effect at that time and the payment form you elect.

Employee Contributions

Any mandatory participant contributions will be reflected as a nontaxable portion of your monthly benefit when it is commenced. Also, the Pension Plan includes a refund feature to make sure that the cumulative benefit distributions are at least equal to the amount of your contributions plus applicable interest.

Normal Forms of Payment

You will receive your plan benefits under the plan's normal form of payment based on your marital status when you retire, unless you elect an optional form of payment.

For Married Employees

If you are married when you elect to receive your benefits, the normal form of payment is a 50% joint and survivor benefit. Under this form of payment, your pension is reduced and, after your death, 50% of that benefit is continued to your surviving spouse for the rest of his or her life. This reduction reflects the fact that benefits are payable during both of your lifetimes.

If your spouse dies before you, this form of payment will "pop up" to the amount that would be paid to single employees, upon receipt of required documentation. For those who retired prior to April 1, 1990, this "pop-up" provision became effective July 1, 2001. For a table of reduction factors, contact the ORNL Benefits Office.

If you die before you begin to receive plan benefits, your spouse will receive 50% of the benefit you would have received had it begun on the date of your death.

Married participants may also elect a 75% survivor annuity option. Under this form of payment, your pension is reduced and, after your death, 75% of that benefit is continued to your surviving spouse for the rest of his or her life. If your spouse dies before you, this form of payment does not "pop up" to the amount that would be paid to a single employee. (For a table of 75% Surviving Spouse reduction factors effective for the date you commence your benefit, contact the ORNL Benefits Office.)

For Single Employees

The plan's normal form of payment for a single employee is a life annuity. Under this form of payment, you receive the full benefit earned at retirement for your lifetime. After your death, no benefits are paid to anyone else.

Optional Forms of Payment

If you wish, you may choose an optional form of payment when you elect to receive your benefits. If you are married, you will need your spouse's written consent, witnessed by a notary public or a representative of the Plan Administrator, in order to elect one of the following optional forms of payment.

You may revoke or change your election at any time before benefits begin, subject to your spouse's written and witnessed consent.

Life Annuity Option for Married Employees

This option for married employees is the same as the normal form of payment for single employees. Under this form of payment, you receive your full pension benefits for your lifetime only. No benefits are paid to anyone after your death.

50% Survivor Benefit Option

You can elect a reduced pension in order to provide continuing income to a dependent child under age 23 or a dependent parent.

The amount of reduction in your pension depends on your age and the age of your named survivor. For tables of survivor reduction factors, contact the ORNL Benefits Office.

The terms "Dependent Child" and "Dependent Parent" are defined in the Glossary.

After your death, 50% of your reduced benefit will continue to your dependent child until age 23 (or as long as the child remains totally and permanently disabled) or your dependent parent for the rest of his or her life.

If you retire early and die before your pension benefits start, your named survivor will receive 50% of the reduced pension you would have received had it begun on the date of your death.

Your election of a survivor benefit cannot be changed after your pension begins. If your named survivor should die before you, this payment form will automatically "pop up" to the amount that would be paid to single employees. For those who retired prior to April 1, 1990, this "pop-up" provision became effective July 1, 2001.

Level Income Option

If you retire before age 62 and choose to have your pension benefits begin before you are eligible to receive Social Security benefits, you may elect the level income optional form of payment. Under this option, your plan income is increased until age 62 and is decreased after age 62 so that your combined income from the plan and Social Security is approximately level throughout your retirement. The Social Security amount used in the level income calculation is not your actual Social Security amount but is an estimate based on your Average Straight-Time Monthly Earnings for the calendar year immediately preceding your retirement date.

"Average Straight-Time Monthly Earnings" is defined in the Glossary.

If you elect the level income option, the survivor's benefit will be based on the pension amount before adjustment for this option.

The level income option is not available with the 75% surviving spouse coverage.

Social Security

Social Security retirement benefits are entirely in addition to benefits paid from the Pension Plan. Social Security provides retirement benefits to you and your eligible spouse based on earnings covered under the law. If you were born before 1938, full Social Security retirement benefits can start at age 65. Your spouse is eligible for an additional 50% of your benefit—or a benefit based on his or her own covered earnings, if greater—when he or she reaches age 65. Disability benefits may also be provided for you and eligible family members, as well as survivor's benefits.

For employees born after 1937, the age for unreduced Social Security benefits will gradually increase from age 65 to age 67. Ultimately, for employees born after 1959, full Social Security benefits will not become payable until age 67. Reduced benefits are available as early as age 62.

Please remember that, although you and the Company each pay taxes toward the cost of your Social Security benefits, these benefits are not paid automatically. You must apply for them in all cases. To get more information about the law and your personal status under it, contact your local Social Security office. You can also access the Social Security Administration's website at www.ssa.gov.

Reemployment After Retirement

If you have been receiving pension payments and return to work at the Company, your Pension Plan benefits will be suspended during your period of reemployment until you reach age 70½ —when you may choose to begin your benefits.

Your benefits will be suspended for any month in which you receive payment from the Company for hours of service performed on each of eight or more days (or separate work shifts). When payments begin again, they will be adjusted to reflect any benefit that may have accrued after returning to work.

Other Important Information

Withholding Taxes

Under federal tax law, federal income taxes must be withheld from pension payments—unless you elect otherwise. You may contact the ORNL Benefits Office for more information about tax withholding.

Change of Address

It is important that you notify the Company of any change in your address after you retire so you will be assured of receiving benefit communications which the Company may send to you, including your annual tax information.

Direct Deposit of Payments

Your pension payments will be directly deposited into the bank of your choice.

Administrative Information

Information about the administration of your retirement benefits can be found in the chapter titled "Administrative Information."

Savings Plan

Your Savings Plan benefits are designed to work together with the Pension Plan and Social Security benefits to provide you with retirement income.

