Your Benefits Summary Plan Description

DISCOVER your WORLD of benefits

Introduction

OAK RIDGE National Laboratory

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

July 2020

Dear Active Employee:

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

With the exception of the Disability Chapter, which is effective February 28, 2020, this Benefits Booklet is effective as of January 1, 2020.

The employee SPD is available to view or download at http://benefits.ornl.gov/employee-book-of-benefits-igua-spo/. 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 Service Center at 1-800-211-3622.

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. ໂທຣ 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.

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1. About Your Benefits

Your benefits have been designed to support you during the different times of your life—providing comprehensive financial security while you are working as well as income security after you retire.

Highlights

Your Benefits ...

Provide Eligibility for You and Your Family

As a **Regular Full-Time Employee or a Regular Part-Time Employee** you are eligible for coverage under most benefit plans, including Medical, Dental, Life, Legal, and Accident Insurance and the Savings Plan on your first day of work.

Offer Coverage Automatically

If you are in the class of employees eligible for benefits, you are covered automatically under the following plans:

- Employee Assistance Program
- Short-Term Disability and Long-Term Disability (eligible as defined in the "Disability Coverage" and "Glossary" chapters)
- Business Travel Accident Insurance
- Pension Plan—For the International Guards Union of America (IGUA) employees (Security Police Officer [SPO] and Central Alarm Station [CAS] Operator) hired prior to August 15, 2016, only

See the "Eligibility at a Glance" chart in this section for a summary listing of employees who may be eligible for benefits.

Let You Choose the Coverage That Is Right for You

These benefits are optional, giving you the opportunity to choose the coverage you want and need:

- Medical (including Prescription Drugs)
- Dental
- Flexible Spending Accounts
- Basic and Supplemental Life Insurance
- Spouse and Dependent Life Insurance
- Special Accident Insurance
- Legal Insurance
- Savings Plan
- Vision

Offer Tax-Effective Coverage

Contributions for Medical Plans, Dental Plans and Flexible Spending Accounts are automatically deducted from your Pay on a pre-tax basis and according to US Internal Revenue Service (IRS) rules. You can also make pre-tax contributions to the Savings Plan.

The term "Company" refers to UT-Battelle LLC. Other terms are defined in the Glossary.

Eligibility and Enrollment

Employee

You are eligible to participate in the benefit plans described in this book if you are employed and paid as a Regular Full-Time Employee of the Company working on a regular basis or as a Regular Part-Time Employee working a fixed schedule.

As a Bargaining Unit Employee, you are eligible for Business Travel Accident insurance and those benefit plans in which your collective bargaining unit has agreed to participate.

Individuals who are paid as independent contractors or who are leased from another employer are not employees and are not eligible to participate in the benefit plans described in this benefit summary book. **The terms "Regular Full-Time Employee" and "Regular Part-Time Employee" are defined in the Glossary**.

Dependents

Eligible dependents may include your spouse and your children. You may choose to cover your eligible dependents for Medical (including prescription drugs), Dental, and Vision coverage. Your spouse and children are eligible for Life, Special Accident, and Legal Insurance coverage. All eligible dependents may also use the Employee Assistance Program.

Dependent Verification

To enroll your eligible dependents in the medical and/or dental plans, you are obligated to submit proof of dependent status for children and spouse, which includes birth certificate, marriage certificate, or other documents that may be needed to prove eligibility. Enroll your dependents in the plans and upload the documents at the time of enrollment. If you do not have copies of the documents available at enrollment, you must provide the documents by the Verification Deadline on the Dependent Verification Notice. This notice will either be emailed to your work email address or mailed as a paper copy to your home address.

Such coverage for your dependents will not be valid until such evidence is provided. Once the evidence is provided, coverage will be official back to the date of the qualifying event. If evidence is not provided within the time frame, your dependent's enrollment in the plan will be denied. If any claims were paid during the pending eligibility period, the claims will be invalid and will be recovered by United Healthcare, Express Scripts, Vision Service Plan, or MetLife/Delta Dental. You will be refunded appropriate premiums as if you never had the coverage for the family member.

Continuation of Coverage

Medical (including prescription drugs) Dental, Vision, and Legal Insurance 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 attaining the maximum age, and you remain a participant in the plan. Additional proof of the child's continuing disability will be required periodically.

Administrative Information

Information about COBRA can be found in the chapter titled "Administrative Information."

When your dependents are no longer eligible for Medical and Dental coverage, they may be eligible to continue coverage for up to 36 months under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Legal Insurance may be converted into an individual policy when a dependent is no longer eligible under the employer plan.

Child Life Insurance 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.

Special Accident Insurance coverage may be continued indefinitely 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 19. **The terms "Eligible Dependents" and "Spouse" are defined in the Glossary**.

Eligibility ... At a Glance		
Benefit Plan	**When You Are Eligible to Enroll**	
	Regular Full-Time Employees working a minimum of 30 hours per week	**Regular Part-Time Employees** *(Hired to work from 50% to 70%, on a declared schedule)*
Medical (including Prescription Drugs)	On your first day of work Premiums are based on employee/employer cost sharing	On your first day of work Premiums are based on employee/employer cost sharing
Dental	On your first day of work Premiums are based on employee/employer cost sharing	On your first day of work Premiums are based on employee/employer cost sharing
Vision	On your first day of work Premiums are based on employee/employer cost sharing	On your first day of work Premiums are based on employee/employer cost sharing
Flexible Spending Accounts	On your first day of work	On your first day of work
Basic, Supplemental, Spouse, and Dependent Life Insurance	On your first day of work	On your first day of work
Special Accident Insurance	On your first day of work	On your first day of work
Legal Insurance	On your first day of work	On your first day of work
Savings Plan	On your first day of work	On your first day of work
	Enroll anytime at workplace.schwab.com	

Eligibility ... At a Glance		
Benefit Plan	**When You Are Eligible to Enroll**	
Company-Provided Benefits: If you are eligible, you receive these benefits		
	Regular Full-Time Employees working a minimum of 30 hours per week	**Regular Part-Time Employees** *(Hired to work from 50% to 70%, on a declared schedule)*
Employee Assistance Program	On your first day of work	On your first day of work
Long-Term Disability	On your first day of work	Not Eligible
	The benefit requires a 180 day period of disability before you are entitled to payment	
Business Travel Accident Insurance	On your first day of work	On your first day of work
Pension Plan	On your first day of work. For IGUA employees hired prior to August 15, 2016, only	On your first day of work. For IGUA employees hired prior to August 15, 2016, only

Special Eligibility Rules for Families

If you and your spouse both work for the Company and are eligible to participate in the Company's benefit plans, you may enroll in the plan as an employee, or you may be enrolled as a spouse.

However, you may not enroll for coverage as an employee and as a spouse. In addition, only one of you may enroll your eligible dependent children.

If you are under age 26 and you and one of your parents work for the Company and are eligible to participate in the Company's benefit plans, you may enroll in the plan as an employee, or you may be enrolled as a dependent.

However, you may not enroll for coverage as an employee and a dependent.

Many benefits and programs are available to you. Although some benefits are provided automatically, enrollment is necessary for others.

Benefits with no enrollment required:

- Employee Assistance Program
- Short-Term Disability
- Long-Term Disability
- Business Travel Accident Insurance
- Pension Plan—For IGUA employees hired prior to August 15, 2016, only

To receive these benefits, you must enroll when you are first eligible:

- Medical (including Prescription Drugs)
- Dental
- Vision
- Flexible Spending Accounts
- Basic and Supplemental Life Insurance
- Spouse and Dependent Life Insurance
- Special Accident Insurance
- Legal Insurance
- Savings Plan

When You May Enroll

You may elect benefits coverage when you first become eligible to enroll, regardless of when coverage begins. All newly hired employees are eligible to enroll as of their first day of work and must enroll within 30 days of their hire date.

Open Enrollment

All employees may enroll for Medical, Dental, Vision, and Legal Insurance during the annual Open Enrollment period, held in October or November of each year. Enrollment in the Flexible Spending Account is not automatic and must be reelected each year. Coverage is effective beginning January 1 of the following year. All other benefit elections remain in effect without reenrollment each year.

Enrollment for all benefits, except the Savings Plan, is conducted through the ORNL Benefits Service Center website at https://portal.adp.com or by phone at 1-800-211-3622. To enroll your dependents in the Medical and/or Dental plans, you must provide a copy of your marriage certificate for your spouse and a copy of the birth certificate for each of your children.

Savings Plan

You are eligible to enroll in the Savings Plan immediately upon hire. When you begin work, you will receive a Savings Plan enrollment kit, which includes investment fund fact sheets and a beneficiary form. You also will receive a separate mailing containing your web password and personal identification number (PIN).

You can enroll in the Savings Plan at any time at workplace.schwab.com. Click the Enroll Now button near the top right corner, then follow the on-screen instructions.

You may also call Schwab Retirement Plan Services Company. Hours are 7 a.m.–11 p.m. Eastern time, Monday through Friday (except on days when the New York Stock Exchange is closed).

- In the United States—1-800-724-7526
- International—1-330-908-4777
- TTY Service—1-800-345-2550

Refer to the “Savings Plan” chapter for more information on the Savings Plan enrollment process.

Beneficiaries

When you enroll for Life Insurance, Accident Insurance, or the Savings Plan, you will be asked to name a beneficiary to receive any benefits that may become payable in the event of your death.

When You May Change Your Elections

You may add or change coverage for Basic Life, Supplemental Life, and Spouse Life with an approved statement of health. You may add Special Accident Insurance at any time. You may cancel these coverages at any time. You may change most Savings Plan elections at any time. There are limited circumstances under which you may change other benefit elections.

Other election changes can be made annually, during the Open Enrollment period, or within 30 days of a Qualifying Life Event or a qualifying significant change in cost or in coverage.

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.

If you would like to request a midyear election change because of a qualifying event, you must do so through the ORNL Benefits Service Center website at https://portal.adp.com or by phone at 1-800-211-3622. This election must be made **within 30 days** of the event.

When Coverage Begins

New Hires

If you enroll as a newly hired employee, your coverage will begin according to the following chart, provided you meet the plan's eligibility requirements. Any coverage you elect for your eligible dependents will begin on the same day your coverage begins.

Current Employees

Changes Made During Open Enrollment

Medical and Dental coverage, Legal Insurance, and Flexible Spending Account elections you make during the fall Open Enrollment period will be effective on January 1 of the following year.

Changes at Other Times

If you change the elections for your Medical, Dental, or Legal Insurance or your Flexible Spending Account because of a Qualifying Life Event, or change the elections for your Life or Accident Insurance, the changes will be effective on the date described on the chart below.

Benefit Plan	Your Coverage Will Begin…
Medical (including Prescription Drugs), Dental, Vision, and Legal Insurance	**New Regular Full-Time Employees, Regular Part-Time Employees:** on your first day of work, provided you enroll within 30 days of that date. If you do not enroll within 30 days after you first become eligible, you will have to wait until the next Open Enrollment to enroll. Your coverage will become effective the first day of the plan year following Open Enrollment, currently January 1.
	Current Employees: Election and enrollment changes made as a result of a Qualifying Life Event must be made within 30 days of the event. In this case, coverage is effective on the qualifying event date.
Employee Assistance Program	On your first day of work.
Flexible Spending Accounts	**New Employees:** Payroll deductions begin as soon as administratively possible and in accordance with IRS rules following your election; however, you may claim eligible expenses beginning on your first day of work. Pre-tax and after-tax deductions are made based on IRS rules. Casual Employees are not eligible.
	Current Employees: Election and enrollment changes made as a result of a Qualifying Life Event must be made within 30 days of the event. Coverage is effective beginning the date the election is made**. For birth or adoption, coverage is effective beginning the date of the event.**
Short-Term Disability	First of the month after one month of service
Long-Term Disability	On your first day of work.
Savings Plan	Your contributions in the form of payroll deductions will begin as soon as administratively possible after you enroll, generally within 30 days.

Benefit Plan	Your Coverage Will Begin…
Pension Plan	On your first day of work. For IGUA employees hired prior to August 15, 2016, only.
Basic Life Insurance	**New Employees**: On your first day of work, provided you enroll within 30 days after you become eligible. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
	Current Employees: Satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
Supplemental Life Insurance	**New Employees:** On your first day of work, provided you enroll within 30 days after you become eligible. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
	Current Employees: Satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
Spouse and Dependent Life Insurance	**New Employees:** On your first day of work, provided you enroll within 30 days after you become eligible for guaranteed issue amounts. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
	Satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
Special Accident Insurance	**New Employees**: On your first day of work, provided you enroll within 30 days after you become eligible.
	Current Employees: If changes are made to the plan using the Life Accident Insurance changes life event, the change is effective the date of the event.
Business Travel Accident Insurance	On your first day of work.

Changes at Other Times

Qualifying Life Events

You may change your pre-tax Medical, Dental, Vision, and Legal Insurance elections as well as your Flexible Spending Account contributions during the year only on account of and consistent with a Qualifying Life Event or when certain significant changes in cost or in coverage happen. A change during the year must be made within 30 days of the qualifying event or certain special enrollment events.

A Qualifying Life Event includes

- marriage, legal separation, annulment, or divorce
- the death of your spouse or child
- the birth or adoption (or placement for adoption) of your child
- the loss or gain of benefit eligibility of your child
- the termination or commencement of employment of you, your spouse, or your child
- reduction or increase in hours of employment of you, your spouse, or your child, including a switch between part-time and full-time employment, a strike or lockout, or commencement of or return from an unpaid leave of absence
- a change in health coverage due to your spouse’s employment
- a “special enrollment period” under the group health plan as required by law, including loss of coverage for Medicaid or a state Children’s Health Insurance Program (CHIP) or gaining eligibility for Medicaid or CHIP

- a Qualified Medical Child Support Order that requires your child to be covered under the group Medical, Dental and/or Vision plan
- you, your spouse or child becomes eligible (or loses eligibility) for Medicare or Medicaid

  or
- involuntary loss of other group health plan coverage.

REMINDER: Enrollment must be completed within 30 days of any Qualifying Life Event or a special enrollment period for gaining eligibility or losing coverage, or premium assistance under Medicaid or CHIP. Otherwise, you will have to wait until Open Enrollment to enroll, and the coverage will not be effective until the next January 1.

Here are a few examples of election changes that are consistent with a Qualifying Life Event:

Example of Election Changes Consistent with a Qualifying Life Event

With this Qualifying Event	You can make these changes, if consistent*
Marriage, birth, adoption, or placement for adoption of a child	Add yourself, your spouse, and/or children; drop coverage if you are to be covered by your spouse's plan
Divorce, legal separation, or annulment	Drop your spouse and/or children; add coverage if you had been covered under your spouse's plan
Death of you, your spouse, or a child	Drop coverage for spouse or child; add coverage if you had been covered by your spouse's employer
Involuntary loss of other group medical coverage	Add coverage
Your child ceases to be an eligible dependent	Drop dependent coverage

**To add a dependent, you must provide dependent verification as outlined in the "Dependents" section above.*

For your election to be effective, the Plan Administrator must determine that your requested midyear change is consistent with the event.

Changes in Cost or Coverage

In addition to the changes listed above, if there is a **significant** change in the cost of coverage of a benefit option, you may be entitled to make a corresponding change in your election within 30 days of the event (except with respect to the Health Care Flexible Spending Account). If a new benefit option is added or improved significantly or curtailed by the Company or by your dependent's employer, you may be permitted to make a corresponding new election. Changes to your Health Care Flexible Spending Account are not allowed by law for these reasons.

If you contribute to the Dependent Care Flexible Spending Account, and there is a significant increase or decrease in the cost of services by a day care provider who is not your relative, you may be able to make corresponding changes to your contribution election for your Dependent Care Spending Account by submitting a new election within 30 days of the change. If your dependent care provider changes or services are significantly curtailed, you may be able to change your election within 30 days. For example, if midyear, your

mother will begin taking care of your child at no cost and you no longer need your current dependent care center, you can revoke your election to contribute to the dependent care spending account due to a significant change in coverage. However, if your mother wants a payment midyear, you cannot increase your contributions to this account due to a change in cost because she is your relative.

In addition, if annual enrollment for your spouse is for a period of coverage other than the calendar year, you may be permitted to make a corresponding election change under this plan during your spouse's enrollment period. For example, if you elect family medical coverage and, in April, your spouse elects coverage under his or her employer plan for May 1–April 30, you can drop your spouse from our medical plan by submitting an election change by May 30.

Please be aware that if the cost of a benefit option that you pay on a pre-tax basis increases or decreases during a year (but not significantly), your election will be changed automatically to reflect the change in the cost of coverage.

How Changes Affect Your Benefits

Steps to Take If You Get Married or Divorced

If You Get Married …

Notify the Company's Personnel Records Department to update your personnel records if your name changes. You must show your Social Security card as proof of your name change. Update your address and emergency contact information in the Company database.

Change your benefit elections within 30 days of your marriage on the Benefits Enrollment website at https://portal.adp.com or call the ORNL Benefits Service Center at 1-800-211-3622.

Review your spouse's benefits so you can coordinate coverage to your best advantage. If you are adding your spouse to your Medical, Dental, and/or Vision coverage, a copy of your marriage license is required.

Consider increasing your contributions to the Health Care Flexible Spending Account so you can pay for your spouse's unreimbursed medical, dental, and vision care expenses with pre-tax dollars.

Update your Life and Accident Insurance beneficiary records on the Benefits Enrollment website.

Consider enrolling in Legal Insurance, so you and your spouse have access to legal counsel to assist in covered services such as identity theft protection for you and your family, creating a will, or assistance with financial planning.

To update your Savings Plan beneficiary information, request a Savings Plan beneficiary form from the Savings Plan website or by calling Charles Schwab Retirement Plan Services. 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 Charles Schwab Retirement Plan Services or the ORNL Benefits Office for more information.

If You Get Divorced …

Notify the Company's Personnel Records Department to update your personnel records if your name changes. Update your address and emergency contact information in the Company database.

Change your benefit elections within 30 days after the date your divorce is final on the Benefits Enrollment website at https://portal.adp.com or call the ORNL Benefits Service Center at 1-800-211-3622.

If you fail to make the change within 30 days, you are still required to drop your spouse from your benefits; however, you may not be able to reduce your pre-tax premiums through the end of the year.

You must submit a copy of the divorce decree in order to drop coverage for your ex-spouse. Your ex-spouse is eligible to continue Medical, Dental, and Vision coverage for up to 36 months through COBRA. You or your ex-spouse has 60 days to notify the ORNL Benefits Service Center in order to obtain COBRA benefits. See the "Administrative Information" chapter.

You also may add your eligible dependents to your Medical, Dental, and Vision coverage within 30 days of your divorce or if a court establishes that you must provide coverage for dependent children who previously had coverage provided by your ex-spouse.

You also have the opportunity to enroll in Legal Insurance during this time.

Update your Life and Accident Insurance beneficiary records on the Benefits Enrollment website. To update your Savings Plan beneficiary information, request a Savings Plan beneficiary form by calling Charles Schwab Retirement Plan Services.

Contact the Pension and Savings Operations Department if you think a court may issue a Qualified Domestic Relations Order (QDRO) granting your former spouse the right to receive any pension or Savings Plan benefits. You will be sent important information about the procedures and requirements for QDROs.

Call the Employee Assistance Program if you need help with a personal, family, or marital problem.

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 leave options and the deadlines you need to meet to add your baby to your coverage. This will help you maximize your available benefits.

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 preauthorize your hospital or birthing center admission.

Present your medical identification 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 preauthorize your maternity admission. Refer to the back of your identification card for contact information.

If You Adopt a Child ...

Notify your supervisor and the ORNL Benefits Office if you would like to discuss various leave options and make arrangements that best meet the needs of you and your family.

Interview and choose a network pediatrician for your child to receive in-network benefits. Well-child care and immunizations are covered only when you receive them from a network pediatrician.

When Your Child Arrives

For Medical, Dental, and Vision 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.

Consider beginning or increasing your contributions to the Flexible Spending Accounts so you can pay for your child's unreimbursed medical expenses and child care expenses with pre-tax dollars.

Consider enrolling in Legal Insurance so you and your family have access to legal counsel to assist in covered services such as creating or updating a will, identity theft protection, or assistance with financial planning.

Complete your enrollment on the Benefits Enrollment website at https://portal.adp.com 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 If You Become Disabled

If You Become Disabled …

Notify your supervisor, either in person or by telephone, in advance, if you cannot report to work. If you cannot reach your supervisor, notify the Lab Shift Superintendent.

Contact the Company's disability claims administrator to request disability benefits. Remain in contact with the claims administrator and the ORNL Benefits Office and keep them informed about how long you anticipate being away from work.

Receive Short-Term Disability benefits for up to 25 weeks of disability (if eligible). If your disability continues longer than 25 weeks, you can apply for Long-Term Disability benefits.

Contact the claims administrator and file forms for Long-Term Disability benefits if your disability will continue longer than 25 weeks.

Apply for other disability benefits that may be payable (i.e., Social Security, Workers' Compensation, state or individual disability benefits, and auto insurance recoveries).

The terms "Short-Term Disability" and "Long-Term Disability" are defined in the Glossary.

What Happens to Your Benefits If You Become Disabled

Here is what happens to your benefits during a disability:

Medical (Including Prescription Drugs), Dental, Vision and Legal Insurance

During Short-Term Disability
Coverage continues. Contributions are deducted from your disability benefits.

During Long-Term Disability
Coverage continues up to the first of the month following the end of your long-term disability coverage, provided you continue to pay the required premium.

Employee Assistance Program
You may continue to access the services of the Employee Assistance Program.

Health Care Spending Account

During Short-Term Disability
Participation continues, provided your Pay continues. Claims may be submitted for expenses incurred before and during the period of your disability in which you are still making contributions to your account.

During Long-Term Disability
Participation ends unless you elect to continue contributing for the rest of the year on an after-tax basis through COBRA.

You may submit claims for health care expenses incurred before your Short-Term Disability benefits end and for those incurred afterward only if they were incurred in the period in which you continued to participate.

Dependent Care Spending Account

During Short-Term Disability
Participation continues provided your Pay continues. You may submit claims for expenses incurred before your disability began and during your disability if you are unable to care for your eligible dependent.

During Long-Term Disability
Participation ends. You may submit claims for expenses incurred before your disability began, up to the balance in your account. Submit claims for expenses incurred before your disability began and during your Short-Term Disability if you were unable to care for your eligible dependents, up to the balance in your account.

Short-Term and Long-Term Disability

Short-Term Disability provides benefits for up to 25 weeks of disability, depending on your length of service. Long-Term Disability benefits provide a percentage of your annual Pay, up to a maximum of 60% of your annual Pay, not to exceed $15,000 per month, offset by Social Security and other benefits payable. Eligibility for benefits is defined in the “Disability Coverage” chapter. Bargaining Unit employees should refer to the Collective Bargaining Agreement for a description of coverage.

Basic Life Insurance and Supplemental Life Insurance

During Short-Term Disability and Long-Term Disability

Coverage continues at the level in effect at the time your disability began for as long as you meet the disability requirements of the Basic and Supplemental Life Insurance plans, or until you reach age 65. For Bargaining Unit employees, after 13 weeks of disability, this coverage is provided at no cost to you. (If your disability begins after your 63rd birthday, your insurance will continue for 2 years, but not beyond age 70.)

Spouse and Dependent Life Insurance

Coverage continues during Short-Term Disability. After Short-Term Disability ends, you may convert to an individual policy or terminate coverage.

Business Travel Accident Insurance

During Short-Term Disability and Long-Term Disability

Coverage ends. However, if within 100 days of a covered accident, you become Totally and Permanently Disabled as a result of an injury sustained in the accident, you will receive a lump-sum payment of four times your annual Pay, subject to the maximum amount, after you have been Totally and Permanently Disabled for 12 consecutive months.

Special Accident Insurance

During Short-Term Disability and Long-Term Disability

Coverage continues during Short-Term Disability and for up to 12 months during Long-Term Disability, provided you pay the premiums. If you are a Bargaining Unit employee and you become eligible for Total and Permanent Disability within 365 days of a qualifying accident, you will receive an additional monthly benefit after you have been disabled for 12 consecutive months. These benefits will continue for up to 50 months. Refer to the “Life and Accident Coverage” chapter for other Special Accident Insurance benefits.

Pension Plan—For IGUA employees hired prior to August 15, 2016, only

During Short-Term Disability and Long-Term Disability

You continue to earn Company Service while you are receiving short-term or long-term disability benefits.

Savings Plan

During Short-Term Disability

Contributions continue during your paid disability. If you have an outstanding loan, payments will be deducted from your paid disability. Any payments missed will be automatically deducted from your paycheck immediately upon your return to work.

During Long-Term Disability

Contributions end. In case of Total Disability, you become 100% vested in the Company match. You may elect a distribution, or you may choose to defer payment. If you have an outstanding loan, you must continue to make repayments directly to Charles Schwab Retirement Plan Services.