Highlights

The Savings Plan …

… Lets Your Account Grow Tax-Deferred

Your existing account balance is tax-deferred, which means you will not pay federal income taxes on this amount until you take the money out of the Savings Plan. Roth contributions generally are not subject to federal income taxes at distribution.

… Gives You the Opportunity to Invest in Your Future

You can invest your existing account balance in any one or more of the investment funds made available under the Savings Plan.

… Provides 24-Hour Access to Account Information

The Savings Plan Participant Services and Internet access offer up-to-date information about your account 24 hours a day, 7 days a week.

What happens to your benefits when ...

For more information about what happens to your Savings Plan participation when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

Your Savings Plan Account

At retirement, you were entitled to receive the full value of your Savings Plan account. You had the opportunity to receive your savings all at once or over time—or to defer your total account value (that is, leave your savings in the Savings Plan).

If your Savings Plan account has been deferred, your savings will remain invested in the Savings Plan funds as you direct. In any event, Savings Plan required minimum distribution payments will begin no later than December of the year in which you reach age 70½.

The Savings Plan Information Sources

The Savings Plan makes managing your savings easy. It lets you manage your account over the telephone through a voice response unit or by speaking with a Participant Services representative. By calling Participant Services, you can:

- check your account balance and investment performance
- transfer between investment funds
- request a withdrawal

When you call Participant Services, you will need your web ID to use the voice response unit. You may also call Participant Services and speak to a representative.

You will use your web ID and password to access your account information. You may change your web ID and password to personalize them at any time. Your web ID and password are confidential and should be kept in a safe place. If you lose your web ID and/or password, you may call Participant Services or log on to the Internet site and request a reminder; a copy of the number will be sent through an email link or mailed to your home. For security reasons, you can never get your password over the phone.

Working With the Plan

After you log on, you will see the market value of your account as of a particular date. Remember, our Plan is valued daily, and the amount shown on the screen is the market value as of the close of business of the previous business day. This value is updated once a day, so the value you see in the morning will be the same value for that entire day. The system is updated with current information sometime after midnight.

To Reach Participant Services

In the United States:
1-800-724-7526

International:
1-330-908-4777

TTY Service:
1-800-345-2550

Voice Response Unit:
24 hours a day, 7 days a week
(except for occasional maintenance periods)

Customer Service Representatives:
7 a.m.–11 p.m. Eastern time, Monday through Friday (except on days when the New York Stock Exchange is closed)

Internet Access:
To access the Savings Plan via the Internet, visit workplace.schwab.com.

Call Participant Services or use the Internet for …

- Financial information—prospectuses and Fund Fact sheets, to the extent they are available and provided to the Savings Plan
- Investment performance—past and current investment performance of each fund as it becomes available
- Account value—value of each investment fund within your personal account

Your Investment Options

You can transfer existing balances—in 1% increments—among the investment options at any time. Transfers completed before 4 p.m. Eastern time will be effective that day, assuming it is a business day and the New York Stock Exchange is open; otherwise, changes will be effective the next business and market trading day. Confirmation of your transaction will be mailed within 2 business days.

Any investment involves some degree of financial risk. Actual investment results for your Savings Plan balance will vary depending on the fund or funds in which it is invested. Detailed information about each of the funds is provided in the Fund Fact sheets available on the website. This data is provided for informational purposes only. Before making any investment decision, you should also review the Fund Fact sheets.

Neither the Company; the Savings Plan; nor the Savings, Retirement, and Investment Committee makes any representation that the past performance of these funds is a guarantee nor indicative of their future performance. The Savings, Retirement, and Investment Committee may change the funds at any time. The funds are valued at market daily. The funds are not protected by any federal or state deposit insurance Plan. The Savings Plan is intended to constitute a plan described in section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA). Fiduciaries may be relieved of liability for any losses that are the result of investment instructions given by you or your beneficiary.

Investment Earnings

Investment earnings include interest, dividends, and market gains/losses resulting from your investments in any of the Savings Plan's funds. Returns you may earn on your investments are continually reinvested in the funds you have chosen.

Investment Option Summary

Transaction Processing

The transactions you request through Participant Services ordinarily will be processed within the times specified in this Summary Plan Description.

However, in certain circumstances, you may experience difficulty in making your request, or your transaction may be delayed.

Please remember that the Participant Services voice response line is no more than a telephone line. Telephone service can be interrupted from time to time. In addition, a high volume of telephone calls can overload the system and prevent calls from being answered.

Transactions may also be delayed. For example, if market conditions require a daily volume limit on trades in an asset, there is suspension in trading of an asset or a major market or systems disruption. You may be informed if a transaction is not completed on the day requested, and the transaction will be completed as soon as administratively possible thereafter, based on the unit prices in effect when the transaction is completed.

Investment Option Summary (cont.)

Reward vs. Risk

One way to think of the gain or loss potential of an investment is to think of the potential for reward or the level of risk it offers.

Generally, investments with more risk to principal have the potential to yield higher returns over a longer period of time than investments with less risk.

No one can tell you what balance of reward vs. risk is right for you. It is up to you to decide. When making your decision, however, ask yourself the following questions:

When will you need the money in your accounts?

If you are a long way from needing your retirement fund and are investing for the long-term, you may want to consider more aggressive investment choices with higher risks. But you must be prepared to weather the ups and downs of the market and possible loss of your investment. However, stability in your investments may be more important if you have a shorter time horizon.

What are your investment goals?

You may be concerned about preserving your account balances while earning a steady rate of return. Or you may want investments that offer the prospect of substantial growth. Keep in mind that your investment objectives may change depending on how soon you need your retirement funds and how close you are to meeting your financial goals.

Are your investments sufficiently diversified?