Steps to Take If You Leave the Company

If You Leave the Company …

Notify your supervisor.

Apply for COBRA within 60 days from the date your coverage ends if you wish to continue Medical (including prescription drugs), Dental, and Vision coverage or to continue participating in the Health Care Flexible Spending Account.

Convert your Life, Spouse and Dependent Life, and Accident Insurance to a private policy within 30 days of your termination if you wish to continue this type of coverage. Metropolitan Life Insurance will send you a conversion notice. For Special Accident conversion, you may request a form from the ORNL Benefits Service Center.

Notify ARAG within 90 days of your termination date to convert your Legal Insurance to an individual policy.

Decide whether to leave your account balance in the Savings Plan or take a distribution.

Notify the ORNL Benefits Office if your address changes.

What Happens to Your Benefits If You Leave the Company

Medical (Including Prescription Drugs)

Coverage ends on the last day of the month in which your employment terminates. You or your qualified beneficiaries may continue coverage for up to 18 months through COBRA unless you are discharged for gross misconduct.

Dental

Coverage ends on the last day of the month in which your employment terminates. However, if you are undergoing a course of treatment, benefits may be payable for charges related to that treatment that you incur after your termination. Check with your insurance carrier to see if this applies to you. In addition, you or your dependents may continue coverage for up to 18 months through COBRA unless you are discharged for gross misconduct.

Vision

Coverage ends on the last day of the month in which your employment terminates. You or your qualified beneficiaries may continue coverage for up to 18 months through COBRA unless you are discharged for gross misconduct.

Employee Assistance Program

Coverage ends 18 months after employment terminates.

Flexible Spending Accounts

Coverage ends. You may submit Health Care Flexible Spending Account claims and Dependent Care Flexible Spending Account claims for expenses incurred before your termination. You may continue your Health Care Flexible Spending Account participation on an after-tax basis through the end of the year through COBRA, and you may submit claims for expenses incurred during the period you continue to make contributions.

Disability

Coverage ends.

Life and Accident Insurance

Coverage ends on the last day of the month in which your employment terminates. You may convert your Basic Life, Supplemental Life, and Spouse and Dependent Life to individual whole life policies. You may choose the portability option under Supplemental Life Insurance, which allows you to continue this coverage under a term life policy. Metropolitan Life Insurance will send you a conversion notice. You may also convert your Special Accident policy. You may not convert Business Travel Accident Insurance.

Legal Insurance

Coverage ends on the last day of the month in which your employment terminates. You may convert your coverage to an individual policy by calling ARAG within 90 days of your termination date.

Pension Plan—For IGUA employees hired prior to August 15, 2016, only

You may receive pension benefits when you reach the Pension Plan's earliest retirement age if you are vested. If you leave the Company prior to becoming vested, you will receive a refund for the amount of your mandatory participant contributions plus applicable interest, and you will forfeit any other benefit under the Pension Plan.

Savings Plan

Contributions end. You may choose to receive a payout of your full vested account balance, or you may leave it in the Savings Plan. Any outstanding loans must be paid within six months of termination. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

Your Savings Plan distribution is subject to a mandatory 20% tax withholding unless it is paid in a direct rollover into an individual retirement account or another employer's plan within 60 days.

What Happens to Your Benefits When You Turn Age 65

If you are an active employee when you turn age 65, your benefits continue.

Medical (Including Prescription Drugs), Dental, and Vision

Coverage for you and your dependents continues.

Medicare

You become eligible to enroll in Medicare Part A and B, but enrollment is not required. The Company's medical plan will remain primary as long as you are an active employee. Likewise, your spouse is not required to enroll in Medicare at age 65 if covered under the Company's medical plan. (Exception: If you have end stage renal disease or amyotrophic lateral sclerosis [ALS], please see Medicare guidelines for additional requirements.)

When you retire, you and/or your spouse will apply for Medicare as part of a Special Enrollment Period, which allows late enrollment into Medicare without a penalty.

At Age 70…

Your benefit amount for Special Accident Insurance will be reduced as follows:

If you are at least this age:	Your benefit will be this % of your pre-age-70 benefit:
70	82.5%
75	57.5%
80	37.5%
85	20%

The conversion privilege under the special accident insurance plan ends at age 70.

See the "Life and Accident Insurance" chapter for more information.

At Age 70 ½ …

For IGUA employees hired prior to August 15, 2016

You may begin your pension benefit.

See the "Pension" chapter for more information.

Steps to Take When You Retire

If You Are About to Retire …

Visit the ORNL Benefits website to generate a calculation of your estimated pension benefit.

Attend a retirement planning seminar to understand your retirement options.

Notify your supervisor.

Schedule your retirement processing appointment with the ORNL Benefits Office. During this appointment, you will complete forms to elect your pension benefit. You may elect to continue your Medical (including prescription drugs), Dental, Vision, and Life Insurance coverage (if you retire before age 65) or enroll in the Over Age 65 Medicare Supplement program if you are age 65 or older.

If you decide to continue your benefits, you must make these elections immediately upon retiring.

Use the Savings Plan website or call Charles Schwab Retirement Services to get an estimate of your account balance as well as any outstanding loan balances.

Contact Social Security at 1-800-772-1213 to get an estimate of benefits and information about Medicare.

What Happens to Benefits When You Retire

For IGUA employees hired prior to August 15, 2016

Medical (Including Prescription Drugs), Dental, and Vision

If you retire 3 months before or after you turn age 65, the Medicare Initial Enrollment Period rules should be followed to avoid a gap in coverage. Refer to the "Medicare and You" booklet at www.medicare.gov for more information.

If you retire prior to age 65, you may continue coverage until the first of the month in which you reach age 65. At age 65, coverage ends, and you become eligible for the Over Age 65 Medicare Supplement program. However, you may elect to continue coverage under the medical plan for an enrolled younger spouse and eligible dependents until your spouse reaches age 65, as long as you are enrolled in the Over Age 65 Medicare Supplement program. Your under age 65 spouse and dependents can continue enrollment in the Dental Plan until your spouse reaches age 65, regardless of whether or not you are enrolled in the Over Age 65 Medicare Supplement program In any case, when your coverage ends, eligible dependents may be able to continue coverage for up to 36 months (longer under certain circumstances) under COBRA.

- If you are eligible to retire with at least 10 years of full-time Company service, you will pay a share of the cost.
- If you are eligible to retire with less than 10 years of full-time Company service, you will pay the full cost.

For IGUA employees hired on or after August 15, 2016

- If you have at least 10 years of full-time Company service, you will pay the full cost.
- If you have less than 10 years of Company service, you will be offered COBRA.

The Company expects and intends to continue the plans in the benefits program indefinitely but reserves the right to end each of the plans without notice, if necessary. The Company also reserves the right to amend each of the plans at any time without notice. The Company may also increase or decrease its contributions to the plans. The establishment of the plans does not impose on the Company any contractual obligations to continue them in the future.

Employee Assistance Program

Coverage ends 18 months after employment terminates.

Flexible Spending Accounts

You may continue to contribute to the Health Care Flexible Spending Account on an after-tax basis through the end of the year through COBRA. Participation in the Dependent Care Flexible Spending Account ends.

You may submit claims for eligible health care and dependent care expenses incurred before you retire. You may submit Health Care Flexible Spending Account claims for eligible expenses incurred after you retire only if you continue to participate as described above.

Disability

Coverage ends.

Legal Insurance
You may enroll in legal insurance as a retiree within 30 days of your retirement or during Open Enrollment each year.

For IGUA Employees Hired Prior to August 15, 2016

Basic Life Insurance
At retirement prior to age 65, full Basic Life Insurance coverage may be continued at the same premium cost as active employees, or you may take a reduced amount of Basic Life Insurance at no cost to you. At age 65, the reduced amount of Basic Life Insurance coverage will be continued, at no cost to you, for the rest of your life, provided you had Basic Life Insurance coverage for at least 1 year immediately preceding retirement. You may convert your basic life coverage to an individual whole life policy, or you may choose the portability option under Basic Life Insurance, which allows you to continue this coverage under a term life policy. Metropolitan Life Insurance will send you a conversion notice.

Supplemental Life Insurance
At retirement prior to age 65, Supplemental Life Insurance of one times your salary may be continued at the same premium cost as active employees, or you may take a reduced amount of Supplemental Life Insurance at no cost to you. At age 65, the reduced amount of Supplemental Life Insurance coverage will be continued, at no cost to you, for the rest of your life, provided you had Supplemental Life Insurance coverage for at least 1 year immediately preceding retirement. You may convert your supplemental life coverage to an individual whole life policy, or you may choose the portability option under Supplemental Life Insurance, which allows you to continue this coverage under a term life policy. Metropolitan Life Insurance will send you a conversion notice.

For IGUA employees Hired on or after August 15, 2016

Basic and Supplemental Life Insurance
Coverage ends on the last day of the month in which your employment terminates. You may convert your Basic Life and Supplemental Life to individual whole life policies. You may choose the portability option under Supplemental Life Insurance, which allows you to continue this coverage under a term life policy. Metropolitan Life Insurance will send you a conversion notice.

Spouse and Dependent Life Insurance
Group coverage ends at the end of the month in which you cease to be an active employee. However, if you apply within 31 days of your retirement you may convert Spouse and Dependent Life to individual whole life policies. Metropolitan Life Insurance will send you a conversion notice.

Business Travel Accident Insurance
Coverage ends.

Special Accident Insurance
Coverage ends. You may convert your Special Accident Insurance coverage to an individual policy. You may request a Special Accident conversion form from the ORNL Benefits Office.

Savings Plan
Contributions end. You may choose from a variety of payout methods or you can leave your account balance in the Savings Plan until you reach age 70½. Mandatory minimum distribution rules apply after age 70½ if you have retired from the Company. Any outstanding loans must be paid within 6 months of your retirement. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

Steps to Be Taken If You or a Family Member Dies

In the Case of Death, You or Your Family Member (Whichever Applies) Should …

Notify the ORNL Benefits Office of the death.

The ORNL Benefits Office will assist you, or your appropriate family member, in processing any required/applicable documents for collecting (or continuing) your available benefits as a result of the death.

Complete a Life Insurance claim form and Special Accident Insurance claim form, if applicable. Send the completed forms, along with a certified death certificate and other supporting information, to the ORNL Benefits Office.

If You Die, Your Survivors May…

Convert any family Special Accident Insurance coverage to a private policy within 30 days of your death if they wish to continue this coverage.

Convert Spouse and Dependent Life Insurance coverage to an individual policy within 31 days of your death. Metropolitan Life Insurance will send a conversion notice.

Convert Legal Insurance coverage into an individual policy by notifying ARAG within 90 days of your death if they would like to continue coverage.

Decide whether to continue Medical, Dental, and vision coverage. Your spouse and other eligible dependents may elect to continue their medical coverage under the Company's plan. Their cost and the length of continuation will be based on the length of your full-time service and age at the time of your death.

If Your Spouse or Dependent Dies, You Should ...

Notify the ORNL Benefits Office and complete a Life Insurance claim form, if applicable.

Complete a Special Accident Insurance claim form if you are enrolled for family special accident insurance coverage and the death was accidental. Send the completed form(s), along with a certified death certificate and other supporting information, to the ORNL Benefits Office.

Change your Medical (including prescription drugs), Dental, Vision, Flexible Spending Account, Life, and Special Accident Insurance elections within 30 days of the death if coverage changes are appropriate.

Review your beneficiary elections for Life and Accident insurance and the Savings Plan.

Remember, the Employee Assistance Program is available if you or your family members need counseling.

What Happens to Your Benefits If You Die

Medical (Including Prescription Drugs) Dental and Vision

Your eligible dependents may elect to continue Medical (including prescription drugs), Dental, and Vision coverage for 3 months at the appropriate active employee contribution rate.

> **Administrative Information**
>
> Information about COBRA can be found in the chapter titled "Administrative Information."

If you were not eligible to retire under the Pension Plan when you died, your eligible dependents may continue coverage after the initial 3-month period for an additional 33 months through COBRA.

If you were eligible to retire under the Pension Plan, your eligible spouse and any eligible child dependents may elect to continue coverage through the retiree Medical, Dental, and Vision plans. Your eligible dependents may remain in the under age 65 plans until your spouse reaches age 65. When your spouse reaches age 65, he or she may enroll in the Over Age 65 Medicare Supplement program, and any eligible child dependents will be offered COBRA. Your eligible dependents must pay the appropriate retiree cost associated with the coverage.

If you were hired before August 15, 2016:

- If you were eligible to retire with at least 10 years of full-time Company service, your eligible dependents will pay a share of the cost.
- If you were eligible to retire with less than 10 years of full-time Company service, your eligible dependents will pay the full cost.

If you were hired on or after August 15, 2016:

- If you were eligible to retire with at least 10 years of full-time Company service, your eligible dependents will pay the full cost.
- If you have less than 10 years of Company service, your eligible dependents will be offered COBRA.

Employee Assistance Program

Coverage continues for 18 months for your dependents after your death.

Flexible Spending Accounts

Coverage ends. Dependents may submit Health Care Flexible Spending Account claims and Dependent Care Flexible Spending Account claims for expenses incurred before your death. Dependents may continue Health Care Flexible Spending Account participation on an after-tax basis through the end of the year through COBRA and may submit claims for expenses incurred during the period they continue to make contributions. See the “Flexible Spending Accounts” chapter for eligible expenses.

Life and Accident Insurance

Your beneficiary will receive the following benefits, depending on the coverage elected:

- Basic Life Insurance benefit
- Supplemental Life Insurance benefit
- Business Travel Accident Insurance benefit if you die while traveling on a Company business trip
- Special Accident Insurance benefit if your death is the result of an accident

Spouse and Dependent Life Insurance coverage ends, but they may be converted to individual whole life policies. Metropolitan Life Insurance will send a conversion notice.

Family Special Accident Insurance coverage ends, but it may be converted to an individual policy. Request a Special Accident conversion form from the ORNL Benefits Service Center.

Legal Insurance

Dependents may convert Legal Insurance coverage into an individual policy by notifying ARAG within 90 days of your death.

Pension Plan—IGUA employees hired prior to August 15, 2016

If you are vested, your surviving spouse/beneficiary will receive any survivor benefit. The ORNL Benefits Office will contact your beneficiary to provide information about any plan benefits that might be payable.

Savings Plan

Your beneficiary may receive your full account balance in a lump sum or as a rollover to an individual retirement account. 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 laws.

Paying for Your Benefits

For coverage paid on a pre-tax basis, the IRS restricts when pre-tax contributions may begin and end. Therefore, the required contributions for coverage purchased with pre-tax dollars will be deducted as follows:

For initial elections made within 30 days of your date of hire, the pre-tax deductions will begin retroactive to your hire date. For casual employees, pre-tax deductions will begin on the payroll following your coverage effective date. For elections made within 30 days of a Qualifying Life Event other than the birth, adoption, or placement for adoption of a child, the pre-tax deductions will begin on the payroll following the date your election is processed. Any payments due for coverage from the date of the Qualifying Life Event until the date pre-tax deductions begin will be deducted on an after-tax basis.

For elections made within 30 days of the birth or adoption or placement for adoption of a child, all payments required for coverage from the date of such event will be deducted on a pre-tax basis if elected within 30 days. Pre-tax payroll deductions can be changed only if you have a Qualifying Life Event and you contact the ORNL Benefits Service Center within 30 days of the Qualifying Life Event. Therefore, if you have a Qualifying Life Event and drop a dependent but do not notify the ORNL Benefits Service Center within 30 days of the Qualifying Life Event, you may have a change in coverage level but no change in premium until the following year.

Rights and Responsibilities

The Company may—but is not required to—share in the cost of the benefits offered to you. You must enroll in a timely manner and pay your share of any cost. To participate in the plans, you must allow the Company to use your individual information (such as address and phone numbers, including private phone numbers, or whatever is minimally necessary to fully administer any and all benefit plans). The Company will share your individual information with third-party vendors only to the extent minimally necessary to support the administrative processes and features of the benefit plan. Vendor and service contracts will be maintained that exclusively limit the use of your individual information to the operation of the specific benefit program for which the vendor provides service. Benefit plans such as medical and prescription drugs may include managed care, disease or wellness management, and utilization management programs, which are incorporated programs of the benefit plan. The Company reserves the right to incorporate these management programs into the benefits plans offered.

Pre-Tax Contributions

Pre-tax contributions offer special tax advantages. You do not pay federal, Medicare, Social Security or, in most cases, state or local income taxes on the pre-tax Pay you use for buying Medical or Dental coverage or for participating in the Flexible Spending Accounts. This is also true for pre-tax Savings Plan contributions, except Medicare and Social Security taxes will apply.

Even though pre-tax contributions reduce your Pay for income tax purposes, the Company will continue to recognize your full basic rate of Pay for your other Pay-related benefits, such as Life Insurance, Disability coverage, and Pension benefits.

Benefit Plan	The Company pays the full cost of coverage	You share the cost of coverage with the Company through:	You pay the full cost of coverage through:
Medical (including Prescription Drugs), Dental, and Vision		Pre-tax contributions	
Employee Assistance Program	**X**		
Flexible Spending Accounts			Pre-tax contributions
Short-Term Disability	Refer to the “Disability Coverage” chapter.		
Long-Term Disability	**X**		
Basic Life Insurance		After-tax contributions	
Supplemental Life, Spouse, and Dependent Life Insurance			After-tax contributions
Business Travel Accident Insurance	**X**		
Special Accident Insurance			After-tax contributions
Legal Insurance			After-tax contributions
Savings Plan		Pre-tax or after-tax contributions and Company matching contributions	
Pension Plan		After-tax contributions	

When Coverage Ends

Coverage for You

Unless otherwise noted, coverage under the Company’s benefit plans will end on the earliest of the following dates:

- the date your employment terminates, with these exceptions:
  - for Medical (including prescription drugs), Dental, and Vision and Legal Insurance coverage, the last day of the month in which your employment terminates
  - for Long-Term Disability coverage, the date your employment terminates for any reason, unless you are totally disabled
  - for Basic Life Insurance coverage, the last day of the month in which your employment terminates for any reason other than retirement (if hired prior to August 15, 2016) after you become eligible for an immediate pension benefit or total disability (see the “Life and Accident Coverage” chapter for more information)
- the date you are no longer considered eligible because of a change in your employment status
- the last day of the period for which your last contribution was made (if you fail to make any required contribution)

or

- the date the plan is terminated.

In the event of fraud or intentional misrepresentation, your coverage may be terminated retroactively.

If your coverage ends, you may be eligible to extend Medical coverage (including prescription drugs) Dental and Vision coverage as well as Health Care Flexible Spending Account participation under COBRA.

You will no longer be able to contribute to the Savings Plan upon your termination of employment. However, you will be a participant in that Plan until you have received a complete distribution of your Savings Plan account. See the “Savings Plan” chapter for more information.

Coverage for Your Dependents

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 (including prescription drugs), Dental, Vision, and Legal Insurance will end at the end of the month of their 26th birthday.

When your dependent child turns age 26, coverage for Child Life Insurance will end at the end of the month of their 26th birthday. UT-Battelle does not maintain a record of covered dependents for Child Life Insurance. It is the employee’s responsibility to cancel coverage when appropriate. Otherwise, premiums will continue to be taken.

Special Accident Insurance coverage for a dependent child will end the earliest of the date the employee’s coverage terminates, or the first premium due date after the dependent no longer qualifies as a covered person. Employment during school break periods is not considered full-time employment. If the dependent child is not enrolled in school full-time, coverage for that child will end at age 19.

Administrative Information

Information about COBRA can be found in the chapter titled “Administrative Information.”

Glossary

Eligible Dependents

For Medical, Dental and Vision Coverage, Employee Assistance Program, and Health Care Flexible Spending Accounts
Your eligible dependents are:

- the person who is recognized under applicable law as your spouse and
- a child who is less than 26 years old.

For Dependent Care Flexible Spending Accounts
Your eligible dependents are:

- the person who is recognized under applicable law as your spouse and who is mentally or physically disabled and unable to provide care for himself or herself
- a child who is less than 13 years old.

For Business Travel Accident Insurance
Dependent Child(ren) means those unmarried Child(ren) of the Insured, and those unmarried Child(ren) of his or her legally married Spouse, who rely on the Insured for more than 50% of their support, and are either: 1) less than 19 (nineteen) years of age; 2) less than 26 (twenty-six) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.

Special Accident Insurance
Your eligible dependents are your spouse under age 70 and your unmarried children from birth through 18 years of age. For Special Accident Insurance, an unmarried child under age 26 also is considered your eligible dependent if he or she is enrolled as a full-time student.

For Spouse and Dependent Life Insurance
Your eligible dependents are your spouse and your unmarried children from birth to 26 years.

For All Plans
An eligible dependent may include your child who is disabled even after the limiting age. For more information, see the chapter titled “About Your Benefits.”

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.

Disability

Under UT-Battelle’s Disability plans, you are determined to have a disability if:

- you are unable to perform all the material duties of your regular job with the Company due to illness or injury
- you are unable to earn 80% or more of your Covered Earnings
- you are under the appropriate care and treatment of a licensed practicing physician.

The Company’s Claims Administrator makes that determination.

Employee

An individual who is employed by UT-Battelle LLC. The following are the different employee classifications:

- **Regular Full-Time Employee**—A non-exempt employee who is scheduled to work at least 30 hours per week on a regular basis
- **Regular Part-Time Employee**—A Regular Part-Time employee must work a declared schedule equal to or greater than 50% of a regular, full-time schedule. Schedules are declared in 10% increments (50%, 60%, 70%). Certain benefits are prorated based on the declared schedule, not the actual hours worked.

Long-Term Disability

Your long-term disability benefits are designed to provide continuing income if you become ill or injured and are unable to work. You become eligible for benefits after you have been totally disabled for 25 weeks.

Short-Term Disability

The short-term disability plan is designed to protect your income if you are unable to work due to illness, injury, or pregnancy.

Total Disability or Totally Disabled

For Long-Term Disability
During the first 24 months you are absent from work under the long-term disability plan, you are considered Totally Disabled if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the regular care of a licensed practicing physician. After you have been absent from work for 24 months, you are considered Totally Disabled if you remain under the regular care of a licensed practicing physician and you are unable to work at any job for which you might be qualified based on your education, training, and experience.

2. Medical Plans

Choice Plus and Choice Preferred Medical Plans Overview

How The Choice Plus And Choice Preferred Plans Work

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider.

Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non- Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in the *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non- Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of UT-Battelle, LLC or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non- Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid.

Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

UT-Battelle, LLC has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on 140% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
  - 50% of CMS for the same or similar laboratory service.
  - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
    - When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at

www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products as described under *Pharmaceutical Products*, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuter*s (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card

Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non- Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of- Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

Personal Health Support And Prior Authorization

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well- being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support

Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to *Additional Coverage Details*.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting UnitedHealthcare or Personal Health Support is easy.

Simply call the number on your ID card.

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization

timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

Plan Highlights – Choice Plus Plan

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Copays		
In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.		
• Emergency Health Services.	$50	$50
• Physician's Office Services.	$20	Not Applicable
• Urgent Care Center Services.	$35	Not Applicable
• Virtual Visits.	$20	Not Applicable
Copays do not apply toward the Annual Deductible. Copays apply toward the Out-of-Pocket Maximum.		
Annual Deductible		
• Individual	$75	$500
• Family (not to exceed the applicable Individual amount for all Covered Persons in a family)	$150	$1,000
Annual Out-of-Pocket Maximum		
• Individual (single coverage)	$500	$1,500
• Family (not to exceed the applicable Individual amount for all Covered Persons in a family	$2,000	$4,000
The Annual Deductible does not apply toward the Out-of-Pocket Maximum for any Covered Health Services.		

Plan Features	Network Amounts	Non-Network Amounts
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited	

Schedule of Benefits Choice Plus Plan

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to *Additional Coverage Details*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Ambulance Services	*Ground and/or Air Ambulance*	*Ground and/or Air Ambulance*
• Emergency Ambulance.	100% after you meet the Annual Deductible	Same as Network
• Non-Emergency Ambulance.	100% after you meet the Annual Deductible	Same as Network
Ground or air ambulance, as the Claims Administrator determines appropriate.		
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider. See *Cancer Resource Services (CRS)* in *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Cellular and Gene Therapy For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
COVID-19 Testing - effective for testing incurred on or after 2/4/20 and before the end of the National Emergency. See *COVID 19 Testing* in *Additional Coverage Details*, for limits.	100%	100%

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management Items • Diabetes equipment.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.
Durable Medical Equipment (DME), Orthotics and Supplies • Insulin pump. See *Durable Medical Equipment* in *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a Copayment of $50 per visit	Same as Network
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.	
Hearing Aids • Benefits are limited to $5,000 per 36 months. • No maximum for children up to age 18.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care • Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider UnitedHealthcare identifies.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Lab, X-Ray and Diagnostics - Outpatient		
• Lab Testing - Outpatient.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• X-Ray and Other Diagnostic Testing - Outpatient.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Mental Health Services		
• Inpatient.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• Outpatient.	100% after you pay a Copayment of $20 per visit	70% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
• Inpatient.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• Outpatient.	100% after you pay a Copayment of $20 per visit	70% after you meet the Annual Deductible
Ostomy Supplies	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient Medical Setting ***Note:*** Does not include prescriptions dispensed by Express Scripts.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
• Office Visit	100% after you pay a Copayment of $20 per visit	70% after you meet the Annual Deductible
• Home Visit	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services		
• Physician Office Services.	100%	70% after you meet the Annual Deductible
• Lab, X-ray or Other Preventive Tests.	100%	70% after you meet the Annual Deductible
• Breast Pumps.	100%	70% after you meet the Annual Deductible
Prosthetic Devices See *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment Any combination of Network Benefits and Non-Network Benefits is limited to: • 40 visits per calendar year for physical therapy. • 40 visits per calendar year for Manipulative Treatment. • 40 visits per calendar year for cardiac rehabilitation therapy. • 40 visits per calendar year for pulmonary therapy. • 40 visits per calendar year for occupational therapy (includes cognitive rehabilitation). • 40 visits per calendar year for speech therapy. • 40 visits per calendar year for post- cochlear implant aural therapy.	100% after you pay a Copayment of $20 per visit	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Any combination of Network Benefits and Non-Network Benefits is limited to: 60 days per calendar year.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
• Inpatient.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• Outpatient.	100% after you pay a Copayment of $20 per visit	70% after you meet the Annual Deductible
Surgery - Outpatient	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Therapeutic Treatments - Outpatient	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation Services	100% after you meet the Annual Deductible	Non-Network Benefits are not available
Urgent Care Center Services	100% after you pay a Copayment of $35 per visit	70% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $20 per visit	Non-Network Benefits are not available.

[1]Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in *Additional Coverage Details*.

Plan Highlights – Choice Preferred Plan

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Copays		
In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.		
• Emergency Health Services.	$250	$250
• Physician's Office Services – Primary	$30	Not Applicable
• Physician's Office Services - Specialist	$50	Not Applicable
• Urgent Care Center Services.	$75	Not Applicable
• Virtual Visits.	$30	Not Applicable
Copays do not apply toward the Annual Deductible. Copays apply toward the Out-of-Pocket Maximum.		
Annual Deductible		
• Individual.	$1000	$2000
• Family (not to exceed the applicable Individual amount for all Covered Persons in a family).	$2000	$4,000
Annual Out-of-Pocket Maximum		
• Individual (single coverage).	$5000	$10,000
• Family (not to exceed the applicable Individual amount for all Covered Persons in a family).	$10,000	$20,000
The Annual Deductible does not apply toward the Out-of-Pocket Maximum for any Covered Health Services.		
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited	

Schedule of Benefits Choice Preferred Plan

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to *Additional Coverage Details*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Ambulance Services	*Ground and/or Air Ambulance*	*Ground and/or Air Ambulance*
• Emergency Ambulance.	80% after you meet the Annual Deductible	Same as Network
• Non-Emergency Ambulance.	80% after you meet the Annual Deductible	Same as Network
Ground or air ambulance, as the Claims Administrator determines appropriate.		
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider. See *Cancer Resource Services (CRS)* in *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Cellular and Gene Therapy For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	100% after you pay a Copayment of $500 per Inpatient Stay	60% after you meet the Annual Deductible
COVID-19 Testing - effective for testing incurred on or after 2/4/20 and before the end of the National Emergency. See COVID 19 Testing in *Additional Coverage Details*, for limits.	100%	100%
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management Items • Diabetes equipment.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Durable Medical Equipment (DME), Orthotics and Supplies • Insulin pump. See *Durable Medical Equipment* in *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a Copayment of $250 per visit	Same as Network
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.	
Hearing Aids • Benefits are limited to $5,000 per 36 months. • No maximum for children up to age 18.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care • Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider UnitedHealthcare identifies.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	100% after you pay a Copayment of $500 per Inpatient Stay	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient		
• Lab Testing - Outpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• X-Ray and Other Diagnostic Testing - Outpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
• Inpatient.	100% after you pay a Copayment of $500 per Inpatient Stay	60% after you meet the Annual Deductible
• Outpatient.	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
• Inpatient.	100% after you pay a Copayment of $500 per Inpatient Stay	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
• Outpatient.	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient Medical Setting ***Note:*** Does not include prescriptions dispensed by Express Scripts.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
• Office Visit – Primary Care	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
• Office Visit – Specialist	100% after you pay a Copayment of $50 per visit	60% after you meet the Annual Deductible
• Home Visit	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services		
• Physician Office Services.	100%	60% after you meet the Annual Deductible
• Lab, X-ray or Other Preventive Tests.	100%	60% after you meet the Annual Deductible
• Breast Pumps.	100%	60% after you meet the Annual Deductible
Prosthetic Devices See *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment Any combination of Network Benefits and Non-Network Benefits is limited to: • 20 visits per calendar year for physical therapy. • 20 visits per calendar year for Manipulative Treatment. • 20 visits per calendar year for cardiac rehabilitation therapy. • 20 visits per calendar year for pulmonary therapy. • 20 visits per calendar year for occupational therapy (includes cognitive rehabilitation). • 20 visits per calendar year for speech therapy. • 30 visits per calendar year for post- cochlear implant aural therapy.	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Any combination of Network Benefits and Non-Network Benefits is limited to: 60 days per calendar year.	100% after you pay a Copayment of $500 per Inpatient Stay	60% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
• Inpatient.	100% after you pay a Copayment of $500 per Inpatient Stay	60% after you meet the Annual Deductible
• Outpatient.	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services	100% after you meet the Annual Deductible100% after you pay a Copayment of $500 per Inpatient Stay	Non-Network Benefits are not available
Urgent Care Center Services	100% after you pay a Copayment of $75 per visit	60% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $30 per visit	Non-Network Benefits are not available.

[1]Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in *Additional Coverage Details*.

Information for Choice Plus and Choice Preferred Medical Plans

Additional Coverage Details

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in *Exclusions and Limitations*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See the *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain prior authorization as soon as possible before transport.

If you fail to obtain prior authorization from the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in the *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Prior Authorization Requirement

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life- threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.

- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement

You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Prior Authorization Requirement

For non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization from the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 as described under the Virtual Visit Section.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.

- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair the damage caused by accidental Injury must conform to the following time-frames: Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care), Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Benefits for non-accidental dental services are covered for the following care:

- Anesthesia and Facility charges associated with dental surgery or procedures performed by a dentist, oral surgeon or oral maxillofacial surgeon normally excluded under the medical plan as medically necessary when there is an appropriately trained and licensed professional to both administer and monitor MAC/general anesthesia in EITHER ofthe following locations:
    - A properly-equipped and staffed office.
    - A hospital or outpatient surgery center.
- For ANY of the following:
    - Individual age seven years or younger.
    - Individual who is severely psychologically impaired or developmentally disabled.
    - Individual with American Society of Anesthesiologists (ASA) Physical Status Classification of P3 or greater.
- Individual who has one or more significant medical comorbidities which:
    - Preclude the use of either local anesthesia or conscious sedation OR forwhich careful monitoring is required during and immediately following the planned procedure.
- Individuals in whom conscious sedation would be inadequate or contraindicated forany of the following procedures:
    - Removal of two or more impacted third molars.
    - Removal or surgical exposure of one impacted maxillary canine.
    - Surgical removal of two or more teeth involving more than one quadrant.

- Routine removal of six or more teeth.
- Full arch alveoplasty.
- Periodontal flap surgery involving more than one quadrant.
- Radical excision of tooth-related lesion greater than 1.25 cm or ½ inch.
- Tooth-related radical resection or ostectomy with or without grafting.
- Placement or removal of two or more dental implants.
- Extraction with bulbous root and/or unusual difficulty or complications noted.
- Removal of exostosis involving two areas.
- Removal of torus mandibularis involving two areas.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME), Orthotics, Prosthetics and Supplies

The Plan pays for Durable Medical Equipment (DME), Orthotics, Prosthetics and Supplies that are:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.

- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the specifications for your functional needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Equipment to assist mobility, such as a standard wheelchair pediatric wheel chair, or custom wheel chair when prescribed by a physician to meet a medically necessary functional need.
- A standard Hospital-type beds, hospital type crib, hospital youth bed, custom hospital bed.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics when prescribed by a Physician.
- Custom foot orthoses for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat
- curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Elastic/compression stockings when prescribed by a physician and is used for a medical condition.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Service.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this *SPD*.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
- Powered exoskeleton devices.

UnitedHealthcare will decide if the equipment should be purchased or rented.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section. This limit does not apply to wound vacuums.

Prosthetic Devices:
Prosthetic Device coverage is limited to those Prosthetic Devices that replace a limb or external body part that are listed below:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears, and nose.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras.
    - Prosthetic Devices must be ordered by or under the direction of a physician.
    - Manufactured Prosthetic Devices must be approved by the Food and Drug Administration (FDA) or otherwise generally considered to be safe and effective by Generally Accepted Standards of Medical Practice.
    - Implantable devices/prostheses, such as artificial heart valves, are not prosthetics.
    - These devices are covered as a surgical service.
    - Coverage is available for repair and replacement, when it is not due to theft, loss, misuse, malicious damage or gross neglect.

Specialized, Microprocessor or Myoelectric Limbs

Computerized, bionic, microprocessor or myoelectric terms are considered the same for the purpose of this document.

Lower Extremity Specialized, computerized or microprocessor limbs are based on a member's current functional capabilities and his/her expected functional rehabilitation potential.

Coverage of computerized and specialized lower limb prostheses is based on maximum prosthetic function level of the member (see Lower Limb Rehabilitation Classification Levels 1-4 in Definitions section).

- Member meets criteria for prosthetic limbs above; and
- Member has or is able to gain Lower Limb Rehabilitation Classification Levels 2-4 for prosthetic ambulation (see Definitions section).

Prosthetic limbs are a covered health care service when criteria are met:

- Ordered by a physician;
- Member is evaluated for his/her individual needs by a healthcare professional with the qualifications and training and under the supervision of the ordering physician to make an evaluation (documentation should accompany the order);

- Ordering physician signs the final prosthetic proposal;
- The records must document the member's current functional capabilities and his/her expected functional rehabilitation potential, including an explanation for the difference, if that is the case. (It is recognized within the functional classification hierarchy that bilateral amputees often cannot be strictly bound by functional level classifications);
- Prosthetic replaces all or part of a missing limb;
- Prosthetic will help the member regain or maintain function;
- Member is willing and able to participate in the training for the use of the prosthetic (especially important in use of a computerized upper limb); and
- Member is able to physically function at a level necessary for a computerized prosthetic or microprocessor, e.g., hand, leg or foot.

Myoelectric Upper Limbs (arms, joints and hands) are covered when criteria are met:

- Member meets all the criteria for prosthetic limbs above;
- Member has a congenital missing or dysfunctional arm and/or hand; or
- Member has a traumatic or surgical amputation of the arm (above or below the elbow);
- The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a Myoelectric Prosthetic Device (usually 3-5 muscle groups must be activated to use a computerized arm/hand), no external switch;
- A standard passive or body-powered Prosthetic Device cannot be used or is insufficient to meet the functional needs of the individual in performing activities of daily living (ADL's); and
- The medical records must indicate the specific need for the technologic or design features.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

To receive Network Benefits, you must purchase, rent, or obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or purchase it directly from the prescribing Network Physician.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment or orthotic once every three calendar years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in *How the Plan Works*.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in your SPD.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:

  - Bilateral mastectomy or breast reduction

- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Prior Authorization Requirement for Non-Surgical Treatment

You must obtain prior authorization as soon as the possibility of surgery arises.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits for hearing aids is limited to $5,000 per 36 months.

No maximum for children up to age 18.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in the *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to the *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

The Plan pays coverage for one newborn Home Health Care visit following obstetrical care.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods, or as soon as is reasonably possible.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital- based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement

For Non-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medicaltreatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement

For Non-Network Benefits for Genetic Testing and sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medicaltreatment options following Genetic Counseling.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement

For Non-Network Benefits for and CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.

If you do not obtain prior authorization from the Claim Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient Medical Setting

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional.

Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication dispensed by a prescription are covered under Chapter 3, *Prescription Drug Plan*.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include Genetic Counseling.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

The Plan pays for nutritional counseling due to bariatric surgery. Benefits are limited to 3 visits per calendar year.

When a test is performed or a sample is drawn in the Physician's office Benefits for the analysis or testing of a lab, radiology/X-rays or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-Ray and Diagnostics - Outpatient*.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committeeon Immunization Practices of the Centers for Disease Control and Prevention.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. There is no limit on the number of mastectomy bras a member could purchase. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except as described in *Exclusions and Limitations,* under *Devices, Appliances and Prosthetics*.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds $1,000 in cost per device.

If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in the *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedures.

Prior Authorization Requirement

For Non-Network Benefits for you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must provide notification to the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.

- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal- directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the

Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Under the Choice Plus Plan, benefits are limited to:

- 40 visits per calendar year for physical therapy.
- 40 visits per calendar year for Manipulative Treatment.
- 40 visits per calendar year for cardiac rehabilitation therapy.
- 40 visits per calendar year for pulmonary therapy.
- 40 visits per calendar year for occupational therapy (includes cognitive rehabilitation).
- 40 visits per calendar year for speech therapy.
- 40 visits per calendar year for post-cochlear implant aural therapy.

Under the Choice Preferred Plan, benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for Manipulative Treatment.
- 20 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for pulmonary therapy.
- 20 visits per calendar year for occupational therapy (includes cognitive rehabilitation).
- 20 visits per calendar year for speech therapy.
- 30 visits per calendar year for post-cochlear implant aural therapy

These visit limits apply to Network Benefits and Non-Network Benefits combined. Visit limits for Manipulative Treatment applies to Network Benefits only.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits that apply to certain preventive screenings are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in the *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions.)

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

The facility charge and the charge for supplies and equipment.

Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement

For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant, vein procedures and sleep apnea surgery, cochlear implant you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Surgical and Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.

Prior Authorization Requirement

For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider or a Network facility that is not a Designated Provider.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Prior Authorization Requirement

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre- transplantation evaluation is performed at a transplant center).

In addition, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in the *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Clinical Programs And Resources

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

UT-Battelle, LLC believes in giving you tools to help you be an educated health care consumer. To that end, UT-Battelle, LLC has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and UT-Battelle, LLC are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey

You and your Spouse are invited to learn more about health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access health care information.
- Support by a nurse to help you make more informed decisions in your treatmentand care.
- Expectations of treatment.
- Information on providers and programs. Conditions for which this program is availableinclude:
- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays and Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies and supports a Covered Person who has cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at 1-866 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms,warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.
    - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in the *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you mayuse the information in your report to engage your Physician in discussions regarding your health and the information UnitedHealthcare provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Complex Medical Conditions Programs and Services

Travel and Lodging Expenses Only Applies to Organ Transplant Services

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses oftwo companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/hercompanion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient (when not in the Hospital) or the caregiver.
- Per diem is limited to $100.00 per day, for the patient and one caregiver. When a childis the patient, two persons may accompany the child.

  Examples of items that are not covered:

  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most directroute between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Maternity Support Program (Effective 2/1/2020)

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Exclusions And Limitations: What The Medical Plan Will Not Cover

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Additional Coverage Details*.
7. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia except as described under *Dental Services - Accident Only* in *Additional Coverage Details*).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Additional Coverage Details.*

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extractions (including wisdom teeth), restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident- related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Additional Coverage Details*.

4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
5. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
6. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Additional Coverage Details*.
8. Oral appliances for snoring.
9. Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.
10. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.

Drugs – Outpatient Medical Setting (This section does not apply to medications dispensed by Express Scripts.)

1. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
2. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
3. Over-the-counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact thatan Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in *Additional Coverage Details*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Additional Coverage Details*.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.

- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies

1. Prescribed or non-prescribed medical supplies. Examples include:
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment or prosthetics devices for which Benefits are provided as described under *Durable Medical Equipment* and *Prosthetic Devices* in *Additional Coverage Details*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Additional Coverage Details*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Additional Coverage Details*.
   - Urinary catheters (non-ostomy) for which Benefits are provided as described under
   - *Ostomy Supplies* in *Additional Coverage Details*.
2. Elastic/compression stockings, unless when prescribed by a physician and is used for a medical condition as described under *Durable Medical Equipment* in *Additional Coverage Details.*
3. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Additional Coverage Details*.
4. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
5. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the

   United States Preventive Services Task Force requirement. This exclusion does not apply to medical education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
3. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.
4. Foods that are not covered include:
   - Enteral feedings and other nutritional and electrolyte formulas, including when administered using a pump, infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.
5. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, tobacco cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.

3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidentals for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
    - Exercise equipment and treadmills.
    - Hot and cold compresses.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Medical alert systems.
    - Motorized beds, non-Hospital beds, comfort beds and mattresses.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Safety equipment.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.
    - Treadmills.
    - Vehicle modifications such as van lifts.
    - Video players.
    - Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in the *Glossary*. Examples include:
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Hair removal or replacement by any means.

- Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Treatments for hair loss.
- Skin abrasion procedures performed as a treatment for acne.
- Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Additional Coverage Details*.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
4. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss.
5. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.
2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Habilitative services for maintenance/preventive treatment.
5. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or stroke.
6. Speech therapy to treat stuttering, stammering, or other articulation disorders.
7. Rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in *Additional Coverage Details*.
8. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
9. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
10. Chelation therapy, except to treat heavy metal poisoning.
11. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
12. The following treatments for obesity:
    - Non-surgical treatment of obesity, even if for morbid obesity with exception of the medical weight loss program managed by WellOne Clinic.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in *Additional Coverage Details*.
13. Medical and surgical treatment of excessive sweating (hyperhidrosis).

14. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.
15. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims

    Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Additional Coverage Details*.
16. Helicobacter pylori (H. pylori) serologic testing.
17. Intracellular micronutrient testing.
18. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services ordered or delivered by a Christian Science practitioner.
4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:

    - All costs related to reproductive techniques including:
        - Assistive reproductive technology.
        - Artificial insemination.
        - Intrauterine insemination.
        - Obtaining and transferring embryo(s).
    - Health care services including:
        - Inpatient or outpatient prenatal care and/or preventive care.
        - Screenings and/or diagnostic testing.
        - Delivery and post-natal care.

    The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
   - Donor sperm – The cost of procurement and storage of donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in *Coordination of Benefits (COB)*.
2. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.
3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
4. While on active military duty.
5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services for transplants involving animal organs.
3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Additional Coverage Details*.

Types of Care

1. Custodial Care or maintenance care as defined in the *Glossary* or maintenance care.

2. Domiciliary Care, as defined in the *Glossary.*
3. Multi-disciplinary pain management programs provided on an inpatient basis foracute pain or for exacerbation of chronic pain.
4. Private Duty Nursing received on an inpatient basis.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensedhospice care agency for which Benefits are provided as described under *Hospice Care* in *Additional Coverage Details*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person towork or to prepare a person for specific work).

Vision and Hearing

1. Routine vision examinations, including refractive examinations to determine the needfor vision correction.
2. Implantable lenses used only to correct a refractive error (such as *Intacs*corneal implants).
3. Purchase cost and associated fitting charges for eyeglasses or contact lenses, except for the purchase of the first pair of eyeglasses, lenses, frames, or contact lenses that follows keratoconus or cataract surgery.
4. Purchase cost and associated fitting and testing charges for hearing aids, BoneAnchor Hearing Aids (BAHA) and all other hearing assistive devices.
5. Eye exercise or vision therapy.
6. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.
2. Charges for:
   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.
3. Charges prohibited by federal anti-kickback or self-referral statutes.
4. Diagnostic tests that are:
   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIVand Pregnancy tests.
5. Expenses for health services and supplies:
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage underthe Plan ends.

- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
- That exceed Eligible Expenses or any specified limitation in this SPD.

6. In the event a Non-Network provider waives, does not pursue, or fails to collect the Copayment, Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Copayment, Coinsurance and/or deductible are waived.
7. Foreign language and sign language interpretation services offered by or required to be provided by a Network or non-Network provider.
8. Long term (more than 30 days) storage of blood, umbilical cord or other material.
9. Health services and supplies that do not meet the definition of a Covered Health Service
   - see the definition in the *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this SPD under *Additional Coverage Details* and in *Plan Highlights.*
   - Not otherwise excluded in this SPD under this *Exclusions and Limitations*.
10. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non- Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
11. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:
    - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in *Additional Coverage Details*.
    - Related to judicial or administrative proceedings or orders.
    - Required to obtain or maintain a license of any type.

Claims Procedures

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your

Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting your Benefits Representative. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
    - The *Current Procedural Terminology (CPT) codes*.
    - A description of, and the charge for, each service.
    - The date the Sickness or Injury began.
    - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion

make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to- understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See the *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare atthe number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefitdetermination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.

- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request. You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure thatis at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcaremay process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal
*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.	

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	**15 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
• if the initial claim is complete, within:	**30 days**
• after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against UT-Battelle, LLC or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against UT-Battelle, LLC or the Claims Administrator, you must do so within three years from the

expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against UT-Battelle, LLC or the Claims Administrator.

You cannot bring any legal action against UT-Battelle, LLC or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against UT- Battelle, LLC or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against UT-Battelle, LLC or the Claims Administrator.

Coordination Of Benefits (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non- Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spousesage 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) and to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan.

Subrogation And Reimbursement

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no- fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against anythird party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made- Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and thePlan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.

- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details anyoutstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss anyoutstanding balance owed to the Plan.

Other Important Information

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).

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.

Medicare Eligibility

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of- pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Glossary

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by UT-Battelle, LLC. The CRS program provides:

- Specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United HealthCare) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in *How the Plan Works*.

Company - UT-Battelle, LLC.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this SPD under *Plan Highlights* and 5,
- *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not otherwise excluded in this SPD under *Exclusions and Limitations.*

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled

services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- **Deductible** - see Annual Deductible.
- **Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug
- **Dependent** - an individual who meets the eligibility requirements specified in the Plan, as described in Chapter 1, *About Your Benefits.* A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.
- **Designated Provider** - a provider and/or facility that:
- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee - an Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under Chapter 1, *About Your Benefits*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer - UT-Battelle, LLC.

EOB - see Explanation of Benefits (EOB).

ERISA - see *Employee Retirement Income Security Act of 1974 (ERISA)*.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.

  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance- related and addictive disorders treatment program that may be freestanding or Hospital- based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Lower Limb Rehabilitation Classification Levels - A clinical assessments of member rehabilitation potential must be based on the following classification levels:

- K-Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility.
- K-Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
- K-Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
- K-Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
- K-Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Microprocessor Controlled Ankle Foot Prosthesis - (e.g., Proprio Foot) is able to actively change the ankle angle and to identify sloping gradients and ascent or descent of stairs as the result of microprocessor-control and sensor technology.

Microprocessor Controlled Lower Limb Prostheses - Microprocessor controlled knees offer dynamic control through sensors in the Device. Microprocessor controlled knees attempt to simulate normal biological knee function by offering variable resistance control to the swing or stance phases of the gait cycle. The swing-rate adjustments allow the knee to respond to rapid changes in cadence. Microprocessor controlled knee flexion enhances the stumble recovery capability. Prosthetic knees such as the microprocessor controlled knee that focus on better control of flexion abilities without reducing stability have the potential to improve gait pattern, wearer confidence, and safety of ambulation. Available devices include but are not limited to Otto-Bock C-Leg device®, the Ossur RheoKnee® or the Endolite Intelligent Prosthesis®.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders,

condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by UT-Battelle, LLC who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Myoelectric Prosthetic: A myoelectric prosthesis uses electromyography signals or potentials from voluntarily contracted muscles within a person’s residual limb via the surface of the skin to control the movements of the prosthesis, such as elbow flexion/extension, wrist supination/pronation or hand opening/closing of the fingers. Prosthesis of this type utilizes the residual neuro-muscular system of the human body to control the functions of an electric powered prosthetic hand, wrist or elbow. This is as opposed to a traditional electric switch prosthesis, which requires straps and/or cables actuated by body movements to actuate or operate switches that control the movements of a prosthesis or one that is totally mechanical. It has a self-suspending socket with pick up electrodes placed over flexors and extensors for the movement of flexion and extension respectively

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non- Network providers. Refer to 4 *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by UT-Battelle, LLC, during which eligible Employees may enroll themselves and their Dependents under the Plan. UT-Battelle, LLC determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to *Plan Highlights* for the Out-of-Pocket Maximum amount. See *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The UT-Battelle, LLC Medical Plan.

Plan Administrator - UT-Battelle, LLC or its designee.

Plan Sponsor - UT-Battelle, LLC.

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Prosthetic Device - An external device that replaces all or part of a missing body part.