Investment professionals seek to reduce risk by diversifying their investments—not putting too many eggs in one basket. They may diversify over different types of investments, such as stocks and bonds, and within types of investments by buying stocks and bonds of a number of different companies. Because most of the funds offered under the Savings Plan are made up of several types of investments, there is a basic level of diversification within most funds. However, you can diversify further by investing in several different funds to take advantage of the different investment objectives and strategies offered by the funds.

Withdrawals from Your Deferred Account

If you choose to defer your total account value, you may make partial withdrawals of your savings during retirement, within certain plan limits. To request a withdrawal, call Participant Services.

Plan Payouts

If you left the Company before you were immediately eligible for a pension or Total Disability benefits, you will receive a single lump sum payment when you decide to receive your payment. If you were eligible for an immediate pension or Total Disability benefits when you left your employment with the Company, you have a choice of payout methods when you decide to receive your payout. You may elect to receive:

- a single lump-sum payment of your total account value
- a partial payment
- a fixed dollar amount per month that you choose. The fixed amount may be changed by you while payments are ongoing.
- monthly installment payments of your account value over a fixed period of 10, 15, or 20 years (as long as this method meets the IRS minimum distribution requirements), with monthly recalculations based on market value and the remaining payment period
- monthly installment payments over a period equal to your life expectancy or the joint life expectancy of you and your spouse, with monthly recalculations based on market value and the remaining payment period. Life expectancies are recalculated each year.

  or
- monthly installments using the uniform life expectancy table with monthly recalculations based on market value and the remaining payment period. Life expectancies are recalculated each year.

Once you choose an installment payment method, you may not change your election.

Partial payments and installments will be distributed from your after-tax contributions first. You will also have the option of requesting a total distribution from your Roth account.

If you die, your beneficiary may receive your Savings Plan balance in a lump sum. However, if your spouse is your beneficiary, your spouse may elect a lump-sum payment or monthly installment payments over a 5 year period. Your spousal beneficiary also may choose to defer payment.

Electing a Payout Method

When you decide to receive your payout, you may make your payout election over the phone by calling Participant Services. If you choose installment payments, you will receive the applicable forms.

Request a Payout

To apply for a Savings Plan payout, you should call Participant Services at 1-800-724-7526. If you die with a remaining balance in the Plan, your beneficiaries should contact the Recordkeeper for information on obtaining a distribution.

If you elect a lump sum payout, you will be mailed the payout generally within 3 business days from the date Participant Services receives the request. If you elect to receive installment payments, you will receive the required forms to complete and return. The installment payments will begin as soon as administratively practicable after Participant Services receives your properly completed forms.

Plan Payouts (cont.)

Naming Your Beneficiary

Your beneficiary is the person you name to receive benefits from the Savings Plan if you die with a vested balance remaining in your Savings Plan account. Your beneficiary can be anyone you wish. However, if you have been married for at least 1 year and you wish to name someone other than your spouse, you must have your spouse's written and notarized consent.

Be sure to keep your beneficiary designation up to date. If you do not make a beneficiary designation or if you have named someone as your beneficiary while you were single and then get married and you have been married for at least 1 year at the time of your death, your spouse will receive the value of your vested Savings Plan account unless your spouse has signed a waiver form. If you are single and do not name a beneficiary, your vested Savings Plan account will be paid to your estate.

You may change your beneficiary at any time. Simply call Participant Services or access the Savings Plan via the Internet to request a beneficiary form. Your beneficiary election will be effective when the Recordkeeper receives your completed form.

Taxation of Withdrawals and Final Payouts

In general, your before-tax contributions, Company matching contributions, and investment earnings on all types of contributions other than Roth contributions are taxable when you receive them. The actual tax treatment will depend on your age at the time of receipt.

Before Age 59½

If you receive a payment before you reach age 59½ and you do not roll it over, then, in addition to the regular income tax, you may have to pay an extra tax equal to 10% of the taxable portion of the payment. The additional 10% tax does not apply to your payment if it is:

- paid to you because you separate from service with your employer during or after the year you reach age 55
- paid to you because you retire due to disability

  or

- paid to you as equal (or almost equal) payments over your life or life expectancy (or your and your beneficiary's lives or life expectancies).

See IRS form 5329 and the Special Tax Notice available upon request or on the website for more information on the additional 10% tax. You can avoid the income and 10% tax if you roll the taxable portion of your payment over into an IRA or other eligible retirement plan within the time period permitted by law.

Beneficiaries are never subject to the additional 10% tax, regardless of your age at death.

At Age 59½ or Later

If you make a withdrawal or receive a Savings Plan distribution after age 59½, you will not have to pay the extra 10% tax.

To be sure you are using your benefits to their full advantage, you should check with a tax advisor regarding the specific requirements for using these and other forms of favorable treatment that may apply to your payout. The ORNL Benefits Office cannot give you tax advice.

Roth Contributions

Special rules apply to payments of Roth contributions and earnings on those contributions. Payments of your Roth contributions are not subject to federal income tax. Earnings on your Roth contributions will be subject to federal income tax unless the distribution is made after you turn age 59½, upon your death, or upon your disability, and the distribution occurs at least five years after the first day of the taxable year in which you made your first Roth contribution to the Savings Plan. If you made a direct rollover of Roth contributions from the plan of a former employer, the five-year period begins from the first day of the taxable year in which you made your first Roth contribution to the other plan.

Taxation of Withdrawals and Final Payouts (cont.)

Rollovers and Withholding

Withdrawals and lump sum distributions of your before-tax contributions, after-tax contributions, Roth contributions, and Company matching contributions, as adjusted for investment earnings and losses, can be rolled over to an IRA, a Roth IRA, or another eligible retirement plan. Required minimum distributions to employees who have reached age 70½ or retired from the Company after age 70½ and distributions paid out in installments are not eligible for such a rollover. You may roll over the non-taxable (your after-tax contributions) portion of your distribution to an IRA and certain qualified defined contribution plans.