Prosthetist - A person, who measures, designs, fabricates, fits, or services a prosthesis as prescribed by a licensed physician, and who assists in the formulation of the prosthesis prescription for the replacement of external parts of the human body lost due to amputation or congenital deformities or absences. A Prosthetist is a person that has been certified to fit prostheses to residual limbs of the upper and lower extremities.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi- private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by

UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married.

Substance-Related and Additive Disorder Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Transitional Living - Mental health services and substance-related and addictive disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Upper Limb Prosthetic Categories - Upper limb prostheses are classified into 3 categories depending on the means of generating movement at the joints: passive, body-powered, and electrically powered movement:

- **Body-powered prosthesis** utilizes a body harness and cable system to provide functional manipulation of the elbow and hand. Voluntary movement of the shoulder and/or limb stump extends the cable and transmits the force to the terminal device. Prosthetic hand attachments, which may be claw-like devices that allow good grip strength and visual control of objects or latex-gloved devices that provide a more natural appearance at the expense of control, can be opened and closed by the cable system.
- **Hybrid system**, a combination of body-powered and myoelectric components, may be used for high-level amputations (at or above the elbow). Hybrid systems allow control of two joints at once (i.e., one body-powered and one myoelectric) and are generally lighter and less expensive than a prosthesis composed entirely of myoelectric components.
- **Myoelectric prostheses** use muscle activity from the remaining limb for the control of joint movement. Electromyographic (EMG) signals from the limb stump are detected by surface electrodes, amplified, and then processed by a controller to drive battery- powered motors that move the hand, wrist, or elbow. Although upper arm movement may be slow and limited to one joint at a time, myoelectric control of movement may be considered the most physiologically natural. Myoelectric hand attachments are similar in form to those offered with the body-powered prosthesis, but are battery powered. Member dissatisfaction with myoelectric prostheses includes the increased lack of proprioception, cost, maintenance and weight.
- **Passive prosthesis** is the lightest of the three types and is described as the most comfortable. Since the passive prosthesis must be repositioned manually, typically by moving it with the opposite arm, it cannot restore function.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

On-Site Medical Services: Occupational Medical Division

Introduction

The ORNL Occupational Medical Division ("ORNL Medical") manages ORNL's occupational medical program to help provide for the safety and health of workers at ORNL facilities through the delivery of medical and other occupational health-related services by qualified personnel who possess appropriate licensing, certification, and training. The scope and nature of these medical services rendered are based on regulatory requirements for occupational medical monitoring and surveillance necessary to support the diverse research and operational activities of ORNL. All components of the occupational medical program are evaluated and prioritized with respect to regulatory compliance, their impact on our workers' health and safety at the site, and their benefit/effectiveness in relation to cost to help contain health care expenditures and to allocate funds in the most judicious manner. For purposes of the reporting and disclosure obligations of the Employee Retirement Income Security Act of 1974, it is a component of the Medical Plan.

Eligibility

You are eligible to receive occupational medical services from ORNL Medical if you are employed and paid as a Regular Full-Time Employee of the Company working on a regular basis, a Regular Part-Time Employee working a fixed schedule, a Full-Time Temporary Employee or a Casual Employee working on an ad hoc or intermittent basis. Casual Retirees are not eligible to participate receive occupational medical services.

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

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

Enrollment

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

Cost of Services

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

Services Provided

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

ORNL Medical also provides occupational medical services for all UT-Battelle employees with an on-the-job illness or injury (including x-ray services), physical therapy[1], and emergency services. ORNL Medical is available to provide emergency response (stabilization) medical services to anyone at the ORNL main campus.

1. Due to COVID-19, physical therapy services are suspended at this time.

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

Accessing Services

ORNL Medical is open Monday through Friday, 7:00 a.m. to 4:30 p.m. The telephone number is 574-7431, email address is medical@ornl.gov, and website is https://portal09.ornl.gov/sites/hrd/onsitemed/medical.html. If you need care after hours, call 911 (land line only) or the Laboratory Shift Supervisor (LSS) at 576-4LSS or 574-6606.

How Changes Affect Your Benefits

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

Claims and Appeal Procedures

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

For appeal procedures, see “Claims Review and Appeals” in the “Administrative Information” chapter.

Glossary

Employee

An individual who is employed by UT-Battelle, LLC. The following are the different employee classifications:

- **Casual Employee**—An employee who works on an intermittent or on-call basis.
- **Full-Time Temporary Employee**—An employee who is scheduled to work on a full-time basis not to exceed 3 years.
- **Regular Full-Time Employee**—A non-exempt employee who is scheduled to work at least 40 hours per week on a regular basis or an exempt employee who is scheduled to work at least 173.3 hours per month on a regular basis.
- **Regular Part-Time Employee**—A Regular Part-Time employee must work a declared schedule equal to or greater than 50% of a regular, full-time schedule. Schedules are declared in 10% increments (50%, 60%, 70%, 80%, or 90%). Certain benefits are prorated based on the declared schedule, not the actual hours worked.

On-Site Medical Services: The WellOne Clinic

Introduction

The WellOne Clinic assists in achieving and maintaining the highest physical and emotional health of all employees so that optimal job performance may be achieved with minimal stress. This will reduce absenteeism, enhance productivity, and prolong the employee's productive years. The WellOne Clinic is a self-insured, self-administered workplace-based medical services facility that provides outpatient health care to those with access to ORNL facilities. For purposes of the reporting and disclosure obligations of the Employee Retirement Income Security Act of 1974, it is a component of the Medical Plan.

Eligibility

You are eligible to receive benefits and services from the WellOne Clinic if you are authorized to access ORNL facilities. No enrollment is necessary for employees.

Cost of Services

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

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

Services Provided

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

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

Primary Care Services

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

- Annual physical exams,
- Preoperative exams,
- Health care screenings,
- Well-woman exams (including breast exams and pap smears),
- Well-man exams,
- Biometric (wellness) screenings,
- Blood pressure screenings,
- Cholesterol screenings,
- Complete health screenings,
- Diabetes screenings,
- HPV and STD screenings,
- Smoking cessation, and
- Flu vaccinations and allergy shots.

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

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

Acute Care Services

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

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

Accessing Services

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

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

How Changes Affect Your Benefits

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

Claims and Appeal Procedures

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

3. 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.

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 Choice Plus:	
Cost of medication	$3500
Copayment Assistance	$2500
Copayment	$40
Plan Pays	$960
Applied to Out-of-Pocket	$40

Example under Choice Preferred	
Cost of medication	$3500
Copayment Assistance	$2500
Copayment	$100
Plan Pays	$900
Applied to Out-of-Pocket	$100

SaveonSP Program

SaveonSP is a specialty pharmacy copayment assistance program available to those members enrolled in the Prime Select Medical Plan. Certain specialty medications are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum (The list of the drugs can be found on the Benefits Website under Health Care Plans/Prescription Drugs/Quick Finder). Although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant. Copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance.

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.

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

Livongo Diabetes Program

The Livongo for Diabetes program was designed to support you in your diabetes management. The program is offered at no cost to you through a partnership between Livongo Health and ORNL. Please contact Member Support at 800-945-4355 for any questions.

What's included?

The Livongo for Diabetes program includes:

- Livongo Welcome Kit: Get a Livongo meter, a lancing device, 150 test strips, 100 lancets, and a carrying case.
- Unlimited supplies: Have test strips and lancets shipped to you whenever you need them.
- Personal coaching: Interact with coaches by phone, by text message, and through the Livongo mobile app
- Online access: Access your readings, along with graphs and insights, online or on your mobile device.

Who is eligible to register?

Employees, spouses, and dependents are eligible as long as the employee, spouse, and/or dependents are covered by one of our partner companies, health providers, or health plans and meet any additional eligibility requirements these organizations have. Members looking to enroll in the program must be diagnosed by their physician with type 1 or type 2 diabetes. Contact Member Support at 800-945-4355 for registration details.

Infertility Drug Coverage

Infertility drugs are not covered under either the Choice Plus or Choice Preferred 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

Covered Services	Choice Plus	Choice Preferred
Retail Prescription Drugs (Up to a 30 day supply). In and Out-of-Network.	Generic: $5 co-pay Preferred Formulary $10 co-pay Non-preferred Formulary $25 co-pay	Generic: $20 co-pay Preferred Formulary $40 co-pay Non-preferred Formulary $60 co-pay
Mail Order—Home Delivery (Up to a 90 day supply). In-network only	Generic: $10 co-pay Preferred Formulary $20 co-pay Non-preferred Formulary $50 co-pay	Generic: $50 co-pay Preferred Formulary $100 co-pay Non-preferred Formulary $150 co-pay

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 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.

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

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

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.

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).

4. 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	$10 copay for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal, or polycarbonate (for dependent children) Frames allowance of up to $130 plus 20% off excess of $130 every 24 months; **OR** Contact lens every 12 months covered up to $150 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 No charge for standard progressive lenses	
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.

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.

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)(I)(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.

5. Dental Plan

The Delta Dental Plan pays 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 Plan …

Encourages Preventive Care

The Delta Dental Plan promotes 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.

Offers Protection for More Extensive Treatment

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

Provides 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 Plan ...

- 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 Dental plan. 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 Plan can be found in the chapter titled “Administrative Information.”

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 up to $150 family maximum per 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.

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

Delta Dental Plan 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/$150 family maximum
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 2 years
• Bite-wing X-rays	One in a calendar year
• Fluoride	Two in a calendar year, under age 19
• Sealants	Once per tooth per lifetime for the occlusal surface of the first and second permanent molars up to age 16
• Space Maintainers	Up to age 15

Delta Dental Plan Summary of Benefits	
Refer to the "Schedule of Benefits" section on the following pages for details.	
Services Covered	**Amount of Coverage**
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.
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

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.

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 2years, unless special need is shown.

c) One set 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 15 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) Porcelain, composite, and 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).

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.

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.

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.

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

Glossary

Child

- 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 (i.e., your stepchild), 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.

Crown

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

Eligible Dependents

Your eligible dependents are:

- the person who is recognized under applicable law as your spouse and
- a child who is less than 26 years old.

Eligible Employee

With respect to a benefit plan, an employee who has satisfied the eligibility and waiting period requirements, if any, for such a benefit plan.

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.

Orthodontic Treatment

Science of the movement of teeth in the correction of malocclusion.

Partial Denture

An appliance supporting artificial teeth less than the full number of teeth in one jaw.

Periodontics

The treatment of disease of the gum and tissues surrounding the teeth.

Prosthodontic Services

The making of artificial devices for replacement of missing teeth and structures in the mouth.

Space Maintainers

Appliances to prevent adjacent teeth from moving into space left by a lost tooth.

6. Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential service designed to help you and your family solve personal problems that may affect your health, family life, or job performance.

Highlights

The EAP …

Offers Services at No Cost to You and Your Eligible Dependents

Consultations with program counselors are provided free of charge, and you may have up to five sessions per personal problem or concern per year.

Is Available 24 Hours a Day, 7 Days a Week

In an emergency, you can call any time, day or night, on any day of the week. Otherwise, counselors are available for appointments during normal business hours. Appointments are also available during evening hours and Saturdays.

Ensures Complete Confidentiality

Your discussions with counselors are strictly confidential. No information about you or your eligible dependents will be released unless you give written permission, or unless required by law.

What Happens to Your Benefits When ...

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

How the EAP Works

The EAP is administered by an outside firm. The provider offers confidential, professional assessment, referral, and counseling services on a one-on-one basis. The EAP can help you and your eligible dependents with:

- family or marital problems
- job-related issues
- drug or alcohol abuse
- stress, anxiety, depression, or other emotional problems

Program counselors are available for appointments during business hours and are on call for emergencies 24 hours a day, 7 days a week.

When you call the EAP, you will be encouraged to make an appointment to meet with a trained counselor in person. If you decide to meet face-to-face, you will be offered an appointment with a program counselor within 5 days. In an emergency, a counselor will be available to meet with you as soon as possible.

Together, you and the counselor will discuss your concerns and decide the appropriate course of action. You may decide that no additional services are needed, or you may choose to meet with a program counselor for up to four additional sessions (for a maximum of five sessions per personal problem per year). If necessary, the EAP can also help you identify specialized services.

Cost of Treatment

Any consultation between a program counselor and you or your eligible dependents is free of charge.

If you are referred outside the program for treatment, you will be responsible for paying for the treatment. Treatment outside the program may be covered by your medical coverage.

Continuing Treatment ...

If you require extended treatment after your EAP sessions end, you can use the behavioral health benefits available through your UnitedHealthcare Medical Plan. Be sure to ask your EAP provider if he or she also is a UnitedHealthcare provider so you can continue treatment with the same provider on an in-network basis. If your EAP provider is not a UnitedHealthcare provider, you may select an in-network UnitedHealthcare provider or continue to see your EAP counselor on an out-of-network basis.

Confidentiality

Using the EAP is strictly confidential. The provider will never release any information about you or an eligible dependent unless you give your written permission or unless required by law.

Administrative Information

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

How to Contact the EAP

If you or someone in your family needs help, contact the EAP directly at 1-800-888-2273.

7. Flexible Spending Accounts

Flexible Spending Accounts (FSAs) offer a convenient way to pay for health and dependent care expenses on a pre-tax basis.

Highlights

The FSAs...

Give You Choices

You can contribute to the Health Care FSA, the Dependent Care FSA, or both per Internal Revenue Service (IRS) guidelines. Each year, you can contribute up to the limits set by the IRS for each account. You can use the Health Care FSA to pay for certain eligible out-of-pocket medical, dental, vision care, and prescription expenses, and you can use the Dependent Care FSA to pay for day care and elder care expenses for eligible dependents.

Offer Convenience

Your FSA contributions are automatically deducted from each paycheck and credited to your FSAs.

Save You Money in Taxes

The money in your accounts is not subject to federal income taxes, Social Security taxes, or Medicare taxes, and, in most places, state and local taxes also do not apply. This means that many of your routine health and dependent care services will cost you less.

Require Careful Planning

You need to estimate your expenses for the upcoming year carefully, during the annual benefits Open Enrollment, when deciding how much to contribute to the FSAs. According to IRS rules, any money left in your account will be forfeited.

What happens to your benefits when ...

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

How the FSAs Work

Use these guidelines to put the FSAs to work for you:

Estimate your expenses. Each year, you calculate these expenses for the upcoming year: any out-of-pocket medical, dental, vision care, or prescription drug expenses, and your dependent care expenses. You should estimate carefully because you will forfeit any unused funds.

Decide on your annual contributions to the Health Care FSA and the Dependent Care FSA based on the Plan limits. The two accounts are separate, and you may not transfer funds between the two. Once you begin contributing, you may not change or stop your contributions during the year unless you have a Qualifying Life Event as described in the "About Your Benefits" chapter.

When the accounts are effective. For new hires and newly eligible participants, you may use your accounts for expenses incurred beginning the day you first become eligible. For elections made during the annual Open Enrollment, the accounts are effective beginning the following January 1.

Using your account. The FSA administrator maintains a web-based participant portal that makes account information readily available. On the portal, you can do the following:

- Set up direct deposit for your reimbursements
- Get your account balance
- View payment card charges
- Enter claims and view claim status
- Submit required receipts
- View reimbursement schedule
- Find eligible and ineligible expenses, consumer tools, and frequently asked questions.

Incurring expenses. Expenses must be incurred in the plan year for which the election was made and while you were an active participant in the plan. The deadline for filing claims is March 31 following the plan year for which the election was made.

Receive reimbursement. Reimbursements from your accounts are made with pre-tax dollars.

Should You Participate?

Here are some questions you may want to ask yourself before you decide to contribute to an FSA:

What do you expect your out-of-pocket health care expenses will be?

Start with your deductibles, and then add any medical, dental, vision care, or prescription drug expenses that are not covered, such as copayments, charges above the Medicare-based Maximum Reimbursable Charge charges, or charges above plan maximums**.**

Note: If you are enrolled in a High Deductible Health Plan (HDHP), you are not eligible to participate in a Health Care FSA. (See the "Medical Plans" section.)

What do you expect your dependent care expenses will be?

Consider any times of the year when you do not have these child care expenses, such as vacation periods. Also, if your child will turn 13 during the year, estimate your expenses only for the portion of the year before your child's thirteenth birthday.

You may also want to use an FSA calculator to help determine how much you should contribute.

Grace Period

IRS regulations provide for a 2½ month grace period for both Health and Dependent Care FSAs. Under this provision, you are allowed to file claims for expenses incurred through March 15 of the following plan year.

However, if you elect to participate in the Health Savings Account following a year you participated in the Health Care FSA, you will only be reimbursed during the grace period from the Health Care FSA for expenses incurred for vision care or dental care.

Changing your Contribution

You may not change or stop your contributions to the FSAs during the year unless you have a Qualifying Life Event, such as a birth, a marriage, or a job loss by your spouse. The change in contributions must be consistent with the Qualifying Life Event. For example, with the birth of a child, you can increase your contributions but not decrease them, and the change must be made within 30 days of the Qualifying Life Event.

Changes in Cost for Dependent Care

If you contribute to the Dependent Care FSA, and there is a significant increase or decrease in the cost of services by a day care provider who is not your relative, you may be able to make corresponding changes to your contribution election for your Dependent Care FSA by submitting a new election within 30 days of the change. For example, if mid-year, your mother will begin taking care of your child at no cost and you no longer need your current dependent care center, you can revoke your election to contribute to the Dependent Care FSA due to a significant change in coverage. However, if your mother wants to start receiving an income, you cannot increase your contributions to this account due to a change in cost because she is your relative.

See the “About Your Benefits” chapter for more information on Qualifying Life Events. If you stop contributing to the FSAs, you can be reimbursed only for eligible health and dependent care expenses incurred before you stopped contributing.

Tax Savings

The health care and dependent care FSAs are designed for one purpose: to help you save on taxes. Your taxable income is reduced by the amount you contribute to the accounts.

How Much Can You Save on Your Taxes?

Your participation in the FSAs may reduce your Social Security retirement benefits, but the current tax advantages generally offset any reduction in Social Security benefits.

To determine the amount of federal tax you will save, multiply the amount of your contribution by your federal tax bracket (percentage). You may also save on Social Security and Medicare taxes—and depending on where you live, state and local taxes.

Health Care FSA

Contributions

You can contribute from $100 up to the Plan limit to the Health Care FSA. Contributions are deducted from your pay each pay period and credited to FSA.

Limit for Highly Compensated Employees

Certain highly compensated employees may be limited by the IRS as to how much they can contribute to the Health Care FSA each year. You will be notified if this limit applies to you.

Eligible Expenses and Dependents

You can use the Health Care FSA to pay for eligible out-of-pocket medical, dental, vision care, and prescription drug expenses for you and your eligible dependents. (**The term "eligible dependents" is defined in the Glossary.)**

You and your eligible dependents do not have to be covered under the Company's medical or dental plans to participate in the health care spending account. In general, you may be reimbursed for any health care expense that is not paid for by an insurance plan and is considered a deductible medical expense by the IRS, except health care insurance premiums. However, you cannot claim, as an income tax deduction, any expenses reimbursed or payable through the Health Care FSA.

Refer to IRS Publication 502 for a current list of eligible deductible expenses. To order a copy, call the IRS toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.

Examples of eligible expenses that currently are allowable by the IRS include medically necessary:

- fees for physicians, surgeons, dentists, ophthalmologists, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, social workers, and Christian Scientist practitioners
- fees for hospital services; therapy; nursing services; ambulance fees; and laboratory, surgical, obstetrical, diagnostic, dental, and x-ray services
- rehabilitation services
- special equipment such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf
- special items such as dentures, artificial limbs, contact lenses, eyeglasses, hearing aids, crutches, and guide dogs for the vision or hearing impaired
- prescription medicines, drugs, and insulin
- cost of vasectomies, hysterectomies, and birth control
- acupuncture
- radial keratotomy and laser vision correction
- non-elective cosmetic surgery
- smoking cessation programs
- over-the-counter drugs that are prescribed and treat a medical condition
- weight loss programs prescribed by a physician to treat a medical condition.

Expenses Not Eligible

Examples of health care expenses that are ineligible for reimbursement through the Health Care FSA include:

- expenses incurred before your date of participation
- expenses reimbursed or reimbursable through any other policy, plan, or program
- expenses claimed as a deduction or credit on your federal income tax return
- elective cosmetic surgery
- orthodontia for cosmetic purposes
- tooth-whitening procedures
- marriage or family counseling fees

- household and domestic help, even if recommended by a doctor
- custodial care in an institution
- funeral and burial expenses
- illegal operations or treatments
- weight-loss programs, unless prescribed by a doctor to treat an existing disease/medical condition
- maternity clothes, diaper services, etc.
- vitamins or food supplements taken for general health purposes
- cosmetics, toiletries, etc.
- health care insurance premiums
- hair transplant or removal
- transportation expenses to and from work, despite a physical handicap
- expenses merely beneficial to health, such as vacations or fitness programs, even if recommended by a doctor
- any expenses incurred after you stop making contributions
- over-the-counter drugs that are not prescribed by a physician

Filing Claims

When you incur an eligible medical, dental, vision care, or prescription drug expense, you may pay using your Healthcare Payment Card or pay out of pocket and request reimbursement. In all cases, you must save itemized receipts because the IRS requires that your charges be verified. You may submit claims on the plan administrator's website or submit paper forms, available on the Employee Benefits website.

If you have incurred eligible health care expenses, you may be reimbursed up to the total contribution amount you have elected for the plan year, regardless of your account balance.

Refer to IRS Publication 502 for a current list of eligible deductible expenses. To order a copy, call the IRS toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.

Dependent Care FSA

Contributions

You may contribute to the Dependent Care FSA if you have eligible dependent care expenses (that is, you incur expenses to enable you to work). If you are married, you may contribute to this account only if your spouse is:

- gainfully employed outside the home
- actively searching for a job
- enrolled as a full-time student at least 5 months of the year

or

- mentally or physically disabled and unable to provide care for himself or herself.

If your spouse's employment ends during the year, or your child turns age 13, you should contact the ORNL Benefit Service Center immediately because you may no longer be eligible to participate in this account.

You can contribute from $100 up to the IRS annual limit in pre-tax dollars to your Dependent Care FSA. In some cases, however, the IRS limits the amount you can contribute, as shown in the following chart. Dependent care contributions are reported on your W-2, according to IRS rules.

Limit for Highly Compensated Employees

Certain highly compensated employees may be limited by the IRS as to how much they can contribute to the Dependent Care FSA each year. You will be notified if this limit applies to you.

Special Dependent Care FSA Limits if You Are Married

If this is your situation …	You will be taxed on reimbursements that exceed …
You or your spouse earn less than $5,000	The amount the lower-paid spouse earns*
Your spouse also participates in a similar dependent care spending account	$5,000 combined
You file separate federal income tax returns	$2,500

* If your spouse is a full-time student for at least 5 months of the year or is disabled, he or she will be treated as earning $250 a month if you have one eligible dependent ($500 a month if you have two or more eligible dependents), adjusted for future years as required by the IRS.

Eligible Dependents

You may use the Dependent Care FSA to pay for the care of your eligible dependents so that you or, if you are married, you and your spouse, can work. Eligible dependents include:

- your children under age 13
- your spouse, if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year

  or
- a disabled dependent of any age (including parents) if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year.

An eligible dependent is someone you can claim as a dependent on your federal income tax return.

If you are divorced or legally separated and have custody of your eligible child, you may use the Dependent Care FSA even though you have agreed to let your spouse claim the child as a dependent for tax purposes. If you have joint custody, you may also use the Dependent Care FSA provided you have custody of your child for a longer period during the year than your spouse does.

Eligible Expenses

Expenses eligible for reimbursement are those incurred to enable you to work and include:

- services provided in your home by a babysitter or companion, including wages and related taxes
- services provided by a dependent care center that meets local regulations, cares for more than six nonresidents, and receives a fee for such services, whether or not for profit

- services provided outside your home, such as day camp, preschool tuition, or other outside dependent/child care services, such as before- and after-school programs, but only if the care is for a dependent under age 13 or other eligible dependent who regularly spends at least 8 hours a day in your home.

Generally, eligible child care costs include only those for the actual care of your child, not costs for education, supplies, or meals—unless those costs cannot be separated.

Expenses Not Eligible

Expenses that are not eligible for reimbursement through the Dependent Care FSA include:

- dependent care provided by your child (or stepchild) who is under age 19 at the end of the taxable year or by another dependent whom you can claim as an exemption
- dependent care obtained for non-work-related reasons such as babysitting after your working hours
- dependent care provided while you are away from work because of illness or leave of absence
- dependent care that could be provided by your employed spouse whose work hours differ from yours
- expenses for overnight camp
- dependent care expenses incurred if your spouse does not work, unless your spouse is actively seeking employment, a full-time student, or disabled
- any expenses you claim for the dependent care tax credit on your federal income tax return
- expenses paid by another organization or provided without cost
- transportation to or from the dependent care location
- care provided in a group care center that does not meet state and local laws
- agency finder fees
- charges for referral to dependent care providers
- costs for after-school educational programs
- costs for clothing, entertainment, or food
- educational expenses (such as those for private school) for kindergarten or higher
- expenses incurred before you began contributing to the account or after you stop contributing.

Dependent Care FSA vs. the Federal Tax Credit

Under the current tax law, you can save taxes on dependent care expenses either by claiming a tax credit on your federal income tax return or by participating in the Dependent Care FSA. Both are intended to offer you tax savings. The best method for you depends on your income, the number of eligible dependents you have, and other factors. However, for most people, using the Dependent Care FSA provides a greater tax advantage.

Dependent Care Provider Identification

When you file a claim for reimbursement through the Dependent Care FSA, you must include an original receipt from your dependent care provider. You will have to provide the caregiver's name, address, and taxpayer identification number (or Social Security number) on IRS Form 2441 when you file your federal income tax return and when you submit a claim for reimbursement. If you cannot supply this information, you should not use the dependent care spending account.

To obtain IRS Form 2441, call the IRS at 1-800-829-3676 or visit the IRS website at www.irs.gov.

You may use both approaches, but you may not "double deduct" the same expense. In addition, the expenses you apply toward the tax credit will be reduced dollar-for-dollar by the amount of expenses reimbursed from your account.

You should consult a personal financial or tax advisor to help you decide whether the tax credit or the Dependent Care FSA is more favorable for you.

Refer to IRS Publication 503 for a discussion of the tax credit. To order a copy, call the IRS toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.

Filing Claims

When you have an eligible dependent care expense, you must pay the provider and then submit a claim, along with a bill or receipt, to the FSA administrator. Be sure to include the dependent care provider's Social Security or tax identification number. **Note: You may be reimbursed only up to the amount available in your account at the time you file a claim.** The annual deadline for filing prior year claims is March 31.

You will be reimbursed only for dependent care services you have already received. For example, if you pay in advance for 3 months of care, you cannot be reimbursed for the entire amount until after the end of the 3 month period. However, you can be reimbursed for a portion of the bill at a time.

You will be reimbursed for the lesser of your current account balance or the amount of the claim. If you submit a claim for an amount that exceeds your account balance, you will be reimbursed for the remainder of the claim after you have made sufficient additional contributions for that year to cover the expenses.

Payment of eligible expenses incurred, received, and processed will be made weekly.

FSA reimbursement request forms are available on the Benefits Enrollment website or from the account administrator.

Remaining Funds

Estimate your FSA contributions carefully. You may continue to file claims for expenses incurred during the plan year until March 31 of the following year. According to IRS rules, you must "use up" amounts deducted from your pay by incurring and filing claims for eligible expenses up to the amount you have had deducted. Otherwise, you lose the money you have left in your account.

No Transfers Allowed

Remember, you may not transfer money between FSAs. Money set aside in your health care spending account cannot be used to reimburse dependent care expenses or vice versa.

Any forfeited amounts will be used to offset the plan's administrative expenses.

Account Statements

You may obtain account information any time by phone or by accessing the FSA vendor website.

In addition, each time you receive a reimbursement, the attached explanation provides a summary of year-to-date activity.

Continuation of Coverage

You may be eligible to continue your Health Care FSA participation in certain cases when your participation would otherwise end. You may not, however, continue your participation in the Dependent Care FSA. Refer to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in the "Administrative Information" chapter.

Administrative Information

Information about the administration of the FSAs can be found in the chapter titled "Administrative Information."

8. Disability Coverage

Your Disability benefits are designed to provide continuing income if you become ill, injured, or pregnant and are unable to work.

Highlights

Your Disability Benefits …

Provide Coverage at No Cost

Coverage under the Short-Term Disability Plan and Long-Term Disability Plan is provided automatically, at no cost to you.

Continue Part of Your Pay for Up to 180 Calendar Days

The Short-Term Disability Plan continues part of your Pay for up to 180 calendar days of disability, based on your length of service and the duration of your disability. *NOTE: 6 months or 26 weeks of disability are administered as 180 days.*

Replace Part of Your Pay for Disabilities that Continue Past 180 Calendar Days

The Long-Term Disability Plan continues part of your Pay after you have been disabled for 180 calendar days with benefits payable until you reach age 65 or until your disability ends, if earlier. If you become disabled on or after reaching age 60 but before age 69, benefits may continue for 5 years (starting with the date you begin long-term disability), or until you reach age 70, whichever comes first. If you become disabled on or after reaching age 69, benefits may continue for up to 12 months (starting with the date you begin long-term disability).

Are Coordinated with Other Disability Income

Your short-term disability and long-term disability benefits may be reduced by other income benefits, such as Workers' Compensation and Social Security, you receive while disabled.

What Happens to Your Benefits When ...

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

Short-Term Disability Plan

The short-term disability plan is designed to protect your income if you are unable to work due to pregnancy or non-occupational illness or injury. Employees who are on a leave of absence without pay, including educational leave, personal leave, military leave, or family medical leave for bonding or to care for a family member with a serious health condition, are not eligible for short-term disability benefits.

Short-Term Disability

IGUA SPO employees participate in the Short-Term Disability Plan described in the collective bargaining agreement. The collective bargaining agreement may be obtained from UT-Battelle Labor Relations.

If you are absent for a pregnancy or non-occupational illness or injury, you may receive short-term disability benefits after an unpaid waiting period of 24 hours subject to approval by a third-party claims administrator for the Company. The waiting period does not include scheduled days off. The waiting period is calculated as an absence of 24 consecutive work hours, including a partial day absence, regardless of which shift you work.

There are two cases in which you may receive benefit payments for the waiting period:

- You may receive benefit payments for the first 24 hours of a short-term disability absence if the disability extends beyond two (2) calendar weeks in which event payment will be made on the basis of absences for hours, which would normally have been worked had the employee performed his regular schedule of work during the first 24 hours of absence.
- If an employee is admitted to the hospital as an inpatient or treated on an outpatient basis and provided services that would otherwise require admission to the hospital as an inpatient during the first 24 hours of a certified non- occupational disability, any remaining hours of the 24-hour waiting period will be waived. In no case shall the period of payment exceed the schedule established herein.

Certification by a physician is required in both cases for the day(s) you are absent, and benefit payments are subject to approval by the claims administrator (**"Physician" is defined in the Glossary**).

Successive Disabilities

Periods of disability are treated as separate absences if they are:

- due to unrelated causes and are separated by your return to active work for at least one full regularly scheduled work day (normally 8 consecutive hours for a full-time employee),

or

- due to related causes and are separated by a return to active work of at least 520 hours or 3 calendar months, whichever is longer.

Active work as referenced above does not include light duty assignments.

Each separate disability absence begins with a waiting period of 24 hours and is tracked separately against the applicable short-term disability maximum duration (**"Hour of Work," "Disability," and "Light Duty Assignments" are defined in the Glossary**).

Benefit Duration and Amount

Following an unpaid 24 hour waiting period, if you are unable to work due to a pregnancy or non-occupational illness or injury, an employee employed 6-months or more, who is disabled and unable to work due to illness, pregnancy, or non- occupational injury, will be paid his or her basic straight-time hourly rate in accordance with the following schedule:

- Tier 1: 100% of Pay for the first 42 calendar days (6 weeks) of disability

- Tier 2: 80% of Pay for the next 42 calendar days (6 weeks) of disability
- Tier 3: 60% of Pay for the remaining 96 calendar days (14 weeks) of disability.

*Eligible employees are allowed to supplement approved disability pay, up to 100% of base pay, with the employee's accrued and unused Vacation benefits. The employee is required to submit timely requests to the designated Company representative, for applying any supplemental payment. For the purposes of determining your length of Company Service, the normal Company Service rules apply. While on short-term disability, you will not accrue Company Service for the purposes of determining the duration of your short-term disability benefit. However, you will accrue Company Service for certain other benefits ("Pay" is defined in the Glossary).

Supplementing Tier 2 and Tier 3 Benefit Payments with Vacation Pay

You may supplement the Tier 2 (80%) and Tier 3 (60%) benefit payments with vacation pay, up to the maximum amount of vacation available to you, to reach 100% of Pay by completing an authorization form after a short-term disability claim is initiated.

- The amount of vacation required to reach 100% of Pay is 6 days for the 42 days of benefit payments at Tier 2 (i.e., 1 day of vacation per week of disability) and 28 days for the 96 days of benefit payments at Tier 3 (i.e., 2 days of vacation per week of disability).
- Current year, banked, and deferred vacation may be used to supplement the benefit payments. If you accrue vacation, you may supplement the benefit payments with vacation pay up to the amount you have accrued at the time of the payments. Additional supplementation may continue as additional vacation is accrued.
- To have benefit payments supplemented with vacation pay, you must complete a Vacation Supplement Authorization form and return the completed form to the ORNL Disability Administration Office at the address on the form. You will receive the form from the third-party claims administrator for the Company after you file a short-term disability claim. The form is also available on the ORNL Benefits Forms web page.
- Vacation may be used to supplement the benefit payments in 1 hour increments.
- If you do not complete and return the Vacation Supplement Authorization form or do not have vacation available to supplement the benefit payments, you will receive only the amount of the tiered benefit.

Claiming Short-Term Disability Benefits

If you are unable to come to work because of a short-term disability absence, you must contact the claims administrator for the Company in order to receive benefits.

- You must call on the fourth work day of your absence or earlier if you are admitted to a hospital as an inpatient or receive treatment as a day surgery patient during the waiting period.
- You also must contact the claims administrator for anticipated absences related to pregnancy or a scheduled surgery or other procedure or treatment.

The claims administrator will give you further instructions, send you an information packet via US mail for your claim for benefits, and answer any questions you may have.

Also, you must furnish periodic medical evidence of your pregnancy, illness, or injury if requested by the Company or claims administrator; you must provide the requested information within the timeframe stated in the request, or your benefits may be suspended or denied. The Company and claims administrator reserve the right to confirm your disability with a physician and/or require a written statement from your attending physician at any time during your absence. Upon return to work, a physician's statement may be required indicating your fitness to resume work duties (**"Physician" is defined in the Glossary**).

In addition, during your disability, you may be required to undergo periodic evaluations in order for the Company to determine if you are able to return to light duty. If your physician determines that you are able to return to light duty, you must then be evaluated by Your Company's designated physician for final clearance to return to work. If you are cleared to return to light duty, your short-term disability benefits will end.

The claims administrator has the authority to interpret and administer the plan for the Company. The claims administrator will notify you of the decision regarding approval of your claim or if additional information is needed to make a decision on your claim.

If you take an unpaid leave of absence, you must return to active work for at least one full regularly scheduled work day (normally 8 consecutive hours) to resume eligibility for short-term disability benefits.

Benefit Payments

Plan benefits will be reduced by income benefits you are eligible to receive from other sources because of your disability, such as Workers' Compensation or any state or federal disability or occupational disease laws or benefits.

If your absence extends beyond 180 calendar days, benefits may become payable according to the Company's long-term disability plan. Any short-term disability benefit overpayments you receive may be recovered by the Company from amounts owed to you when you go on long-term disability or from benefit payments you receive under the long-term disability plan. Your plan benefits will not be reduced by any private disability coverage that you have purchased.

Exclusions

Short-term disability benefits are not payable for disabilities:

- if you are not under the appropriate care and treatment of a licensed practicing physician
- that result from working for yourself (in an income-producing capacity except for Company-approved arrangements) or an employer other than UT-Battelle
- due to willful misconduct, violation of Company rules, or refusal to use safety appliances
- due to any intentionally self-inflicted injury
- resulting from your attempt to commit or the commission of a crime under state or federal law.
- occurring during the first 12 months that your plan coverage is in effect if caused by any condition for which you received treatment during the 3 month period immediately before your plan coverage became effective

or

- directly or indirectly due to war, declared or undeclared.

When Short-Term Disability Benefits End

Benefits for any absence will end on the first of the following days when:

- you refuse to contact your supervisor and the claims administrator to report your disability or to provide updates about your continuing disability
- you do not provide requested satisfactory evidence of or provide incorrect information about your disability
- you refuse to be examined by a physician, ignore a physician’s appointment, or stop following a physician’s prescribed course of treatment
- you refuse to follow any step related to the administration of the short-term disability plan
- you become self-employed or perform services for a third party without the prior written permission of the Company or claims administrator
- you are no longer considered eligible because of a change in your employment status
- you recover from your disability
- you return to work
- you do not return to work for light duty if you are able
- you have received the maximum number of benefit payments
- your employment with the Company is terminated for any reason
- you are confined in a jail, prison, or other penal facility or correctional facility
- you are no longer an active employee
- you voluntarily decline the benefits
- the collective bargaining agreement expires *or*

- the plan terminates.

Appeal Procedures

You may file claims for plan benefits and appeal adverse claim decisions. For appeal procedures, see "Claims Review & Appeals" in the "Administrative Information" chapter.

Long-Term Disability Plan

Your long-term disability benefits are designed to provide continuing income if you become ill or injured and are unable to work. You are eligible to participate in this plan as described in the "About Your Benefits" chapter. You are not eligible to participate in this plan if you are on leave without pay, including educational leave, personal leave, family medical leave, or military leave.

You become entitled to benefits after you have been totally disabled, as defined in the **Glossary**, for 180 calendar days. Long-term disability benefits pick up where short-term disability benefits leave off, after you have been disabled for 180 calendar days.

NOTE: 6 months or 26 weeks of disability are administered as 180 days.

Benefit Amount

Your monthly Long-Term Disability Plan benefit equals 60% of your regular monthly Pay as of your last day of short-term disability, up to a maximum monthly benefit of $5,000, reduced by income you are eligible to receive from other sources, as described under "Reduction of Benefits (**"Pay" is defined in the Glossary**).

Duration of Benefits

Benefits under the Long-Term Disability Plan are payable to you once you have been totally disabled, as defined in the **Glossary**, for 180 calendar days, subject to approval by the claims administrator for the Company.

Phase One

Under the Long-Term Disability Plan, you are considered totally disabled during your first 24 months of long-term disability if you are unable to perform the duties of your regular job with the Company due to illness or injury, and are under the appropriate care and treatment of a licensed practicing physician (**"Appropriate Care and Treatment" is defined in the Glossary**).

Should you recover from your illness/injury during the first 24 months of long-term disability leave, you must contact the Company Disability Administration Office to request a return-to-work medical evaluation.

The decision on whether you return to work will be based on the results of this medical evaluation and the availability of a position for which you qualify. The Disability Administration Office will verify that a position is available for you. If a position is available, a return-to-work medical evaluation will be completed.

Phase Two

After you have received long-term disability benefits for 24 months, you are considered totally disabled if you remain under the appropriate care and treatment of a licensed practicing physician and you are unable to work at any job for which you might be qualified, based on your education, training, and experience.

You may be eligible for severance pay after receiving long-term disability benefits for 24 months. Severance pay benefits are calculated based on your last day worked. See the collective bargaining agreement for details.

While you are receiving long-term disability benefits under either Phase One or Two, you must furnish periodic medical evidence of your illness or injury if requested by the Company, and you may be required to undergo periodic evaluations in order for the Company to determine whether you are able to return to work. Failure to do so can result in your benefits being discontinued.

Normally, if you qualify for benefits under the provisions of the plan as stated above, long-term disability benefits are payable until you recover or until you reach age 65, if earlier (unless one of the events under "When Long-Term Disability Benefits End" occurs). However, special provisions apply if you are age 60 or older when you become totally disabled. If you become totally disabled:

- at age 60 but before age 69, benefits are payable for up to 5 years (starting with the date you begin long-term disability) or until age 70, whichever comes first
- at or after age 69, benefits are payable for up to 12 months (starting with the date you begin long-term disability).

Determining Your Long-Term Disability Benefit

To calculate the amount you are eligible to receive under the Long-Term Disability Plan, follow these steps:

Step 1: Multiply your monthly Pay by 60% to determine your maximum monthly benefit from the plan, up to $5,000.

Step 2: Subtract other income you are eligible to receive, except for family Social Security, to find your adjusted monthly benefit from the plan. Continue on to Step 3 only if you are eligible to receive family Social Security.

Step 3: Add your adjusted monthly benefit (from Step 2) to all other income you are eligible to receive, including family Social Security. If the resulting total of all income benefits you are eligible to receive is more than 75% of your monthly Pay, your monthly long-term disability benefit will be reduced by the excess of your total income benefits over 75% of your monthly Pay.

Reduction of Benefits

Your long-term disability benefits are reduced by other sources of income that are payable to you because of your disability. Income that will reduce your long-term disability benefits includes but is not limited to:

- Workers' Compensation benefits or benefits provided under a similar law; state disability benefits; and other statutory benefits for disability, retirement, or unemployment
- benefits provided through Company benefit plans, including the pension and business travel accident insurance plans
- income you receive for working on a reduced-hour basis or for rehabilitative employment

or

- any Social Security disability benefits for which you are eligible (refer to the Social Security and long-term disability benefits chart that follows).

If you are receiving benefits for Social Security Retirement Income and/or pension, prior to the date of disability, benefits are not reduced.

If any of this income is paid as a lump sum and results in an overpayment of disability benefits to you, you must reimburse the Company for the amount of the overpayment. If you do not repay the Company, your long-term disability benefit will be calculated as if this income were paid monthly. The Company has the right to recover any overpayments you receive, and your monthly benefit payment will be reduced by the maximum amount possible, as determined by the claims administrator, to recover any overpayment you receive.

The claims administrator that pays the long-term disability benefits will instruct you on how to apply for Social Security benefits. If you do not exhaust the steps to obtain Social Security benefits, your long-term disability benefits will be reduced by your estimated Social Security benefits, as calculated by the claims administrator. See the following "Social Security and Long-Term Disability Benefits" chart for more information.

Your long-term disability benefits will not be reduced by any private disability coverage that you have purchased.

Disability Example	
Assume you earn $3,000 a month.	
Monthly Pay……	$3,000
× long-term disability benefit percentage……	× 60%
Maximum monthly long-term disability benefit……	***$1,800***
Assume you are eligible for primary Social Security disability benefits of $800 a month.	
Maximum monthly long-term disability benefit……	$1,800
– Primary Social Security……	– $800
Adjusted monthly long-term disability benefit……	***$1,000***
Assume you are eligible for family Social Security disability benefits of $500 a month.	
Adjusted monthly long-term disability benefit……	$1,000
+ Primary Social Security……	+ $800
+ Family Social Security……	+ $500
= Total disability income……	$2,300
– 75% of monthly Pay……	– $2,250
= Benefit reduction……	$50
Final monthly long-term disability benefit……	***$950***

Social Security and Long-Term Disability Benefits

You should apply for Social Security disability benefits within 90 days of the date your long-term disability leave becomes effective.

If you have not received a benefit determination from Social Security after you have been receiving long-term disability benefits for 12 months, or if your original claim is denied and you do not file an appeal within 30 days of your receipt of the denial, then your long-term disability benefits will be reduced by your estimated Social Security benefits, as calculated by the claims administrator.

If...	Then...
You later complete the Social Security appeals process and are denied benefits	Your long-term disability benefits will be retroactively reinstated, and you will receive a "catch-up" payment
You receive a cost of living increase to your Social Security disability income after your long-term disability benefit has been calculated	Your long-term disability benefits will not change
Your disability makes you eligible to receive family Social Security benefits	Your total disability income from all sources may not exceed 75% of your monthly Pay

Claiming Long-Term Disability Benefits

Long-term disability benefits cannot begin until the claim forms sent to you by the claims administrator have been satisfactorily completed by you and your physician and received by the claims administrator. The claims administrator and the Disability Administration Office will assist you in filing your claim.

You are required to apply for Social Security and any other income you may be eligible to receive as a result of your disability. If your initial application for Social Security is denied, you are required to pursue the entire Social Security benefits appeals process through the Social Security Office.

Exclusions

Long-term disability benefits are not payable for disabilities:

- occurring during the first 12 months that your plan coverage is in effect if caused by any condition for which you received treatment during the 3-month period immediately before your plan coverage became effective
- if you are not under the appropriate care and treatment of a licensed practicing physician
- that result from working for yourself (in an income-producing capacity except for Company-approved arrangements) or an employer other than UT-Battelle
- due to willful misconduct, violation of Company rules, or refusal to use safety appliances
- due to any intentionally self-inflicted injury
- resulting from your attempt to commit or commission of a crime under state or federal law

or

- directly or indirectly due to war, declared or undeclared

Example of Offset for Rehabilitative Income

Assume you begin receiving rehabilitative income of $1,500 per month.

Monthly rehabilitative income...	$1,500
× 70%	
Maximum rehabilitative income offset ...	***$1,050***

Assume your long-term disability benefit is $2,500 per month.

Monthly long-term disability benefit …	$2,500
– Monthly rehabilitative income offset …	*– $1,050*
= Adjusted disability benefit...	$1,450
+ Rehabilitative income...	+ $1,500
Final monthly income...	***$2,950***

Taking a Job While Disabled

If you return to work at the Company in a full-time position your long-term disability benefits will end.

The claims administrator provides a rehabilitative employment program to assist you in pursuing other employment opportunities if it is determined that you will not be able to return to your job at the Company. If you participate in the rehabilitative employment program, you will be eligible to continue to receive part of your long-term disability income during your participation. Your monthly long-term disability benefits will be reduced by 70% of any income you receive from your rehabilitative employment. Your combined long-term disability benefit and rehabilitative employment income cannot exceed 100% of your regular monthly Pay as of your last day of short-term disability. Your participation in the rehabilitative employment program and the length of time you participate are subject to the discretion and approval by both the Company and the claims administrator.

When Long-Term Disability Benefits End

- Long-term disability benefits will end on the first of the following days when:
- you refuse to provide updates about your continuing disability
- you do not provide requested satisfactory evidence of or provide incorrect information about your disability
- you refuse to be examined by a physician, ignore a physician's appointment, or stop following a physician's prescribed course of treatment
- you refuse to follow any step related to the administration of the long-term disability plan
- you become self-employed or perform services for a third party without the prior written permission of the claims administrator
- you recover from your disability
- you return to work
- you have received the maximum number of benefit payments
- you are confined in a jail, prison, or other penal facility or correctional facility
- you retire
- you die
- you voluntarily decline the benefits
- the collective bargaining agreement expires

or

- the plan terminates.

Successive Disabilities

If you receive long-term disability benefits, return to work for less than 520 hours or 90 calendar days (whichever is longer) and again become disabled due to the same illness or injury, long-term disability income will resume without a 6 month waiting period. However, if you have been working for at least 520 hours, or more than 90 calendar days (whichever is longer), you will need to satisfy the waiting period before long-term disability benefits begin.

Administrative Information

Information about the administration of your Disability Coverage can be found in the chapter titled "Administrative Information."

Disabilities due to unrelated causes will be treated as separate disabilities requiring satisfaction of separate waiting periods if the disabilities are separated by your return to work for 8 consecutive hours.

Appeal Procedures

You may file claims for plan benefits and appeal adverse claim decisions. For appeal procedures, see "Claims Review & Appeals" in the "Administrative Information" chapter. In addition, the collective bargaining agreement contains information related to the resolution of disputes for Bargaining Unit employees.

Glossary

Appropriate Care and Treatment

During disability, medical care and treatment that is:

- received from a physician whose medical training and clinical experience are suitable for treating your disability;
- necessary to meet your basic health need and is of demonstrable medical value;
- consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and health care coverage organizations and government agencies;
- consistent with the diagnosis of your condition; and
- maximizing your medical improvement.

Disability

Under UT-Battelle's Disability plans, you are determined to have a disability if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the appropriate care and treatment of a licensed practicing physician. The Company's Claims Administrator makes that determination.

Hour of Work

Each hour of work for the Company for which you are paid, including straight time, overtime, holidays, and jury duty. However, vacations, personal leave, and time off for union business are not included in calculating your hours of work.

Light Duty Assignments

Temporary modified duties assigned as the result of temporary physical limitations due to non-occupational injury or illness or pregnancy that prevent an employee from performing the full scope of duties of his or her regular assigned job.

Pay

For Short-Term Disability and Long-Term Disability
Your monthly basic rate of pay in effect just before your total disability begins and before any pre-tax salary reductions. Pay does not include overtime, bonuses, or any other form of extra compensation.

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.

Totally Disabled

For Long-Term Disability
During the first 24 months you are absent from work under the long-term disability plan, you are considered Totally Disabled if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the regular care of a licensed practicing physician. After you have been absent from work for 24 months, you are considered Totally Disabled if you remain under the regular care of a licensed practicing physician and you are unable to work at any job for which you might be qualified based on your education, training, and experience

9. Life and Accident Insurance

Your Life and Accident Insurance benefits are designed to provide financial security for your survivors in the event of your death, and for you, in case of accidental dismemberment, disability or, in the case of Special Accident, paralysis.

Highlights

Your Benefits …

Provide Security for Your Family Through Basic Life Coverage

Your Basic Life Insurance coverage pays a benefit of at least two times your Pay to your beneficiary in case of your death from any cause. You and the Company share the cost of this coverage.