You can roll over all or a portion of your eligible plan payouts either directly or indirectly to an IRA, a Roth IRA, or other eligible retirement plan. With a direct rollover, the Recordkeeper will send you a check payable to the trustee of the eligible IRA, Roth IRA, or plan you designate. If you elect a direct rollover, no federal tax withholding will apply to your rollover amount. The portion that is not rolled over will be subject to mandatory 20% tax withholding.

If you want to roll over your eligible payout yourself—an indirect rollover—there are some important facts to keep in mind:

- Mandatory 20% tax withholding will apply to the distribution when the payout is made to you.

Your rollover must be made within 60 days of the day you receive your payout.

Any portion of the taxable part of your payout not rolled over will be subject to income and penalty taxes (if applicable).

Other withholding rules apply to distributions that are not eligible for a rollover. You will be provided with information on those rules prior to the distribution.

Transfer of Assets for ORNL Participants

On September 3, 2010, some account balances were transferred from the Savings Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee (the “Joint Plan”) to this Savings Plan.

Your account balances in the Joint Plan were transferred to the Savings Plan effective September 3, 2010, if either (i) you were employed (or on leave) at ORNL by UT-Battelle, LLC on September 2, 2010, or (ii) you terminated employment or retired prior to September 2, 2010, and your last employer was UT-Battelle or a previous prime contractor at ORNL. If you satisfy one of these conditions, your account balances will be administered by the Savings Plan rather than the Joint Plan for benefits distributed on or after September 3, 2010.

If you have a question on whether your benefit will be paid from the Savings Plan or the Joint Plan, contact the ORNL Benefits Office.

Your Quarterly Statement

If you defer payment of your Savings Plan account, after the end of each calendar quarter, you will receive a Savings Plan statement that reports your account activity, total fund balances, and investment elections. You can use these statements to track the value of your savings under the Savings Plan.

You also have access to your account statement any time by visiting workplace.schwab.com. You can create an online statement for any time period within the last 24 months.

Claiming Benefits

To apply for a Savings Plan payout, you should call Participant Services at 1-800-724-7526. Your beneficiaries should contact the ORNL Benefits Office.

If you elect a lump-sum payout, you will be mailed the payout generally within 3 business days. If you elect to receive installment payments, you will receive a form to complete.

Other Important Information

Change of Address

It is important that you notify the Company of any change in your address while you are a participant in the Savings Plan so you will be assured of receiving Company communications about the Savings Plan. If you move, call Participant Services for a change form.

Voting Your Shares

The investment manager for each fund will decide how to exercise any voting rights applicable to stock held in that particular fund.

Investment Fees and Expenses

The Savings Plan incurs administrative fees and investment management fees. The administrative fees are the costs to the Savings Plan and your Savings Plan Account, including recordkeeping, accounting, trustee functions, and legal services. The Company pays some of these fees. Some fees are paid by the Savings Plan and charged to all Participant accounts. Fees for items directly related to your account—such as the processing of loans, hardship withdrawals, or domestic relations orders—may be charged to your account. Administrative fees will be shown on your quarterly statement.

Investment management fees are the costs to manage the investment options under the Savings Plan, including investment advice, brokerage fees, commissions, and account maintenance fees. Investment management fees vary by investment and are deducted from your investment returns. Investment management fees for the mutual funds are described in the fund prospectuses.

Responsibility for Investment Decisions

You choose how to invest your money in the Savings Plan among the funds made available. The Savings Plan trustee will follow your investment directions without reviewing your investment decisions.

The Company; the trustee; the Savings Retirement, and Investment Committee; and the other Savings Plan administrators are not responsible or liable for the investment choices you make or investment losses that are the direct and necessary result of your investment choices. This is because the Savings Plan is intended to satisfy the requirements of Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA) and section 2550.404c-1 of the Code of Federal Regulations. Nothing contained in this document is intended to constitute investment advice.

Confidentiality of Investment Directions

Your investment directions for all Savings Plan funds are administered by the Recordkeeper.

The trustee handles all purchases and sales in the name of the Savings Plan without identifying individuals, so your transactions remain confidential.

The Savings, Retirement, and Investment Committee is responsible for monitoring compliance with the procedures that ensure confidentiality. You may contact the committee at:

Savings, Retirement, and Investment Committee
c/o Manager, Retirement Services
P. O. Box 2008
Oak Ridge, TN 37831

Plan Funding

The Savings Plan is funded by participants who designate a part of their eligible earnings to be contributed on their behalf and by the Company through Company matching contributions. The assets of the Savings Plan are held in a trust fund maintained by the trustee.

Tax Treatment

The Company intends to operate the Savings Plan so that it will qualify under Sections 401(a) and 401(k) of the Internal Revenue Code. Accordingly, your before-tax savings will not be taxed until you withdraw them. The earnings of the trust fund, which holds the Savings Plan assets, will not be taxable to you, the trust fund, or the Company at the time earnings are credited to the trust fund, but the earnings will be taxable to you when you receive a distribution.

However, earnings on Roth contributions will not be taxable either in the trust fund or when distributed if you meet certain requirements. Amounts rolled over to a Roth IRA may be taxable to you at the time of the rollover.

Administrative Information

Information about the administration of the Savings Plan can be found in the chapter titled “Administrative Information.”

Glossary and Acronyms

Sometimes, to describe a benefit plan accurately, some technical terms must be used. This Glossary and Acronyms chapter contains brief definitions to help you understand the terms used throughout this book.

Glossary

Annual Pension Benefit

Amount of pension benefit provided under the plan formula.

Average Straight-Time Monthly Earnings

The average of your highest earnings for 3 years during the last 10 years just before you retire.

Beneficiary

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

Birthing Center

An institution which is constituted, licensed, and operated in accordance with the laws of legally authorized agencies to furnish room and board, services of qualified nurses, and a certified nurse midwife to expectant mothers. One or more nurses must be on duty at all times. To qualify as a Birthing Center, an institution must:

- have available at all times, under an established agreement, the services of a physician;
- maintain daily medical records on all patients; *and*
- have agreements with hospitals that will accept patients requiring inpatient hospital care at once.

Child

For medical and dental coverage

- your own child,
- your legally adopted child (or an individual who is lawfully placed with you for legal adoption),
- a child of the person who is recognized under applicable law as your spouse (your stepchild who resides with you full-time in your home), or
- an eligible foster child (an individual who is lawfully placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction).

A child who is an alternate recipient under a Qualified Medical Child Support Order will be considered a “child” for purposes of eligibility for medical or dental coverage regardless of whether such individual otherwise meets the definition of a “child.” Such individual will be subject to the conditions of eligibility set forth in the definition of an eligible dependent.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985; this federal law allows you and your eligible dependents to continue health care coverages under certain circumstances when coverage would otherwise end.

Coinsurance

The percentage of the charges you are required to pay for expenses covered under the plan.

Company

UT-Battelle, LLC

Company Service

The total elapsed time between the date you begin employment with the Company and your last day at work. The Pension Plan uses Company Service to calculate pension benefits—except to determine your eligibility for a vested pension benefit, which uses Credited Service. (Service Credit or Company Service Credit, as referenced under the benefit plans in this book, means Company Service.)

Consumer-Driven Health Plan

A type of health insurance arrangement that allows employees to use a health savings account to pay health care expenses directly along with a high-deductible health plan that protects the participant from catastrophic medical expenses. This type of arrangement encourages covered individuals to be informed and thoughtful consumers of health care services, much as they would be informed and thoughtful when purchasing other goods and services.

Conversion Privilege

Your right to convert a group medical or life insurance policy into an individual policy.

Co-payment

The amount you and your enrolled dependents are required to pay for the services received—in addition to any Coinsurance or Deductible.

Crown

A restoration which replaces enamel, covering the entire crown of a tooth, usually made of porcelain or acrylic.

Deductible

The Deductible is the amount you and your enrolled dependents are required to pay each calendar year for covered expenses before the plan pays; it is in addition to any Co-payments.

Dependent Child

For the Pension Plan

Your natural or adopted child, stepchild, or foster child who is under age 23 and who qualifies as your dependent child for federal income tax purposes.

Dependent Parent

For the Pension Plan

Your natural parent or stepparent who qualifies as your dependent for federal income tax purposes.

Durable Medical Equipment

Any equipment which can withstand repeated use and is medically essential to treat an injury or sickness. If more than one item can meet your functional need, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will only pay the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The Plan covers urinary catheters and tubings, nasal cannulas, connectors and masks used in connection with DME.

Early Retirement

Retirement prior to reaching age 65.

Elective Surgery

A surgical procedure which is not considered emergency in nature and which may be avoided without undue risk to the patient.

Eligible Dependents

For Medical and Dental Coverage

Your eligible dependents are:

- the person who is recognized under applicable law as your spouse
- a child who is less than 26 years old. An eligible dependent may include your unmarried child who is disabled even after the limiting age. For more information, see the chapter titled “About Your Benefits.”

The term “Child” is defined on page 2 of the Glossary.

Eligible Earnings

Your straight-time earnings divided by straight-time hours, then multiplied by scheduled hours.

Emergency Admission

Any hospital admission for an inpatient stay for a condition which:

- has a sudden and unexpected onset
  and
- requires prompt care to protect life, relieve severe pain, or diagnose and treat symptoms which, with delay, could result in serious injury.

Emergency Health Care Services – Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay. Benefits are not available for services to treat a condition that does not meet the definition of an Emergency.

Emergency Treatment

The stabilization or initiation of treatment of an emergency condition. UnitedHealthcare defines an emergency condition as a serious medical condition or symptom (including severe pain) resulting from injury, sickness, or mental illness, that arises suddenly and, in the opinion of a prudent layperson, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of an enrollee.

Glossary (cont.)

ERISA

The Employee Retirement Income Security Act of 1974, as it may be amended from time to time.

Fixed Bridgework

Permanently inserted artificial teeth joined to inlayed or crowned natural teeth on either side called abutments. A fixed bridgework for anterior teeth often requires two abutments on either side.

Full Denture

Upper or lower; artificial teeth in replacement of all teeth in an arch.

Health Reimbursement Arrangement (HRA)

A bookkeeping account provided by the Company that can be used by an eligible retiree or spouse for reimbursement of eligible medical expenses.

Health Savings Account (HSA)

A vehicle that allows retirees enrolled in a qualified medical plan to save—tax free—for health-related expenses. Funds are kept in an interest-bearing bank account until they are needed.

- Contributions to the HSA can be made by an eligible retiree if not enrolled in Medicare Part A or Part B.
- Money deposited into the HSA is generally not taxable. Once the HSA reaches a certain balance, retirees have the option to invest the funds in the account. Several investment options are available.
- The HSA is considered a contractual agreement between the retiree and the bank.

High Deductible Health Care Plan

A federally qualified medical plan with a high minimum deductible that must be met before coinsurance begins. Being covered by a High Deductible Health Care Plan (HDHP) is a requirement to establish a Health Savings Account (HSA).

Home Health Aide

A person who is trained to assist a person with daily living in his or her home after surgery or injury and who reports to and is under the direct supervision of a home health care agency. A home health aide can assist with personal hygiene, changing dressings, and mobility.

Home Health Services

Skilled health care services that the insurance company has determined are medically appropriate to provide in the home.

Hospice Facility

An institution or part of one which primarily provides care for terminally ill patients and fulfills any licensing requirements of the state or locality in which it operates.