Offer the Opportunity for Added Protection through Supplemental, Spouse, and Dependent Life Coverage

You may purchase Supplemental Life Insurance coverage from one to eight times your Pay to a maximum of $1,000,000 to provide greater security for your beneficiary in case of your death from any cause. You may also purchase spouse life insurance in amounts from $10,000 to $50,000 and Dependent Life Insurance in the amount of $10,000.

Automatically Provide Business Travel Accident Coverage

Business Travel Accident Insurance coverage pays a benefit of four times your Pay, up to $500,000, to you or your beneficiary in case of accidental death, dismemberment, or Total and Permanent Disability (as defined in the Glossary) while you are traveling on a Business Trip (as defined in the Glossary). This coverage is provided automatically, at no cost to you.

Give You Extra Security Through Special Accident Coverage

Special Accident Insurance coverage from $20,000 to $500,000 can provide extra financial security for you or your beneficiary in the event of accidental death, dismemberment, or paralysis. Family coverage is also available.

What happens to your benefits when ...

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

Basic Life Insurance

Basic Life Insurance is available on an optional contributory basis. This coverage pays benefits to your beneficiary in the event of your death from any cause while you are insured.

Evidence of Insurability will be required if Basic Life Insurance is elected more than 30 days after date of hire.

Benefit Amounts

During Active Service

If you are actively working at the Company, your Basic Life Insurance amount is equal to two times your annual Pay, rounded to the next higher $1,000 if your annual Pay is not an even multiple of $1,000. (The term "Pay" is defined in the Glossary.)

When your Pay increases enough to put you in a new insurance bracket, your insurance amount will automatically increase. If your Pay decreases, your insurance amount will be reduced if your new Pay rate puts you in a lower insurance bracket.

Any change will be effective immediately. If you are on leave of absence, long-term disability, or strike at that time, the increase or reduction in insurance will take place upon your return to work.

About Your Basic Life Insurance Amount

If your annual Pay is not an even multiple of $1,000, it is rounded up for purposes of determining your Basic Life Insurance amount. This rounding of your Pay means that insurance amounts are actually provided in $2,000 steps as shown by the examples in the following chart.

If your annual Pay is:	Your Basic Life Insurance amount is:
$34,000.01 to $35,000	$70,000
$35,000.01 to $36,000	$72,000
$49,000.01 to $50,000	$100,000
$50,000.01 to $51,000	$102,000
$74,000.01 to $75,000	$150,000
$75,000.01 to $76,000	$152,000
$90,000.01 to $91,000	$182,000
$91,000.01 to $92,000	$184,000
in steps of $1,000	in steps of $2,000

During Disability

After you have been on Short-Term Disability continuously for 13 weeks, your Basic Life Insurance coverage will continue at the level in effect at the time your disability began, providing you pay any required cost. After 13 weeks of continuous disability, your coverage continues at no cost while you are on Short-Term Disability.

If you transition to Long-Term Disability, you may continue your coverage, and you may apply for a waiver of premium. If approved, your coverage will continue at no cost.

If you become Totally Disabled (as defined in the Glossary) during active service and before age 63, your Basic Life Insurance coverage will continue at the level in effect at the time your disability began for as long as you remain Totally Disabled or until the last day of the month preceding your 65th birthday, whichever comes sooner. If your Total Disability begins after your 63rd birthday, however, your insurance will continue for 2 years, but not beyond age 70.

On the first day of the month in which you reach age 65, or at the expiration of the 2 year period if later, you may be eligible to continue a portion of your insurance amount, as described previously.

IGUA Employees Hired Prior to 8/15/2016

During Retirement—At Age 65 and After

If you retire at age 65 or later, a reduced amount of Basic Life Insurance coverage (described below) 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 is currently provided at no cost to you.

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

If you had Basic Life Insurance coverage for at least 5 continuous years immediately preceding your retirement, the amount of your reduced insurance will be the greater of:

- 20% of your Basic Life Insurance just before retirement.

  or
- 1% of your Basic Life Insurance amount just before retirement multiplied by your years of service (including any fraction of a year), plus $500, with a minimum of $2,500 or 25% of your Basic Life Insurance just before retirement, up to a maximum of $10,000

During Retirement—Before Age 65

If you retire before age 65, are eligible for an immediate pension benefit, and had Basic Life Insurance coverage for at least 1 year immediately preceding retirement, you can:

- continue your full Basic Life Insurance amount until the last date 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 “During Retirement—At Age 65 and After”) immediately at no cost to you.

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

On the first of the month in which you reach age 65, your life insurance will be automatically reduced.

The balance between your reduced amount and the original amount can be converted to an individual policy within 31 days of termination of coverage.

IGUA Employees Hired on or After 8/15/2016

Coverage ends the last day of the month upon termination from the company**.** Your coverage can be converted to an individual policy. Refer to “Conversion Privileges” at the end of this section for more information.

Supplemental Life Insurance

Supplemental Life Insurance is available on an optional contributory basis. This coverage provides added protection to your beneficiary in the event of your death from any cause while you are insured. You must elect Basic Life Insurance in order to elect this coverage.

Benefit Amounts

During Active Service

If you are actively working, you can elect Supplemental Life Insurance equal to one to eight times your annual Pay (rounded to the next higher $1,000 if not an even multiple of $1,000), up to a maximum of $1,000,000. (The term “Pay” is defined in the Glossary.)

Evidence of Insurability (EOI) is required for any insurance amount elected greater than five times salary. The amount of coverage in effect prior to the approval or after the denial of the requested insurance coverage will be five times salary.

If Supplemental Life Insurance is elected more than 30 days after date of hire, EOI will be required for the full elected amount.

When your Pay increases enough to put you in a new insurance bracket, your insurance amount will automatically increase. If your Pay decreases, your insurance will be reduced if your new Pay rate puts you in a lower insurance bracket

Any change will be effective immediately. If you are on leave of absence, long-term disability, or strike at that time, the increase or reduction in insurance will take place upon your return to work.

During Disability

After you have been on Short-Term Disability continuously for 13 weeks, your Supplemental Life Insurance coverage will continue at the level in effect at the time your disability began, providing you pay any required cost. After 13 weeks of continuous disability, your coverage continues at no cost while you are on Short-Term Disability.

If you transition to Long-Term Disability, you may continue your coverage and apply for a waiver of premium. If approved, your coverage will continue at no cost.

If you become Totally Disabled (as defined in the Glossary) during active service and before age 63, your Supplemental Life Insurance coverage will continue at the level in effect at the time your disability began for as long as you remain Totally Disabled or until the last day of the month preceding your 65th birthday, whichever comes first.

If your Total Disability begins after your 63rd birthday, however, your insurance will continue for 2 years, but not beyond age 70. On the first day of the month in which you reach age 65, or at the expiration of the 2 year period, if later, you may be eligible to continue a portion of your insurance amount, as described in “Portability” at the end of this section.

IGUA Employees Hired Prior to 8/15/2016

During Retirement—At Age 65 and After

If you retire at age 65 or later, a reduced amount of Supplemental Life Insurance coverage (described below) will continue for the rest of your life, provided you had Supplemental Life Insurance coverage for at least 1 year immediately preceding retirement. This reduced coverage is currently provided at no cost to you.

If you had Supplemental Life Insurance coverage for at least 1 year but less than 5 years immediately preceding your retirement, your reduced life insurance amount will be $312.

If you had Supplemental Life Insurance coverage for at least 5 continuous years immediately preceding your retirement, the amount of your reduced insurance will be the greater of:

- 10% of your Supplemental Life Insurance capped at one times your salary just before retirement.

  or
- 1% of one times your salary Supplemental Life Insurance amount just before retirement multiplied by your years of service (including any fraction of a year), plus $250, with a minimum of $2,500 or 25% of your Supplemental Life Insurance just before retirement, up to a maximum of $5,000

During Retirement—Before Age 65

If you retire before age 65, are eligible for an immediate pension benefit, and had Supplemental Life Insurance coverage for at least 1 year immediately preceding retirement, you can:

- continue your full Supplemental Life Insurance capped at one times your salary amount until the last date of the month preceding your 65th birthday by continuing to make your regular premium payments

  or
- take the reduced Supplemental Life Insurance amount (as described under “During Retirement—At Age 65 and After”) immediately at no cost to you.

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

On the first of the month in which you reach age 65, your life insurance will be automatically reduced.

The balance between your reduced amount and the original amount can be converted to an individual policy within 31 days of termination of coverage.

Your Supplemental Life Insurance coverage terminates unless you convert it to an individual policy or elect the portability option. Refer to “Conversion Privileges” at the end of this section if you would like to convert to an individual policy, or see “Portability” if you would like to elect the portability option.

IGUA Employees Hired on or After 8/15/2016

Coverage ends the last day of the month upon termination from the company**.** Your coverage can be converted to an individual policy. Refer to “Conversion Privileges” at the end of this section for more information.

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.

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 Insurance 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 $500,000 of your Basic Life Insurance coverage and $500,000 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.

Dependent Life Insurance

You may purchase Dependent Life Insurance coverage for your spouse and your eligible dependent children from the date of birth or adoption up to the last day of the month in which they turn age 26. Spouse and child life insurance is not available to those individuals on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard, or if they are

insured under the Group Policy as an employee. You must elect Basic Life Insurance in order to elect this coverage.

Reminder: You cannot be enrolled in Basic Life Insurance as an employee and also be covered as a spouse or dependent under Dependent Life Insurance.

You may purchase $10,000 to $50,000 in increments of $10,000 for your spouse and $10,000 for each dependent child.

Evidence of Insurability is required for a spouse if you are enrolling for coverage after the first 30 days of becoming eligible.

Eligible Child Life Insurance coverage ends on the last day of the month in which they turn age 26.

UT-Battelle does not maintain a record of covered dependents for child life. It is the employee's responsibility to cancel coverage when appropriate. Otherwise premiums will continue to be taken.

All Dependent Life coverage ends on the last day of the month in which an active employee terminates employment or retires. It also ends on the last day of the month when an individual goes on long-term disability, upon divorce, or when a dependent is no longer eligible. Refer to "Conversion Privileges" at the end of this section if you would like to convert to an individual policy.

Business Travel Accident Insurance

Business Travel Accident Insurance pays benefits to you if you should lose sight, speech, hearing, or limb, or become paralyzed or Totally and Permanently Disabled. Benefits are also payable to your beneficiary in case of your death as a result of an accident that occurs while you are traveling on a Business Trip (as defined in the Glossary). This does not include commuting to or from work. If your spouse and/or eligible dependent children are authorized to travel with you, they will also be covered for accidental death or dismemberment.

Coverage is provided 24 hours a day during a Business Trip (as defined in the Glossary), starting when you leave your home or place of business (whichever is later) and continuing until you return to your home or place of business (whichever is earlier). Coverage is also provided while you are on a side trip or vacation that is taken in conjunction with a Business Trip not lasting longer than 14 days, or on the Company premises to which you are permanently assigned in the event of a bomb scare, bomb search, bomb explosion, or felonious assault (committed by someone other than a fellow employee or family member).

Business Travel Accident Insurance benefits are paid in addition to any other life and accident insurance benefits you are eligible to receive.

Travel Assistance Services—Business Travel

Travel assistance services are available 24 hours a day, 365 days a year while traveling on Company business at least 100 miles from your place of residence. Services range from pre-departure information to replacing lost passports to coordinating emergency medical evacuations. Please call 1-800-263-0261 within the United States and Canada or call collect 1-416-977-0277 from any other location. Travel assistance services are provided by Zurich Travel Assist. ID cards are available from the travel office.

Emergency Medical Evacuation

When necessary, Zurich Travel Assist will arrange and pay for your transportation to the nearest adequate medical facility that can properly treat your condition.

Repatriation Benefit

If you die while traveling, Zurich Travel Assist will arrange and pay for all necessary government authorization, and pay for the return of your remains to your place of residence for burial.

Benefit Amounts

While you are actively employed, and until age 70, your Business Travel Accident benefit amount equals four times your annual Pay, with a minimum benefit of $100,000 and a maximum benefit of $500,000. In a Company aircraft accident, your maximum benefit is $100,000.

Your spouse's benefit amount is $100,000, and the benefit amount for each eligible dependent child is $25,000.

A combined maximum benefit of $5,000,000 is payable on behalf of all covered individuals in one aircraft accident. Therefore, for any aircraft accident in which more than $5,000,000 is claimed, there will be a proportionate distribution of the $5,000,000 maximum. In addition, a combined maximum benefit of $10,000,000 is payable on behalf of all covered individuals involved in one on-premises terrorism, on-premises bomb scare, search, explosion, or on-premises felonious assault accident. Therefore, for any such accident in which more than $10,000,000 is claimed, there will be a proportional distribution of the $10,000,000 maximum for those eligible.

As an active employee age 70 and older, your benefit amount will be reduced as follows:

If you are at least this age:	Your benefit will be this percentage of your pre-age-70 benefit
70	82.5%
75	57.5%
80	37.5%
85	20%

Dismemberment Benefits

If you, your spouse, or your eligible dependent children should lose sight, speech, hearing, or limb, or become paralyzed as a result of and within 1 year after an accident which occurs while you are traveling on a business trip, you, your spouse, and your eligible dependent children will receive the following benefits in a lump sum:

For loss of	The plan pays
One hand or one foot and sight in one eye	100% of the benefit amount
Both hands, both feet, or sight of both eyes	100% of the benefit amount
Both speech and hearing (both ears)	100% of the benefit amount
Quadriplegia (total paralysis of both upper and lower limbs)	100% of the benefit amount
One hand, one foot, sight of one eye, speech, or hearing (both ears)	50% of benefit amount
Paraplegia (total paralysis of both lower limbs)	75% of benefit amount
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50% of benefit amount
Thumb and index finger of same hand	25% of benefit amount

If two or more of these losses are sustained in the same accident, your benefit amount will be for the loss with the largest percentage amount payable. For example, if you sustain an injury that entitles you to 25% of your benefit amount and another from the same accident that entitles you to 50%, you will be paid 50% of your benefit amount.

"Loss" is defined in the Glossary.

Payment of Benefits

Death Benefits

If you should die as a result of and within 1 year after an accident which occurs while you are traveling on a business trip, the full amount of your Business Travel Accident benefit will be paid to your beneficiary in a lump sum. In the event of your spouse's or eligible dependent child's death, you will receive their full benefit amount.

Seat Belt Benefit

An extra benefit is payable if you or an eligible dependent on a business trip dies as a result of injuries sustained while driving or riding in a private passenger car equipped with seat belts. If it was certified in the official report of the accident, or by the investigating officer at the time of the accident, that the eligible person was wearing a seat belt (or was protected by a child restraint as defined by state law), that person's benefit will be increased 10%, up to an additional $25,000.

Total and Permanent Disability Benefits

If within 365 days of a covered accident you become Totally and Permanently Disabled as a result of an injury sustained in the accident, you will receive a lump-sum payment after you have been Totally and Permanently Disabled for 12 consecutive months. The amount of this payment will be your full benefit amount, less any other amount payable from this plan as a dismemberment benefit for the same accident.

Exclusions

Business Travel Accident benefits are not payable for losses or death caused by:

A loss will not be a Covered Loss if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for Accidental ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony, an assault, insurrection or riot;
6. being intoxicated while operating a motor vehicle.
    a. An Insured will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be intoxicated, if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the Insured's intoxication.
7. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
8. travel or flight in any aircraft except to the extent stated in the Coverage Section;

Special Accident Insurance

Special Accident Insurance is available on an optional contributory basis. This coverage provides extra financial security for you and your family in the event of accidental death, dismemberment, or paralysis.

Coverage is provided 24 hours a day anywhere in the world, on or off the job, on business or vacation, and at home.

Special Accident Insurance benefits are paid in addition to any other life and accident insurance benefits you are eligible to receive.

Payment of Benefits

Death Benefits

If you or a covered eligible dependent should die as a result of and within 1 year after an accident, the full benefit amount is payable to you or your beneficiary, as applicable, in a lump sum. If you and your covered spouse should both die in the same accident or separate accidents that occur within a 24 hour period, your spouse's benefit will increase to 100% of your benefit. However, the combined benefit will not be more than $1,000,000.

Seat Belt Benefit

An extra benefit is payable if you or a covered eligible dependent dies as a result of injuries sustained while driving or riding in a private passenger car equipped with seat belts. If the covered person was wearing a seat belt (or protected by a child restraint as defined by state law) at the time of the accident, that person's benefit will be increased 10%, up to an additional $10,000.

If it is unclear whether the covered person was wearing the required protection, the plan will pay $1,000 to the beneficiary.

Child Care Center Benefit

If you elect family coverage and you or your spouse dies as a result of an accident, an additional annual benefit of up to 3% of your Special Accident Insurance benefit (to a maximum of $5,000 per year for each child) will be payable for a licensed child care center to care for your surviving child.

To be eligible for this payment, your child must have been enrolled in a legally licensed child care center prior to your death (or your spouse's death) or within 365 days thereafter. This benefit will be paid once a year for up to 4 years, or until your child reaches age 13, whichever comes first.

After the child has been in child care for 12 months following the accident, the claim for child care should be submitted to the ORNL Benefits Office for reimbursement. If the surviving spouse has custody of the child, benefits will be paid to the surviving spouse. If there is no surviving spouse or the child does not live with the spouse, benefits will be paid to the child's legally appointed guardian.

If you had family coverage at the time of the accident, but no children are eligible for the child care benefit, a onetime $1,500 payment will be made to your beneficiary.

Benefit Amounts

If you want to cover your spouse and eligible dependent children, you can elect family coverage. The benefit amount for family members is a percentage of your benefit amount and is based on the composition of your family at the time of loss, as follows:

If you have these dependents at the time of loss,	Your spouse's benefit will be	Each child's benefit will be
Spouse and children	90%	20%
Spouse only	100%	n/a
Children only	n/a	30%

You can elect Special Accident Insurance coverage for yourself from $20,000 to $500,000 in $10,000 increments. You may elect coverage greater than $250,000 only if the amount you choose does not exceed 10 times your Pay.

In any case, your total coverage may not exceed $500,000.

As an active employee age 70 and older, your benefit amount will be reduced as follows:

If you are at least this age,	Your benefit will be this percentage of your pre-age-70 benefit:
70	82.5%
75	57.5%
80	37.5%
85	20%

Your contributions for Special Accident Insurance will not be reduced when your benefit is reduced.

Education Benefit

If you elect family coverage and then lose your life or become permanently disabled as the result of an accident, an annual education benefit of an additional 5% of your benefit amount, up to $15,000 a year, is payable on behalf of any dependent child who, on the accident date is

- enrolled as a full-time student in any institution of higher learning beyond the 12th grade

  or
- enrolled in the 12th grade and, within 365 days after the accident, enrolls as a full-time student in an institution of higher learning beyond the 12th grade.

Benefits are payable for 4 years provided your child remains a full-time student.

If you have family coverage at the time of the accident but no dependent children who qualify for the education benefit, your beneficiary will receive an additional $5,000 lump-sum benefit.

Spouse Retraining Benefit

If you elect family coverage and then lose your life as the result of an accident, a "spouse retraining benefit" is payable to your surviving spouse who enrolls in any professional or trade school or training program to obtain an independent source of income and support. The plan will pay up to $5,000 toward the cost of training received if enrolled in an accredited school within 3 years of the employee's death.

Surviving Spouse Benefit

If you choose family coverage and you or your covered spouse dies as a result of an accident, an additional ½% of your Special Accident Insurance amount will be payable to the surviving spouse each month for 12 months up to a maximum of $2,500.

Total and Permanent Disability Benefit Feature—Available to Bargaining Unit Employees Only

If, within 365 days of a covered accident, you become Totally and Permanently Disabled as a result of an accident, you will receive a monthly benefit after you have been Totally and Permanently Disabled for 12 consecutive months. The amount of this monthly benefit is 2% of your benefit amount, up to $5,000 a month with a maximum of $250,000. Benefits are payable for up to 50 months or until you recover, whichever comes first.

If you should die before receiving the maximum benefit—100% of your benefit amount—your beneficiary will receive the remaining benefit.

There are no Total and Permanent Disability benefits for dependents or Salaried employees.

Dismemberment Benefits

If you or a covered eligible dependent should suffer a loss as a result of and within 1 year after an accident, you or your family member will receive the following benefits in a lump sum:

For loss of	The plan pays
One hand or one foot and sight in one eye	100% of benefit amount
Both hands, both feet, or sight of both eyes	100% of benefit amount
Both speech and hearing (both ears)	100% of benefit amount
Total paralysis of both upper and lower limbs (quadriplegia)	100% of benefit amount
One hand, one foot, or sight of one eye	50% of benefit amount
Speech or hearing (both ears)	50% of benefit amount
Total paralysis of both lower or upper limbs (paraplegia)	75% of benefit amount
Total paralysis of upper and lower limbs on one side of body (hemiplegia)	50% of benefit amount
Thumb and index finger of same hand	25% of benefit amount

If two or more of these losses are sustained in the same accident, your benefit amount will be for the loss with the largest percentage amount payable.

“Loss,” and “paralysis,” are defined in the Glossary.

Rehabilitation Benefit

If you or an eligible dependent is injured (described above) as a result of an accident, an additional benefit of up to $50,000 will be payable for approved rehabilitation expenses incurred within 2 years of the accident.

Covered expenses include physical therapy, home reconstruction, and outfitting of special vehicles. This benefit will be reduced by any other rehabilitation benefits that are payable, such as health or accidental insurance, Workers’ Compensation, occupational disease, or similar law.

You must notify the ORNL Benefits Office in writing of your injury before any rehabilitation benefits are payable.

General Exclusions

A loss will not be a Covered Loss if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for Accidental ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony;
6. being intoxicated while operating a motor vehicle.
    a. A Covered Person will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be intoxicated if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the Covered Person's intoxication.
7. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

Other Important Information

The following information applies to your life and accident insurance benefits.

Naming Your Beneficiary

You may name anyone as your beneficiary, and you also may change your beneficiary designation at any time on the ORNL Benefits Enrollment web site at https://portal.adp.com or by phone at 1-800-211-3622. The beneficiary you name for Basic Life Insurance benefits automatically will be your beneficiary for Supplemental Life and Business Travel Accident Insurance unless you elect otherwise in writing. You may also name anyone as your beneficiary for Special Accident Insurance.

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

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

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

If you elect Dependent Life coverage or family coverage under the Special Accident Insurance plan, you will automatically be the beneficiary in case of the death of a family member unless you elect otherwise in writing.

Costs for Coverage

As described in the "About Your Benefits" chapter, you and the Company share the cost of Basic Life Insurance coverage. You pay the full cost of all supplemental and Dependent Life Insurance and Special Accident Insurance coverage. The Company pays the cost of Business Travel Accident coverage.

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.”

Claiming Benefits

You or your beneficiary must file a claim with the ORNL Benefits Office to receive any life and accident insurance benefits. By contacting the ORNL Benefits Office, you or your beneficiary will receive the necessary forms as well as instructions and assistance in filing forms.

When Coverage Ends

Business Travel Accident Insurance coverage ends on the date your employment terminates for any reason. Special Accident Insurance ends on the last day of the month your employment terminates.

If you are on temporary suspension of work or an approved leave of absence, you may continue your Basic Life Insurance and Supplemental Life Insurance coverage until the end of the third month following the month in which your absence began. In addition, you may elect to continue your Special Accident Insurance coverage for up to 12 months if you are on an approved leave of absence or long-term disability, provided you continue to pay the required premiums.

Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance, Business Travel Accident Insurance, and Special Accident Insurance coverages may end before termination of employment. However, these coverages will end on the earliest of the following dates:

- the date you are no longer considered eligible because of a change in your employment status
- the last day of the period for which your last contribution was made
- the date the plan is terminated.

Special Accident Insurance coverage for a dependent child will end the earliest of the date the employee’s coverage terminates, or the first premium due date after the dependent no longer qualifies as a covered person. Employment during school break periods is not considered full-time employment. If the dependent child is not enrolled in school full-time, coverage for that child will end at age 19.

Conversion Privileges

Within 31 days after your Basic Life Insurance, Supplemental Life Insurance, spouse and Dependent Life Insurance, and Special Accident Insurance coverages 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. The conversion privilege under the Special Accident Insurance plan ends at age 70.

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

Business Travel Accident Insurance may not be converted to an individual policy.

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 (TCA) or the Accelerated Benefits Option.

Within 31 days after your Supplemental Life Insurance coverage terminates due to voluntary termination, retirement, or dismissal, 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 and the maximum amount is the lesser of the amount of Supplemental Life coverage you had at the time your group Supplemental Life benefits ended and $1,000,000. Once you select a coverage amount, you may only decrease coverage in the future; you cannot increase the amount.

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.

Administrative Information

Information about the administration of your life and accident insurance benefits can be found in the chapter titled “Administrative Information.”

NOTE: You 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.

Glossary

Business Trip

Travel authorized by the Company (including trips outside the United States), including relocation trips, home leaves, and rest and relaxation leaves as well as any side trips or vacations taken in conjunction with a business trip.