Hospice Program

A coordinated, interdisciplinary program of care designed to meet the physical, psychological, spiritual, and social needs of dying persons and their families. A hospice program may also provide palliative and supportive medical, nursing, and other health services through home or inpatient care during the terminal illness.

Hospice Care Services

Any services provided by a hospital, skilled nursing facility, home health agency, hospice, or any other licensed facility or agency under a hospice program.

Hospital

A Hospital is an institution constituted, licensed, and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities needed to diagnose and treat injury and sickness. It is an institution which qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital as a provider of services under Medicare and is accredited by The Joint Commission.

A Hospital can specialize in treatment of mental illness, alcoholism, drug addiction, or other related illness. It can also provide residential treatment programs, but only if it is constituted, licensed, and operated in accordance with the laws of legally authorized agencies responsible for medical institutions. It provides all treatment for a fee, by or under the supervision of physicians on an inpatient basis with continuous 24-hour nursing service by qualified nurses.

Any institution which is exclusively a place for rest, a place for the aged, or a nursing home, will not be considered a Hospital.

Glossary (cont.)

Indemnity Plan

A medical plan in which you can use any provider you choose.

Informal Caregiver

For Long-Term Care

A person providing custodial (personal) care, who is not a nurse or therapist or whose services are not provided and supervised by a home health care agency, nursing home, assisted living facility, hospice, or adult day care center or care management organization. Members of the covered person's immediate family may qualify as informal caregivers.

In-Network Benefits

Health care services or items provided by your primary care physician, or authorized services or items provided by another participating provider.

Lifetime Maximum

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

Medicare-based Maximum Reimbursable Charge (MRC)—Medical

The amount reimbursed by the Under age 65 medical plan when you receive out-of-network services, based on a methodology similar to that used by Medicare to determine the Medicare-based Maximum Reimbursement Charge (MRC) in your geographic area for similar services.

Any charges above the 140% of MRC are not covered by the plan, and you will not be reimbursed for that amount. These charges do not count toward your deductible or out-of-pocket maximum.

Medicare Supplement Program

See "Over 65 Medicare Supplement Program."

Mental Health Provider

The company responsible for authorizing mental health and alcohol/drug abuse treatment for UnitedHealthcare Medical Plan participants.

Myofunctional Therapy

Correcting and/or retraining of the muscles to correct an orthodontic disorder.

Necessary Services and Supplies

Any services or supplies, other than bed and board, that are necessary for your treatment and are administered during hospital confinement. Necessary Services and Supplies also will include professional ambulance service to or from the nearest hospital where the necessary medical treatment can be provided, and any charges for the administration of anesthetics during hospital confinement. Necessary services do not include special nursing, dental, or medical services.

Network

A group of health care providers who have agreed to provide care for prenegotiated rates as well as to comply with quality assurance procedures and patient service standards. A network may be regional or national in its coverage area.

Network Manager

The health plan that sets up and manages a network of providers and administers out-of-network benefits, too. The network manager for the company's medical plans is UnitedHealthcare.

Network Pharmacy

A pharmacy that has contracted with the pharmacy benefit management company to provide prescription drugs under a contractual arrangement for discounted costs.

Normal Retirement

Retirement at age 65.

Nurse

A Registered Graduate Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse. A nurse is a professional who has the right to use the respective title and the respective abbreviation R.N., L.P.N., or L.V.N.

Orthodontic Treatment

Science of the movement of teeth in the correction of malocclusion.

Glossary (cont.)

Orthotics

A custom-molded rigid insert that, when placed in the shoe, distributes the patient's weight equally throughout the foot and leg and relieves the stress from any one particular area.

Out-of-Network Benefits

Care that does not qualify as in-network.

Out-of-Pocket Maximum

The maximum you have to pay for eligible medical expenses in one plan year. Once you reach this amount, the medical plan pays 100% of eligible expenses for the rest of that plan year.

Over 65 Medicare Supplement Program

A program available to eligible retirees who are age 65 or over and enrolled in Medicare Part A and Part B. The program includes a prescription drug plan and a Health Reimbursement Arrangement sponsored by UT-Battelle. A variety of individual Medicare Supplement plans are available for the retiree's purchase through a Medicare Exchange vendor. The individual Medicare Supplement plans are not group health plans subject to ERISA and are not sponsored by UT-Battelle.

Paralysis

The loss of all practical use of a limb as it relates to the ability to perform the normal functions and activities of everyday life without the use of a prosthesis or any other mechanical device(s).

Partial Denture

An appliance supporting artificial teeth less than the full number of teeth in one jaw.

Periodontal Splinting

Stabilizing or immobilization of periodontically involved teeth. Splinting may be accomplished with acrylic resin bit guards, orthodontic band splints, wire ligation, provisional splints, and fixed prosthesis.

Periodontics

The treatment of disease of the gum and tissues surrounding the teeth.

Personal Identification Number (PIN)

The number that allows you to access Savings Plan account information through the information line.

Physician

A person who is licensed to prescribe and administer drugs or to perform surgery and who operates within the scope of his or her license.

Point-of-Service Plan

A medical plan through which you may receive care in-network (at the highest level of benefits) or out-of-network (at a lower level of benefits).

Precertification

The process used to certify the medical necessity and length of a hospital confinement.

Prescription Drugs

Medication prescribed by a physician for the treatment of an illness or injury. There are two types of Prescription Drugs: brand-name and generic.

Preventive Care

For purposes of the Medical Plan, preventive care includes the following:

- evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
- other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Primary Care Physician

A physician—generally an internist, general/family practitioner, or pediatrician—whom you select to coordinate all your medical care.

Glossary (cont.)

Prosthodontic Services

The making of artificial devices for replacement of missing teeth and structures in the mouth.

Qualifying Life Event

An event described in the “About Your Benefits” chapter which permits a change in coverage or election on a pre-tax basis.

Rollover Contributions

Distributions from another employer’s qualified plan that you deposit into your Savings Plan account.

Reasonable and Customary Charge

For Dental Coverage

A rate for dental services that is determined by the insurance company by taking into account:

- the usual fees charged by dentists with similar training and experience in your geographic area
- any unusual circumstances or complications that require special skill, experience, or additional time.

If the insurance company considers your dental expenses more than reasonable and customary, you will be responsible for paying the additional amount. These charges do not count toward your Deductible.

Retiree

A Retiree is a former employee who at the time of termination of employment was eligible to receive a retirement benefit.

Room and Board

All charges commonly made by a hospital for rooms and meals and all general services and activities needed for the care of registered bed patients.

Routine

A situation that does not require immediate attention, such as immunizations or annual exams.

Skilled Nursing Facility

A licensed institution, other than a hospital, which specializes in physical rehabilitation or provides skilled nursing and medical care on an inpatient basis. The institution must maintain on the premises all facilities necessary for medical treatment. Such treatment is provided for compensation and must be under the supervision of physicians and provide nurses’ services.

Space Maintainers

Appliances to prevent adjacent teeth from moving into space left by a lost tooth.

Spouse

An individual to whom you are lawfully married, whether the individual is the opposite sex or the same sex. Individuals of the same sex will be considered to be lawfully married for purposes of the plans as long as they were married in the United State, in a US territory, or in a foreign jurisdiction whose laws authorize the marriage of two individuals of the same sex.

Terminally Ill

A medical prognosis of 6 months or less to live.

Urgent Care

Services for a situation that requires prompt medical attention but is not life threatening.

Vesting

Ownership interest in your Pension Plan benefits and Company matching contributions under the Savings Plan. You have an irrevocable right to a benefit when you are fully vested.

Acronyms and Abbreviations

ABO	Accelerated Benefits Option
ACLT	advanced cardiac life treatment
CAT	computed axial tomography
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COLA	cost of living adjustment
CPR	cardiopulmonary resuscitation
CSR	Continued Stay Review
CT	computed tomography
DAO	Disability Administrative Office
EBSA	Employee Benefits Social Security Administration
EOB	Explanation of Benefits
EPA	External Prosthetic Appliance
ERISA	Employee Retirement Income Security Act of 1974
FAQ	frequently asked question
FSA	flexible spending account
HDHP	High Deductible Health Care Plan
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Reimbursement Arrangement
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
ID	identification
IRA	individual retirement account
IRC	Internal Revenue Code
IRO	Independent Review Organization
IRS	US Internal Revenue Service
LTCI	long-term care insurance
MEPP	Multiple Employer Pension Plan
MH/SA	mental health/substance abuse
MRA	magnetic resonance angiography
MRC	Medicare-Based Maximum Reimbursement Charge
MRI	magnetic resonance imaging
OB/GYN	obstetrician/gynecologist

Acronyms and Abbreviations (cont.)

PAC	Preadmission Certification
PBGC	Pension Benefit Guaranty Corporation
PCP	primary care physician
PDP	Preferred Dentist Program
PET	positron emission tomography
PHI	protected health information
PIN	personal identification number
PSA	prostate-specific antigen
QDRO	qualified domestic relations order
QMCSO	qualified medical child support order
SSN	Social Security Number
STD	short-term disability
TCA	Total Control Account
TDD	telecommunication device for the deaf
TTY	telephone text device
UHC	UnitedHealthcare
USERRA	Uniformed Services Employment and Reemployment Rights Act
VSP	Vision Service Plan
WA	Worldwide Assistance Services, Inc.

Administrative Information

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

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

Plan Sponsor and Administrator

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

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

In carrying out its responsibilities under the plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the Plan Administrator are final, conclusive, and binding on all persons.

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

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

Employer Identification Number

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

Plan Documents

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

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

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

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

Claiming Benefits

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the plans, as described throughout this book. All forms required to take any action under the plans are available through the ORNL Benefits Office. All completed forms must be submitted to the appropriate office, as described throughout this book.

Health Claims Review and Appeal Procedures

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

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

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

Other Claims Appeal

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

Notice of Adverse Benefit Determination for Other Claims

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

Notification on Other Claim Decisions

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

1. the specific reasons for the denial with reference to the specific plan provisions on which the denial was based,
2. a description of any additional information needed to complete the claim and an explanation of why such information is necessary,
3. a description of the plan's claim review procedures and applicable time limits, and
4. a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (where applicable).

Other Claim Appeal of an Adverse Benefit Determination

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

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

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

Notification of Other Claims Decision on Appeal

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

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

Legal Process

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

Agent for Service of Legal Process

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

Plan Termination and Amendment

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

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

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may result in the transfer of plan assets and debts to another plan or may split a plan into two or more parts. If the Company does terminate or amend a plan, it may decide to set up a different plan providing similar or identical benefits, but it is under no obligation to do so.

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

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

Special Pension and Savings Provisions

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

Assets Upon Termination

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

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

Pension Benefit Guaranty Corporation

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

The PBGC guarantee generally covers:

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

The PBGC guarantee generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- some or all benefit increases and new benefits-based plan provisions that have been in place for fewer than 5 years at the time the plan terminates
- benefits that are not vested because you have not worked long enough for the Company
- benefits for which you have not met all of the requirements at the time the plan terminates
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age

  and

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

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

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

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

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

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

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

Assignment or Alienation of Benefits

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

Special Pension and Savings Provisions (cont.)

Qualified Domestic Relations Order

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

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

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

Qualified Medical Child Support Order

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

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

Health Insurance Portability and Accountability Act (HIPAA)

This plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) with respect to protected health information (PHI). For purposes of the plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information that relates to your or their eligibility for all group health benefits under the plan. Additional information about your rights under HIPAA is provided separately in a Notice of Privacy Practices.