Loss

For purposes of business travel accident and special accident insurance coverage, loss of hand or foot means complete severance through or above the wrist or ankle joint. Loss of eyesight means the complete or irrecoverable loss of entire sight of either eye. Loss of speech means complete inability to communicate audibly in any degree. Loss of hearing means irrecoverable loss of hearing which cannot be corrected by any hearing aid or device. Loss of thumb and index finger means actual severance through or above the joint closest to the wrist. A Loss must result directly from bodily injuries caused by an accident.

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).

Pay

For Life and Accident Insurance Benefits
Your annual basic rate of pay, determined as described in the “Life and Accident Insurance” chapter, before any pre-tax salary reductions. Pay does not include overtime, bonuses, or any other form of extra compensation.

Total Disability or Totally Disabled

For Basic and Supplemental Life Insurance
You are considered Totally Disabled if,

- because of an illness or injury,
- you cannot do your job, and
- you cannot do any other job for which you are qualified by your education, your training, or your experience.

Totally and Permanently Disabled

For Business Travel Accident and Special Accident Insurance Coverage
You are considered Totally and Permanently Disabled if, as the result of a qualifying accident, you cannot do any work for which you are or can become qualified by reason of your education, experience, or training, and you are not expected to be able to do so for the remainder of your life.

10. Legal Insurance with ID Theft Protection

The Legal Insurance with Identity (ID) Theft Protection provides you and your family affordable, reliable legal coverage to help with everyday life matters and to protect one of your most valuable assets—your identity.

Highlights

The Legal Insurance Plan with Identity Theft Protection …

Helps You Pay the Costs of Planned and Unplanned Legal Needs

The plan provides you with affordable, reliable legal coverage to help with everyday life matters—like identity (ID) theft, a dispute with a contractor, creating a will, buying a home, or an auto repair that doesn't go as planned.

Offers Access to an Attorney for a Consultation

You have access to an attorney who can consult, advise, and represent you if something unexpected happens like identity theft, credit problems, or contractor issues.

What Happens to Your Benefits When ...

For more information about what happens to your Legal Insurance with Identity Theft Protection coverage when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" chapter.

How the Legal Insurance Plan with Identity Theft Protection Works

The UltimateAdvisor® legal plan from ARAG® offers affordable and knowledgeable legal counsel through professional legal guidance and valuable resources to protect you and your loved ones and to help you address everyday life matters or situations that may turn into legal matters, such as:

- Creating or updating a will
- Protecting your personal information against identity theft
- Making a financial plan for retirement
- Adopting a child
- Selling your house and buying a new one
- Settling a legal dispute with a neighbor
- Acting as a caregiver and advocate on behalf of your aging parents

This coverage helps you to avoid paying high-cost attorney fees— most covered legal matters are 100% paid in full when you work with a Network Attorney.

Premiums are paid on an after-tax basis.

What the Plan Pays

You may receive covered services from any attorney; however, benefits are paid differently depending on whether you choose to work with a Network Attorney (an attorney who is part of the ARAG attorney network) or you choose to work with an attorney who is not in the network:

- If you work with a Network Attorney, the plan pays the attorney fees in full for most covered legal matters. The Network Attorney will bill ARAG directly for legal services rendered to you that are covered under the legal plan.
- Network Attorney Guarantee—If there is not a Network Attorney located within 30 miles of your home, ARAG guarantees you will receive in-network benefits. ARAG will work with you to arrange for you to receive covered legal services through an attorney in your area.
- A list of Network Attorneys for each state, which includes the areas of law they practice, their phone numbers, and if they speak a foreign language, is available by calling 800-247-4184. You can also visit the ARAGLegalCenter.com, access code 18095or, to access the online Attorney Finder feature.
- If you choose to receive services from an attorney not in the ARAG Network, you pay the cost of legal services and then file a claim form, along with your attorney's billing statement, to ARAG. You will be reimbursed for covered legal fees up to the lesser amount of actual fees incurred or the benefit amount indicated in your plan Certificate for that specific coverage.
- You must notify ARAG within 60 days of consulting a non-Network Attorney. In addition, your claim for reimbursement must be received by ARAG within 120 days after you incur a legal service.

How to Contact ARAG

If you or someone in your family needs legal or identity theft assistance, contact ARAG at 800-247-4184 or service@ARAGlegal.com.

Administrative Information

Information about the administration of the Legal Insurance with Identity Theft Protection coverage can be found in the chapter titled "Administrative Information."

Covered Services

Service	Network Provider
Law Guide—An extensive library of easy-to-understand legal articles to help you research your legal situation • Law Guide provides overviews of general areas of law including, but not limited to, estate planning, consumer matters, and family law • Law Guide also gives specific information on legal issues including, but not limited to, wills, divorces, and child custody matters	Paid in full
Do-It-Yourself Legal Documents—Access to more than 350 legal documents for the convenience and control of preparing legally valid documents (state-specific) yourself	Paid in full
Identity Theft Protection—A service that gives you access to: • Identity Theft Case Managers who will help you determine appropriate steps to begin recovery and help you monitor the progress of your recovery • Toll-free legal advice from a Telephone Network Attorney to assist with legal-related problems that the theft of your identity may have caused • Identity Theft Materials including: ▪ An Identity Theft Prevention Kit to help protect yourself from becoming a victim of identity theft in the first place ▪ An Identity Theft Victim Action Kit to help speed your recovery should you become an identity theft victim ▪ A tracking document to help you keep track of phone calls, e-mails, and letters for attorneys ▪ An Identity Theft Affidavit to help you report your identity theft to necessary parties • Online access to ID theft prevention resources—A best-in-class experience that makes it easy to access educational content within the portal to help prevent ID theft • ID theft restoration services—Through the use of a Limited Power of Attorney, a Restoration Specialist is able to work on your behalf to restore your identity, saving you time and effort in working with lenders, bureaus, and state and county courts • Lost wallet service—A service that helps you quickly and easily cancel and replace all items commonly carried in wallets and purses including credit cards, debit cards, check books, Social Security cards, insurance cards, passports, identification cards, and traveler's checks	Paid in full
ID Theft Insurance[a]— 1. Coverage with no deductible from an A.M. Best "A-rated" carrier is provided to reimburse you for expenses associated with restoring your identity should you become a victim of identity theft 2. To use the following services, establish an online monitoring account • **Single-Bureau Credit monitoring**: Services designated to track and inform you of any activities or changes to your credit—including loan applications, credit card activations, delinquencies, etc. • **Internet surveillance**: Services that monitor thousands of websites and millions of online data points and will alert you if your personal information is being traded and/or sold • **Child monitoring**: Services that enable you to protect your minor child's information from identity theft by registering and tracking their data. Social Security Number trace monitoring which will detect the creation of a credit file in your child's name	1. Up to $1,000,000 2. Paid in full

Service	Network Provider
• **Change of Address**: Services that monitors address change requests with the United States Postal Service	
Financial Education and Counseling Services—This service provides you toll-free telephone access to Financial Counselors who are available to assist you with questions and guidance on a variety of financial planning matters or provide instructions on how to use the financial tools such as cash and debt management, budgeting, general financial planning information and guidance, retirement planning, individual retirement accounts (IRAs), and investment planning You also can access a financial planning website, where you can manage a secure, easily updateable record of your progress toward goals (such as a down payment on a house, reduction of debt, or college funding for a child). This website includes a comprehensive suite of financial modeling tools as well as an online reference library for creating a personalized financial plan. You can call or chat with a Financial Counselor for personalized guidance on implementation action items Financial Counselors will help you consolidate bill payments and negotiate with creditors to lower payments—in some cases reducing or eliminating interest and fees. Consolidating bills can help you repay your unsecured debt in 3–5 years	Paid in full
Telephone Legal Services—Toll-free telephone advice on how the law relates to your personal legal matter and which action may be taken. Follow-up correspondence and telephone calls to third parties regarding your personal legal matter. Specific document preparation and review. Legal assistance for the preparation or review of a Standard Will or Codicil	Paid in full
Immigration Services 1. Toll-free access to Telephone Network Attorneys for legal advice and consultation on: • General immigration processes and guidelines • Filing and processing of applications or petitions • Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas, and employment authorizations • Deportation and removal proceedings • Document review of any immigration form • Document preparation of affidavits and powers of attorney • Preparation for immigration hearings 2. For additional immigration services, Network Attorneys provide a reduced rate of at least 25% off their normal rates for representation-based immigration services. Network Attorneys will bill you directly	1. Paid in full 2. At least a 25% reduced rate
Reduced Fee Network Attorneys If your legal matter is not fully covered under your insurance policy and is not listed under the “Exclusions” section in your service plan, you are eligible to work with a Network Attorney and receive a reduced fee that will be at least 25% off the attorney’s normal hourly rate. Payment of the attorney fees is handled directly between you and the Network Attorney. Access to a Network Attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to an Attorney within legal practice areas	At least a 25% reduced rate
For matters that include a cap on the number of hours ARAG will pay a Network Attorney, and where your legal matter will exceed the cap set, the Network Attorney will bill you directly at a reduced rate of at least 25% off his or her normal rates for the remaining hours You pay the attorney directly. If your matter cannot be resolved over the phone, is not fully covered under the insurance policy, and is not excluded under the “Exclusions” section in your Service Plan, you are	

Service	Network Provider
eligible to receive at least 25% off the attorney's normal hourly rate. Payment of the attorney fees is handled directly between you and the Network Attorney **Tax Services** Unlimited phone access to experienced tax specialists, who can: • Offer advice regarding Internal Revenue Service (IRS) audits and notifications • Explain tax law changes • Offer tips for state or federal filing of personal taxes • Review your previous year's personal tax return • Provide discounted personal tax return preparation	
Caregiving Services You will have access to ARAG Network Attorneys and Eldercare Advocates to protect and care for your parents and grandparents **Caregiver support services**—You have toll-free access to a Care Advocate who will: • Answer your eldercare-related questions, assess eldercare needs, and help develop a care plan • Send you a customized information guide that contains lists of assisted living facilities, nursing homes, or health care agencies, including comparative quality-of-care ratings and reports on thousands of facilities and agencies—along with helpful eldercare information • Give you access to the nation's most comprehensive eldercare database with more than 90,000 long-term care providers • Conduct searches to determine availability and rates of assisted living facilities, nursing homes, home health care agencies, and adult day care providers. Advocates will also negotiate discounts when available Access to the **ElderAnswers Website,** which provides online access to quality-of-care ratings and reports, direct access to the provider database, and a wide range of eldercare information **Caregiving Guidebook**—access to a "go-to" guidebook that provides tools and resources to take a proactive approach in your caregiving role **Telephone access** for you to obtain legal advice and consultation on how the law relates to your parents'/grandparents' legal matters and which actions may be taken	Services provided by a Network Attorney and/or by an Eldercare Advocate Paid in full

In-Office Legal Services

Service	Network Attorney	Non-Network Attorney
Annual Legal Check-Up—Legal services for you and your parents/grandparents to meet with an attorney on an annual basis. This annual meeting is to discuss the legal needs of your parents/grandparents and discuss any changes to their situation and potential legal implications. THIS SERVICE IS LIMITED TO ONE USE PER FAMILY PER CERTIFCATE YEAR (ANNUAL)	Paid in full	$80[b]
Name Change—Legal services for you to legally change your name.	Paid in full	$240[b]

Service	Network Attorney	Non-Network Attorney
Uncontested Court Adoption—Legal services for you to become adoptive parents. For international adoptions where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States	Paid in full	$400[b]
Contested Adoption—Legal services in a contested adoption for you to become adoptive parent(s). For international adoptions where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $800[b] 2. $1,800 [c] 3. $100,000[d]
Uncontested Guardianship/Conservatorship—Legal services in an uncontested guardianship/conservatorship for you to appoint or be appointed as a guardian/conservator	Paid in full	$480
Contested Guardianship/Conservatorship—Legal services in a contested guardianship/conservatorship for you to appoint or be appointed as a guardian/conservator 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $720[b] 2. $1,800 [c] 3. $100,000[d]
Mental Incompetency or Infirmity Proceedings—Legal services for you in defense of mental incompetency or infirmity proceedings 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $960[b] 2. $1,800 [c] 3. 3$100,000[d]
Consumer Protection—Legal services for you as a plaintiff or defendant regarding written, verbal, or implied contracts or warranties relating to consumer goods or services and/or residential contractor disputes 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $800[b] 2. $1,800 [c] 3. $100,000[d]
Small Claims Court— 1. Legal services for you to obtain advice and counseling to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction) 2. Legal services to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law	Paid in full	1. $320[b] 2. $400[b]
Defense of Debt Collection—Legal services for you as the defendant in a legal dispute related to consumer goods or services 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]

Service	Network Attorney	Non-Network Attorney
Bankruptcy—Legal services for you up to and including filing of a Chapter 7 bankruptcy final report or confirmation of a Chapter 13 bankruptcy and including post confirmation amendments 1. Chapter 7 2. Chapter 13	Paid in full	1. $880 2. $1,200
Foreclosure—Legal services for you regarding written notice of foreclosure related to your primary residence 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
Garnishment—Legal services for you in a legal action for a garnishment against you to collect a judgment related to goods or services. (Exclusion related to postjudgment garnishment is waived for this benefit) 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
Personal Property Protection—Legal services for you as a plaintiff or defendant regarding contracts or obligations for the transfer of your personal property or your personal property rights 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $320[b] 2. $1,800 [c] 3. $100,000[d]
Purchase of Real Estate—Legal services for you for the purchase of your primary residence for the review and preparation of documents including contract for purchase and attendance at closing	Paid in full	$320[b]
Sale of Real Estate—Legal services for you for the sale of your primary residence for the review and preparation of documents including contract for purchase and attendance at closing	Paid in full	$320[b]
Purchase/Sale: Secondary Residence—Legal services for you for the purchase or sale of your secondary residence for the review and preparation of documents including the contract for purchase or sale and attendance at closing	Paid in full	$320[b]
Refinancing: Primary Residence—Advice and review of relevant documents regarding refinancing of your primary residence	Paid in full	$160[b]
Real Estate Disputes—Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your primary residence 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $1,200[b] 2. $1,800 [c] 3. $100,000[d]

Service	Network Attorney	Non-Network Attorney
Real Estate Disputes: Secondary Residence—Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your secondary residence 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $1,200[b] 2. $1,800 [c] 3. $100,000[d]
Document Preparation and Review—Legal services for you for the preparation and review of deeds, mortgages, promissory notes, affidavits, lease contracts, demand letters, and installment contracts	Paid in full	$40 per document
Building Codes—Legal services for you in an administrative action for permit or code violations relating to the renovation and/or improvement of you existing primary residence 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $400[b] 2. $1,800 [c] 3. $100,000[d]
Zoning and Variances—Legal services for you in an administrative action related to a zoning change, variance, or eminent domain proceeding involving your primary residence 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $400[b] 2. $1,800 [c] 3. $100,000[d]
Easement—Legal services for you in an administrative action regarding an easement on your primary residence 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $400[b] 2. $1,800 [c] 3. $100,000[d]
Neighbor Disputes—Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your primary residence, including boundary or property title disputes 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $720[b] 2. $1,800 [c] 3. $100,000[d]
Neighbor Disputes: Secondary Residence—Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your secondary residence, including boundary or property title disputes 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $720[b] 2. $1,800 [c] 3. $100,000[d]
Tenant Matters—Legal services for you as a plaintiff or defendant with your landlord as a tenant of your primary residence, including but not limited to, eviction and security deposit disputes 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $320[b] 2. $1,800 [c] 3. $100,000[d]

Service	Network Attorney	Non-Network Attorney
Defense of Civil Damage—Legal services for you in the defense against civil damage(s) claims, except claims involving the ownership or use of a motorized vehicle or claims that are covered by other insurance, or claims related to a felony charge 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $800[b] 2. $1,800 [c] 3. $100,000[d]
IRS Audit Protection—Legal services for you involving Internal Revenue Service (IRS) audits related to your personal tax return where the initial written notice is received after your effective date 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
IRS Collection Defense—Legal services for you in the defense against collection actions by the IRS related to errors on your personal tax return where the initial written notice is received after your effective date 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
Social Security/Veterans/Medicare—Legal services for you in an administrative legal dispute arising out of Social Security, Veterans, Medicare, or Medicaid benefits 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $400[b] 2. $1,800 [c] 3. $100,000[d]
Prenuptial Agreements—Preparation of premarital or antenuptial agreement	Paid in full	$320[b]
Protection from Domestic Violence 1. Legal services for the named plan member to obtain a protective order related to domestic violence 2. Legal services for you to obtain a protective order related to domestic violence when the opposing party is not a member under the same Certificate	Paid in full	1. $320[b] 2. $320[b]
Uncontested Divorce—Legal services for the named plan member in an uncontested divorce, a legal separation, and/or annulment of marriage	Paid in full	$640[b]
Contested Divorce (15 hours)—Legal services for the named plan member in a contested divorce, a legal separation, and/or annulment of marriage	Paid in full up to 15 hours per covered event	$1,200[b]
Uncontested Child Support Enforcement —Legal services for you for an uncontested motion brought by you to enforce a final decree regarding child support	Paid in full	$320[b]
Contested Child Support Enforcement (8 hours)—Legal services for you for a contested motion brought by you to enforce a final decree regarding child support	Paid in full up to 8 hours per covered event	$640[b]

Service	Network Attorney	Non-Network Attorney
Uncontested Post Decree Defense —Legal services for you for an uncontested motion brought against you to modify a final decree for child support, child custody, child visitation, or alimony	Paid in full	$320[b]
Contested Post Decree Defense (8 hours)—Legal services for you for a contested motion brought against you to modify a final decree for child support, child custody, child visitation, or alimony	Paid in full up to 8 hours per covered event	$640[b]
Uncontested Post Decree Enforcement (8 hours)—Legal services for you for an uncontested motion brought by or against you to enforce a final decree regarding child custody, child visitation, or alimony	Paid in full	$320[b]
Contested Post Decree Enforcement (8 hours)—Legal services for you for a contested motion brought by or against you to enforce a final decree regarding child custody, child visitation, or alimony	Paid in full up to 8 hours per covered event	$640[b]
School Administrative Hearing—Legal services for you in an administrative public or private formal school proceeding related to primary and secondary education regarding disabilities, special education, and student policy violations 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
Habeas Corpus—Legal services prior to and at court proceedings 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
Juvenile Court Proceedings involving a covered child—Legal services for your child charged with a crime (except those related to traffic matters) when the court proceedings are held in juvenile court. If the matter is removed from juvenile court, coverage under this benefit will cease as the date of the removal 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]
Parental Responsibilities—Legal services for you in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for a covered child 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $480[b] 2. $1,800 [c] 3. $100,000[d]

Service	Network Attorney	Non-Network Attorney
Criminal Misdemeanor Defense—Legal services for you in the defense against charges filed in state or federal court for violation of criminal misdemeanor charges except those involving motorized vehicles and domestic violence charges. If the charge is escalated to a felony, coverage will cease as of the date of escalation. If a felony charge is reduced or pled down to a misdemeanor no coverage applies. 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $720[b] 2. $1,800 [c] 3. $100,000[d]
Minor Traffic Offenses excluding DWI related—Legal services for you in the defense of a traffic offense where the conviction of which would not result in the suspension or revocation of your driving privileges. This does not include driving while impaired or under the influence of drugs or alcohol, parking, and any non-moving offense	Paid in full	$240[b]
Driving Privilege Protection excluding DWI related—Legal services for you in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of your driving privileges. This does not include driving while impaired or under the influence of drugs or alcohol or a related offense 1. Legal services prior to trial 2. Trial for 3 days or less 3. Trial starting on day 4 until completion	Paid in full	1. $400[b] 2. $1,800 [c] 3. $100,000[d]
Driving Privilege Restoration excluding DWI related—Legal services for you in an administrative proceeding for the restoration of your suspended or revoked driving privileges. This does not include driving while impaired or under the influence of drugs or alcohol or a related offense	Paid in full	$240[b]
Wills and Durable Powers of Attorney—Individual will or spousal will(s). Does not include any tax planning services done in connection with the will	Paid in full	$320 single document $400 spousal documents
Codicil—Amendment to a will	Paid in full	$40 single document $80 spousal documents
Living Will/Health Care Directive	Paid in full	$40 single document $80 spousal documents
Power of Attorney/Financial Power of Attorney	Paid in full	$40 single document $80 spousal documents
Irrevocable Trusts—Legal services for you for the preparation of a stand-alone irrevocable trust	Paid in full	$$320[b] single document $400[b] spousal documents

Service	Network Attorney	Non-Network Attorney
Revocable Trusts—Legal services for you for the preparation of a stand-alone revocable living trust	Paid in full	$$320[b] single docume*nt* *$400*[b] spousal documents
Estate Administration and Estate Closing—9 hours Legal services provided to you in administering an estate where you have been named the executor	Paid in full up to 9 hours per covered event	$720[b]
General in Office Services—Legal advice, negotiation, document preparation, and review in office with an attorney (except those related to events that specifically excluded or otherwise not covered)	Paid in full up to 4 hours per certificate year	$480[b]

[a] Eligibility, coverage, limitations and exclusions are governed by a separate coverage document. Please see the identity theft plan summary for details.
[b] Non-Network Attorney Indemnity Benefits are up to the stated amount.
[c] Trial Indemnity Benefits are $300 per half day of trial time up to the stated amount.
[d] Trial Indemnity Benefits are $400 per half day of trial time up to the stated amount.

Services Not Covered

Pre-existing Conditions

Any legal matter that occurs or is initiated prior to your effective date will be considered excluded, and no benefits will apply. ARAG defines “initiated” as the earlier of the date

(a) written notice of a legal dispute is sent or filed by you or received by you; or

(b) a ticket or citation is issued; or

(c) an attorney is hired.

Other Services Not Covered

The plan does not cover the following:

- Matters against ARAG, the policyholder, your employer, and/or an insured against the interests of the named insured under the same Certificate.
- Legal services in class actions, punitive damages, malpractice, court appeals, post judgments (settlement agreement signed by all parties, final binding arbitration, judgment issued by a court).
- Legal services deemed by ARAG to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute or in our reasonable belief you are not actively and reasonably pursuing resolution in your case.
- Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director of an organization, and patents or copyrights.
- Plan service do not include: Matters against ARAG, the named plan member or the plan sponsor.
- Matters arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.
- Matters outside the jurisdiction of the United States of America.

Other Important Information

Conversion

You may continue this insurance when you no longer qualify as an employee of UT-Battelle. You must notify ARAG within 90 days of this disqualifying event to make arrangements for premium payment.

For questions regarding the ARAG conversion plan, please contact ARAG at 800-247-4184.

Questions/Concerns

If you have any questions or concerns, please contact the insurer by telephone at 800-247-4184 or by mail at:

ARAG®
500 Grand, Suite 100
Des Moines, IA, 50309

Disclaimer Language

This information is for illustrative purposes only. This information is intended to provide a general review of the plan described. Please remember that only the insurance policy can give actual terms, coverages, amounts, conditions, and exclusions.

Underwriter Information

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa; GuideOne® Mutual Insurance Company of West Des Moines, Iowa; or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC.

This material is for illustrative purposes only and is not a contract. For terms, benefits, or exclusions, call 800-247-4184.

11. Pension Plan

The Pension Plan described in this chapter is intended for grandfathered employees who transitioned to ORNL from the National Strategic Protection Services Plan (NSPS) effective 12/30/2018.

The Pension Plan helps build financial security and provides you with 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 You With Flexibility in Planning Your Retirement

You can retire with a full pension benefit at age 65 or over. You can also receive a full pension benefit when you retire at age 62 or older if you have at least 10 years of Company Service, or when your age and years of Company Service equal 81 or more. You can receive a reduced benefit as early as age 50 if you have at least 10 years of Company Service.

Lets You Choose from a Variety of Payment Forms

There are several payment forms to choose from, including life annuity and survivor benefit options. If you are married, you will be paid in a joint and 50% survivor benefit unless you have your spouse's written consent to elect another payment form.

Offers Financial Security to Your Family in Case of Your Death

If you should die while you are still working, the Pension Plan will pay a survivor benefit if you have at least 5 years of Company Service.

What happens to your benefits when ...

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

Plan Eligibility

Company employees, shown on the regular payroll and personnel records with compensation reported by the Company on an Internal Revenue Service (IRS) Form W-2, automatically become Pension Plan participants unless they are in one of the following excluded categories:

- covered by a collective bargaining agreement unless the collective bargaining agreement provides for plan participation,
- leased employees,
- independent contractors,
- non-resident aliens who do not have earnings from the Company from sources within the United States,
- employees who have entered into a written agreement with the Company waiving the right to participate in the plan,
- IGUA represented employees (Security Police Officers or Central Alarm System Operators) hired on or after August 15, 2016, and
- Non-represented employees hired on or after June 4, 2007.