Other Administrative Facts

UT-Battelle, LLC

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

Other Administrative Facts (cont.)

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

Your Rights Under COBRA

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

COBRA Participation

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

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

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

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

Your Rights Under COBRA (cont.)

COBRA Continuation Period		
Qualifying Event (if accompanied by a loss of coverage)	**Maximum Continuation Period**	
	Spouse	**Child**
You die	36 months*	36 months*
You and your spouse legally separate or divorce	36 months	36 months
Your child no longer qualifies as an eligible dependent	N/A	36 months
*If your dependent is eligible for extended coverage under the Medical Plan, as described in the "Medical Plan" chapter, the maximum COBRA period will be reduced by the length of that extended coverage.		

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to a plan sponsor, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and other eligible dependents also will become Qualified Beneficiaries if bankruptcy results in their loss of coverage under the group health plan.

Choosing COBRA

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

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

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

Your Rights Under COBRA (cont.)

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

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

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

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

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

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

Notification

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

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

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

  or

- the Company's group health plans are terminated.

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

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

Your Rights Under ERISA

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Your Rights Under ERISA (cont.)

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

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

Assistance With Your Questions

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

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

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

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

Contact Information

For all your benefit questions, call ...

ORNL Benefits Service Center
PO Box 32290
Louisville, KY 40232

Website: https://portal.adp.com
Phone: 1-800-211-3622
TTY Service: 1-800-855-2880 (http://relayservices.att.com)
Fax: 1-866-265-8283
E-mail: ORNL.BenefitsSupport@ADP.com

ORNL Benefits Office
PO Box 2008
MS 6465
Oak Ridge, TN 37831-6465

Website:
http://benefits.ornl.gov
1-865-574-7474

Benefit	Plan Provider	Contact Information
Medical—UnitedHealthcare Plans (Under age 65 retirees)	UnitedHealthcare	Member Services 1-844-234-7925
		To file a claim, mail your completed claim form to the address shown on your ID card
		Website **www.myuhc.com**
Hospital Precertification (for the UnitedHealthcare Indemnity Plan)	UnitedHealthcare	Member Services 1-844-234-7925
Prescription Drugs (Under age 65 retirees)	Express Scripts	Member Services 1-866-749-0097
		To mail order forms for new prescriptions: Express Scripts PO Box 650322 Dallas, TX 75265-0322
		To order or manage your prescriptions online: **www.express-scripts.com**
		For the automated refill system: 1-800-473-3455
		For instructions on how to fax your prescription, have your doctor call: 1-888-327-9791

For all your benefit questions, call … (cont.)

Benefit	Plan Provider	Contact Information
Vision (Under age 65 retirees)	Vision Service Plan	Member Services 1-800-877-7195
		To file a claim, mail your claim to: Vision Service Plan Attn: Out-of-Network Provider Claims PO Box 385018 Birmingham, AL 35238-5018
		Website **www.vsp.com**
Dental (Under age 65 retirees)	MetLife	Member Services 1-800-942-0854
		To file a claim, mail your claim to: MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282
		Website **www.metlife.com**
Dental (Under age 65 retirees)	Delta Dental	Member Services 1-800-524-0149
		To file a claim, mail your claim to: Delta Dental PO Box 9085 Farmington Hills, MI 48333-9085
		Website **www.deltadentaloh.com**
Disease Management Program (Under age 65 retirees) *Clinical support for specific chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure*	UnitedHealthcare (UHC)	Disease Management Program 1-844-234-7925

For all your benefit questions, call … (cont.)

Benefit	Plan Provider	Contact Information
Over 65 Medicare Supplement Program, including the Health Reimbursement Arrangement (HRA) (Over age 65 retirees)	Via Benefits	Member Services 1-888-592-8348 TTY: 1-866-508-5123
		Mailing Address Via Benefits PO Box 2396 Omaha, NE 68103-2396
		Website **https://myviabenefits.com/ornl**
Prescription Drugs (Over age 65 retirees)	Express Scripts	Member Services 1-877-701-9946 TTY: 1-800-716-3231
		To mail order forms for new prescriptions: Express Scripts PO Box 30493 Tampa, FL 33633-0561
		To order or manage your prescriptions online: **www.express-scripts.com**
		Telephone refills 1-877-701-9946
		For instructions on how to fax your prescription, have your doctor call: 1-888-327-9791
Long-Term Care Current participants only	MetLife	Member Services 1-800-438-6388
		Mailing Address Metropolitan Life Insurance Company PO Box 937 Westport, CT 06881-0937
		Website **http://utbattelle.metlife.com**
Life Insurance	MetLife	Statement of Health Unit 1-800-638-6420, prompt 1
		For Life Insurance Conversion Information 1-877-275-6387

For all your benefit questions, call … (cont.)

Benefit	Plan Provider	Contact Information
Savings Plan	ORNL Savings, Retirement, and Investment Committee Charles Schwab Savings Information Line	Mailing Address UT-Battelle c/o Plan Administrator's Office PO Box 2008 Oak Ridge, TN 37831
		Participant Services United States: 1-800-724-7526 International: 1-330-908-4777 **TTY Service:** 1-800-345-2550
		Website **https://workplace.schwab.com**
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	ADP	Member Services 1-800-211-3622
		Mailing Address: ADP Benefit Services PO Box 2968 Alpharetta, GA 30023-2968
Direct Billing *Direct billing for medical, dental, and life insurance coverage for Retirees under age 65, Displaced Defense Workers, and employees on Long-Term Disability*	PayFlex	Member Services 1-855-899-5049
		Billing Address PayFlex Benefits Billing Department PO Box 2239 Omaha, NE 68103-2239
Social Security Administration		Toll-Free Number 1-800-772-1213
		Oak Ridge Office 1-800-999-1118