Employee Contributions

Mandatory participant contributions are required to be made to the Pension Plan effective 12/30/2018 by Salaried Employees in the following amounts:

- 2% of employee's compensation (**as defined in the Glossary**) up to the maximum Social Security wage base for the year,
- 4% of the employee's compensation above the Social Security wage base for the year, and
- no mandatory participant contributions may be made for compensation above the 401(a)(17) limit.

If you terminate your employment prior to achieving 5 years of Company Service, you will receive a refund for the amount of your contributions plus applicable interest, and you will forfeit any other benefit under the Pension Plan.

If you terminate your employment after achieving 5 years of Company Service, your contributions will be reflected as a nontaxable portion of your monthly benefit when it commences. 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.

After 12/30/2018, Salaried Employees will be credited only with Company Service under the pension benefit formulas for periods during which you make a mandatory participant contribution.

When You Can Retire

To offer you flexibility in planning for retirement, the Pension Plan provides a choice of retirement dates.

You can retire with a full pension:

- at age 65 or later, regardless of Company Service **(defined in the Glossary)**, or
- at age 62 or later, with at least 10 years of Company Service, or
- when your age and years of Company Service total 81 or more.

You can retire with a reduced pension:

- at age 50, with at least 10 years of Company Service.

Company Service for Prior Contractors

Service with contractors prior to participation in this Pension Plan does not count for any purpose unless specifically credited under the terms of the Pension Plan document.

If you choose to retire after age 65 and continue to work for the Company, you will continue to earn Company Service and pay for plan benefit purposes until you actually retire. In any event, your plan benefits will begin no later than the first of the month after you reach age 70½, unless you decide to defer commencement of your benefit until you actually retire.

There is one important exception to these retirement dates. If your employment is involuntarily terminated by action of the Company (other than for cause), you will be considered to have met the age and service requirements for:

- a full pension benefit if you are age 60 or over and have at least 8 years of Company Service or if your years of Company Service and age total 79 or more, or
- a reduced pension benefit if you are at least age 48 with at least 8 years of Company Service.

Any service added under the involuntary termination provisions will count for your eligibility for the benefit but does not count to determine the amount of benefit.

Determining Your Pension Benefit

Your pension benefit is calculated under three different formulas: Regular, Alternate, and Minimum. The formula that gives you the largest benefit will be used.

All of the formulas are based in part on:

- your Average Straight-Time Monthly Earnings—the average of your highest earnings for 3 years during the last 10 years just before you retire (for a discussion of how these earnings are calculated, continue reading), and
- your Company Service—including all your years and completed months of service—with each completed month counting as 1/12 of a year.

Regular Formula

The Regular formula provides a monthly benefit of:

- 1.2% of your Average Straight-Time Monthly Earnings times your years and months of Company Service plus $18.

Alternate Formula

The Alternate formula provides a monthly benefit of:

- 1.5% of your Average Straight-Time Monthly Earnings times your years and months of Company Service minus 1.5% of your monthly Primary Social Security Benefit times your years and months of Company Service up to 33 1/3 years.

Under this formula, no more than 50% of your Primary Social Security Benefit will be used to offset your earnings. If you provide the Company with complete Social Security Administration records of your covered earnings within 6 months of your retirement date, the Company will use a Social Security benefit based on actual earnings rather than an estimated earnings history if it provides a higher benefit. Otherwise, the Company will use your estimated earnings history.

When you retire, your Primary Social Security Benefit for purposes of this formula is the benefit you would be eligible to receive at your retirement age or age 62, if later. This benefit is based on the Social Security laws in effect on the date you retire.

Minimum Formula

The Minimum formula provides a monthly benefit of:

- $5 for each of your first 10 years of Company Service, plus $7 for each of the 11th through 20th years of service, plus $9 for each year in excess of 20 years of service, plus 10% of your Average Straight-Time Monthly Earnings (if you have less than 8 years of Company Service, this will be reduced 1% a year for each year less than 8), plus $18.

Pension Benefit Formulas	
Formula	**Provides Monthly Benefit of …**
Regular	1.2% of your Average Straight-Time Monthly Earnings times your years and months of Company Service plus $18.
Alternate	1.5% of your Average Straight-Time Monthly Earnings times your years and months of Company Service minus 1.5% of your monthly Primary Social Security Benefit times your years and months of Company Service up to 33 1/3 years.
Minimum	$5 for each of your first 10 years of Company Service, plus $7 for each of the 11th through 20th years of service, plus $9 for each year in excess of 20 years of service, plus 10% of your Average Straight-Time Monthly Earnings (if you have less than 8 years of Company Service, this will be reduced 1% a year for each year less than 8), plus $18.

Reduced Benefits

If you retire before you are entitled to a full pension, your monthly benefit is reduced. The amount of reduction is based on your age and service. For example, if you are age 55 and have 23 years of service, you will receive 85% of your full benefit. (For the reduction factors, see Table 1 at the end of this chapter.)

The three formulas used to calculate full pensions are also used to calculate reduced pensions. The one which produces the largest benefit will be the one used. In the Regular and Minimum formulas, the reduction factor is applied after calculating the total benefit. In the Alternate formula, the reduction factor is applied before subtracting the Primary Social Security Benefit.

Examples of Estimated Monthly Pension Income at Age 65					
Average Straight-Time Monthly Earnings	**Years of Service at Retirement**				
	20	**25**	**30**	**35**	**40**
$2,000	$498	$618	$738	$858	$978
$3,000	738	918	1,098	1,278	1,458
$4,000	978	1,218	1,458	1,698	1,938
$5,000	1,218	1,518	1,818	2,118	2,418
$6,000	1,458	1,818	2,178	2,538	2,898

The above amounts were calculated under the Regular formula. However, the relationship of average earnings and Social Security benefits at the time you retire might result in the Alternate formula producing a higher benefit than shown in some of the above examples. In such a case, the actual benefit will be greater than that shown in the above table, because the highest benefit produced by any of the three formulas is the one used.

If you retire before you are eligible for a full pension, you may postpone starting your pension and thus lessen or eliminate the reduction. In the example above, if you retire at age 55 with 23 years of service but postpone starting your pension until age 58, you will receive a full pension because your 23 years of service and your age will then total 81. You can add years to your age after you terminate employment only if you were eligible for early retirement when you terminated employment.

Any reduction for early retirement is in addition to the reduction that may be made to your plan benefit if you elect to provide continuing plan benefits to your spouse, dependent children, or dependent parents after your death, as discussed on the following pages. (See Tables 3, 4, 5, and 6 at the end of this chapter for survivor reduction factors.)

Guard Supplement

If your job requires compliance with certain medical and physical standards as described in 10 CFR Part 1046 of the *Code of Federal Regulations* for at least 10 years in the last 12 years of your employment with the Company, you may be eligible for this supplemental pension benefit, beginning upon your retirement commencement and ending when you reach age 65. You will only be eligible for this supplemental benefit if it is larger than your benefit calculated under the Plan, without taking the supplement into account. In general, this supplemental benefit applies if you have not accrued a full pension and retire prior to age 65. When you reach age 65, your benefit will be reduced to the pension calculated prior to the additional supplement.

Calculating Your Earnings

Average Straight-Time Monthly Earnings are computed using your straight-time rate of pay (including certain variable pay, shift differential, and hourly cost of living adjustment [COLA]) and your regularly scheduled hours during:

- the 3 calendar years in which these earnings were highest, during the 10 calendar years just before you retire

  or, if greater
- the final 3 years (36 months) just before you retire.

The Average Straight-Time Monthly Earnings during the final 3 years are calculated by using:

- scheduled straight-time monthly earnings in the completed months of the calendar year in which you retire, and
- scheduled straight-time earnings in the 2 preceding calendar years, and
- for any months in the third preceding calendar year, the average of the scheduled straight-time monthly earnings for that year times the number of months used in that year.

You should note that this calculation does not use the actual scheduled earnings for the specific months of the third year. The earnings rate used will be the monthly average for the entire year.

Differential pay during certain periods of military service is included in earnings unless you return to employment following a qualified military service leave within the required time period. In that case, your earnings during the military service leave will be credited based on your rate of pay when your leave started, adjusted as required by a law called the Uniformed Services Employment and Reemployment Rights Act (USERRA). For more information about the impact of a military service leave on your plan benefits, see the discussion titled “Service and Earnings During Military Service Leave” in the “Credited Service and Severance from Service” section.

NOTE: The IRS places restrictions on the amount of compensation to be used in calculating the pension benefit. Certain highly compensated employees may have a limit imposed.

Pension Benefit Example		
A full pension will be the largest amount produced by any of the three formulas. For example, suppose you retire at age 65 with 30 years of Company Service and Average Straight-Time Monthly Earnings of $4,500 a month. Here is how your full pension would be calculated:		
Regular Formula		
.012 × 30 × $4,500 + $18	=	$1,638
Per Month	**=**	**$1,638**
Alternate Formula		
.015 × 30 × $4,500	=	$2,025
minus .015 × $1,400* x 30	=	$630
Per Month	**=**	**$1,395**
Minimum Formula		
$5 × 10 years	=	$50
$7 × 10 years	=	$70
$9 × 10 years	=	$90
10% × $4,500	=	$450
Flat amount	=	$18
Per Month	**=**	**$678**
In this case, the Regular formula would give you a higher pension than the Alternate or Minimum formulas. You would receive the highest benefit of $1,638 a month for the rest of your life. Of course, if you elect to continue benefits to your spouse or other eligible dependents after your death, this amount will be reduced to account for the longer period over which plan benefits will be paid. (See Tables 3, 4, 5, and 6 at the end of this chapter for survivor reduction factors.)		
*This is a typical Primary Social Security Benefit.		

Normal Forms of Payment

You will receive your plan benefit 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 retire, the normal form of payment is a joint and 50% 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 but after your payments start, this form of payment will “pop up” to the amount that would be paid to a single employee, following receipt of proper documentation required by the Plan Administrator. (For the 50% Surviving Spouse reduction factors, see Table 3 at the end of this chapter.)

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 also may 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 but after your payments start, this form of payment will “pop up” to the amount that would be paid to a single employee, following receipt of proper documentation required by the Plan Administrator. (For the 75% Surviving Spouse reduction factors, see Table 6 at the end of this chapter.)

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, the monthly life annuity will cease.

Optional Forms of Payment

You may elect an optional form of payment at retirement. If you are married, you will need your spouse’s written consent, witnessed by a notary public or a representative of the Plan Administrator on the form provided for this purpose by the Plan Administrator, 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. After your death, the monthly life annuity will cease.

50% Survivor Benefit Option

You can elect a reduced pension to provide continuing income to an unmarried dependent child (or unmarried dependent children) under age 23, or a dependent parent (or dependent parents), but not to both dependent children and parents **(terms “Dependent Child” and “Dependent Parent” are defined in the Glossary)**.

If you elect the 50% survivor benefit for your dependent child (or children) after your death, 50% of your reduced benefit will continue to your dependent child until the earliest of: age 23 (or as long as the child remains Totally and Permanently Disabled), or the dependent child dies. If you elect the 50% survivor benefit for your dependent parent(s), after your death, 50% of your reduced benefit will continue to your dependent parent for the rest of his or her life.

The amount of reduction in your pension to provide a survivor benefit depends on your age and the age of your named survivor. (Examples of survivor factors are shown in Tables 3, 4, and 5 at the end of this chapter.) If there are multiple dependents receiving a survivor benefit, and a dependent dies or is no longer eligible for the dependent survivor benefits, his or her benefit will be divided equally among the remaining eligible dependents.

If you 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 50% survivor benefit cannot be changed after your pension begins. If your named survivor should die before you, this payment form will “pop up” to the amount paid to a single employee. You must provide a certified copy of your elected survivor’s death certificate to ORNL Benefits to initiate the “pop up.”

Level Income Option

If you retire before age 62, are eligible for an early retirement benefit, and choose to have your pension benefits begin before you are eligible to receive Social Security benefits, you may elect the level income option. Under this option, your Pension Plan income is increased until age 62 and is decreased after age 62 so that your combined income from the Pension 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.

If you elect the level income option with the 50% survivor's benefit, the 50% survivor's benefit will be based on the pension amount before adjustment for this option.

If you elect the level income option with the 75% survivor's benefit, the 75% survivor's benefit will be based on the pension amount before adjustment for this option.

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 survivor's benefits may also be provided for eligible family members.

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 both you and the Company 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.

Participation While You Are Disabled

Continuation of Plan Participation

If you become Totally Disabled and qualify for benefits under the Company's Long-Term Disability plan, you will continue to accrue Company Service just as if you had continued working. While you continue to be Totally Disabled, your earnings will be assumed to remain the same as at the time you became disabled. For purposes of determining your benefit and for calculating your mandatory participant contributions, your Average Straight-Time Monthly Earnings will be based on:

- the 3 calendar years in which your earnings were highest, during the 10 calendar years just prior to your last day worked, or
- the final 3 years just prior to your last day worked.

For information on how your Average Straight-Time Monthly Earnings during the final 3 years are calculated, refer to "Calculating Your Earnings."

Effect of Disability on Your Pension Benefit

If you continue to be totally disabled until age 65, you will be entitled to retire under the same conditions as any other participant. If your disability ends before age 65, you will receive credit for Company Service for the period of your disability, provided you return to work or transfer from disability status to retirement status immediately upon ceasing to be disabled. If you do not return to work or retire after your disability ends, you will be considered to have terminated employment on the date your disability began.

If You Die While Employed

If you die while you are still employed and have completed at least 5 years of Company Service, the plan will pay a benefit to your surviving spouse or dependent child or dependent parent. The timing and amount of this benefit will depend on your years of Company Service at the time of death.

If you die after completing 10 years of Company Service, the survivor benefit is payable immediately. (The age 50 requirement for early retirement does not apply in determining eligibility for the survivor benefit.) The benefit is a monthly income equal to 50% of the pension you would have received if you had retired on the day of your death. If your survivor is a younger spouse, the benefit will be reduced ½% for each full year more than 5 years that your spouse is younger than you. However, in no event will the survivor benefit be reduced to less than 25% of your full pension, calculated using your average earnings and service at your death.

If you die before completing 10 years of Company Service (but after 5 years), the survivor benefit is payable the first day of the month following the day you would have reached age 65. The benefit is a monthly income equal to 50% of the benefit you would have received had you terminated employment on the day of your death and had you elected to receive your benefit at age 65 in the joint and 50% survivor form of payment.

Your survivor can elect to receive reduced benefits as early as the date you would have reached age 50. The reduction will be 6⅔% for each year before age 65, for up to 3 years (to age 62), plus 5% for each year before age 62 that benefits begin.

The benefit will be paid to your spouse for the rest of his or her life. If you are employed and not married when you die, the benefit will be paid in equal shares to your dependent children until age 23 (or as long as a child remains Totally and Permanently Disabled).

If you have no dependent children, the benefit will be paid in equal shares to your dependent parents for life.

If you have no spouse, no dependent children, and no dependent parents, no survivor monthly benefit is payable. However, a refund of your contributions with applicable interest will be paid to your estate. **The terms “Dependent Child” and “Dependent Parent” are defined in the Glossary.**

Any benefit being paid to a dependent child or dependent parent cannot be transferred to someone else when the child or parent no longer qualifies for it. However, if a spouse dies while receiving the survivor benefit, the spouse’s benefit will continue in equal shares to any of your dependent children under age 23 (or as long as a child remains Totally and Permanently Disabled).

If You Leave Before You Are Eligible for Normal or Early Retirement

If you leave the Company for any reason after completing at least 5 years of Credited Service, you are “vested.” Being vested means you have a nonforfeitable right to receive plan benefits.

Credited Service (**as defined in the Glossary**) generally means the time you work at the Company, from your first hour of service until you sever from service.

Further discussion follows on Credited Service and Severance from Service.

Benefit Amount

The amount of your vested pension payable at age 65 depends on your Average Straight-Time Monthly Earnings (including certain variable pay, shift differential, and hourly COLA), your total Company Service at the time you leave the Company, and your age at the time you want your vested pension payments to begin. The three formulas described previously are used to calculate your vested pension, but with these differences:

- The flat amount of $18 per month under the Regular and Minimum formulas will be multiplied by a "service fraction." This fraction is your actual years of Company Service divided by your years of Company Service that would be credited had you continued with the Company until age 65.
- If your vested benefit is calculated using the Minimum formula and you have less than 10 years of Company Service, that part of the formula using 10% of your Average Straight-Time Monthly Earnings will be reduced by 1% for each full year less than 10.

The Alternate formula is revised to require the following steps:

1. 1.5% × Average Straight-Time Monthly Earnings × your years of service that would be credited had employment continued to age 65 Minus
2. 1.5% × years of service (up to 33 1/3) that would be credited had employment continued to age 65 × Primary Social Security Benefit at age 65, assuming continued employment at current earnings rate Times
3. The service fraction:
   Years of actual service/Years of service had employment continued to age 65

Payment of Benefits

Vested benefits normally become payable at age 65. However, you can elect to receive a reduced benefit as early as age 50, but the benefit will be calculated as described in this section, not as an early retirement benefit. The amount of the reduction will depend on how many years before age 65 you elect to begin benefits. The reduction is 6⅔% for each year before age 65 for up to 3 years (age 62). In addition, the reduction is 5% for each year before age 62 that plan payments start. For example, if you leave the Company and begin receiving your pension at age 60, your benefit will be reduced 30%; that is 20% for the years between 65 and 62 (6⅔% × 3) plus 10% for the years between 60 and 62 (5% × 2).

Your vested benefit will commence effective the first of the month following receipt of your written request. If you are married at the time of your request, your benefit will automatically be paid as a joint and 50% survivor benefit, unless you elect otherwise with your spouse's written consent witnessed by a notary public or representative of the Plan Administrator. If your benefit is paid in the joint and 50% survivor form, it will be reduced according to Table 3 at the end of this chapter. If your benefit is paid in the 75% surviving spouse form, it will be reduced according to Table 6 at the end of this chapter (based on applicable mortality and interest rates as specified by the Internal Revenue Code).

Preretirement Spouse's Benefit

If you leave the Company with vested benefits and you die before plan payments begin, your spouse may be eligible to receive a preretirement benefit equal to 50% of the benefit you would have received under the joint and 50% survivor benefit. Your spouse will be eligible if you and your spouse have been married at least 1 year at the time of your death.

If you die after age 50, payments may begin on the first of the month following your death. If you die before age 50, payments may begin on the first of the month following the date you would have reached age 50.

Forfeiture of Benefits

If your employment terminates before you have completed 5 years of Credited Service, you will forfeit your right to any monthly plan benefits. However, if you are a salaried employee and subject to mandatory pension contributions, you will receive a refund of your contributions plus any applicable interest.

Credited Service and Severance from Service

"Credited Service" (**as defined in the Glossary**) is used to determine whether you are eligible for a vested pension. Note: for former NSPS Plan participants who transition to ORNL on the Employee Transfer Date, your Credited Service includes what was credited under the NSPS Plan.

"Company Service" (**as defined in the Glossary**) is used to determine the amount of your pension benefit. Note: for former NSPS Plan participants who transition to ORNL on the Employee Transfer Date, your Company Service includes what was credited under the NSPS Plan.

Credited Service begins with your first hour of service and ends when you have a severance from service.

A severance from service occurs on the earlier of:

- the day you quit, retire, are discharged, or die, or
- 1 year after your first day of absence due to layoff, or, if earlier, the first day after recall if you fail to return to work, or
- 1 year after your first day of absence while on an approved leave, or, if earlier, the first day after the final day of leave if you fail to return to work, or
- 2 years after your first day of absence for a parental leave due to pregnancy, birth, or adoption, and for child care immediately following the birth or adoption, or, if earlier, the first day after the final day of leave if you fail to return to work.

Special rules apply to determine your severance from service, Credited Service, and Company Service if you are classified as a Casual Employee. Generally, you must perform at least 1 hour of service in a 12 month period to avoid a severance from service and receive Credited Service and Company Service.

If you are reemployed within 1 year of your date of severance, you will receive Credited Service for your period of severance, and your prior Credited Service will be restored. If you are reemployed more than 1 year after your date of severance and you were vested as of that date, your prior Credited Service will be restored automatically upon reemployment, regardless of your period of severance.

If you were not vested as of your date of severance, your prior Credited Service will be restored if you are reemployed more than 1 year after the period of severance, the length of your severance is less than 5 years, and you are employed for at least 1 year after reemployment.

In any event, you will not earn Credited Service during a period of severance lasting 1 year or more.

Reemployment After Retirement

If you had been receiving pension payments and return to work at the Company, your benefit will be suspended during your period of reemployment until you actually retire, or until your work schedule is such that you are not subject to a benefit suspension. Your benefits will be suspended for any month in which you receive payment from the Company for hours of service performed on each of 8 or more days (or separate work shifts). When payments begin again, they will be adjusted to reflect your additional service and earnings after returning to work.

If you are a NSPS Plan Retiree who has commenced a pension or vested benefit under the NSPS Plan before the Employee Transfer Date and as of the Employee Transfer Date you are actively employed by ORNL, you will not have your pension benefits suspended.

If you are a NSPS Plan Retiree who has not commenced your pension or vested benefit under the NSPS Plan before the Employee Transfer Date and as of the Employee Transfer Date you are actively employed by ORNL, you cannot commence any pension or vested benefit until you have terminated employment from ORNL.

If you return to work as a Casual Retiree and work for more than 7 shifts/days in any calendar month, your pension payment is suspended for that month unless you are over age 70½.

If you are considering returning to active service after you retire, you should contact the ORNL Benefits Office to make a determination concerning whether your return to work will cause your benefit to be suspended.

Service and Earnings During Military Service Leave

If you are on a qualified military service leave, you will be treated as not having had a break in service by reason of such leave if you return to employment within the time period during which your reemployment rights are protected by USERRA. Upon your timely return to employment, your leave will be included in your Company Service and Credited Service. If you do not return to employment within the required period (or you do not meet any other USERRA requirements), but you received differential pay from the Company during the leave, the period you received differential pay will be included in your Company Service and Credited Service.

Plan-eligible earnings during a period of qualified military service leave will be credited based on your rate of pay when your leave began, adjusted as required by USERRA if you return to employment within the required period and meet any other USERRA requirements. If you do not return within the required period and meet all other USERRA requirements, your earnings will include only your differential pay.

If you think you have a qualified military service leave and have questions about how it may affect your pension benefit, please contact the ORNL Benefits Office. You may also contact the US Department of Defense, Employer Support of the Guard and Reserve, at 1-800-336-4590 (website: www.esgr.org) about your military service rights and responsibilities under USERRA.

Applying for Benefits

Upon your request, the ORNL Benefits Office will provide you with the necessary information and instructions for receiving benefits and completing payment forms. In case of your death, your spouse, other beneficiary, or personal representative should notify the ORNL Benefits Office and request information about any plan benefits that might be payable as a result of your death.

If the appropriate forms are not completed and submitted, or if any information requested by the ORNL Benefits Office is not provided, benefits will be delayed.

Transfer of Assets and Benefit Liabilities for Grandfathered Employees who Transitioned from NSPS

As of the Asset Transfer Date, accrued benefit liabilities were transferred from The National Strategic Protection Services Plan (the “NSPS Plan”) to the Pension Plan for Employees at ORNL (the “ORNL Plan”). Plan assets were transferred to the ORNL Plan in connection with the benefit liability transfer in accordance with the law.

Your benefit in the plan was transferred to the ORNL Plan effective December 30, 2018, if either (i) you were employed (or on leave) and covered under the NSPS Plan on December 30, 2018, or (ii) you terminated employment or retired on or before December 30, 2018, and you were assigned to ORNL by the DOE. If you satisfy one of these conditions, your benefit will be paid by the ORNL Plan.

Other Important Information

Other Retirement Income

Any benefits due you (or your survivor if you die before retirement) from the Pension Plan will be reduced by the amount (or the actuarial equivalent, if appropriate) of any retirement benefit payable from any of the following sources, provided the benefit is related to service recognized under this Pension Plan and is attributable to contributions made by a Department of Energy contractor:

- any other private plan, or

- any retirement or separation benefit payable under the law of any foreign government, or
- any public pension other than military or Social Security for which you received credit for Company Service.

The reduction will be made under rules which will apply uniformly to all affected employees. If your pension is to be reduced because of this provision, you will be given a full explanation at the time your pension benefit is calculated.

Withholding Taxes

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

Direct Deposit of Payments

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

Change of Address

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

Administrative Information

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

Pension Reduction Tables

Table 1—Early Retirement Reduction Factors

These factors use your age and years of service to determine the percentage of your full pension that is payable.

Age	Years of Service													
YEARS	10–18	19	20	21	22	23	24	25	26	27	28	29	30	31 & over
50	40	45	50	50	55	60	65	70	75	80	85	90	95	100
51	45	45	50	55	60	65	70	75	80	85	90	95	100	100
52	50	50	55	60	65	70	75	80	85	90	95	100	100	100
53	55	55	60	65	70	75	80	85	90	95	100	100	100	100
54	60	60	65	70	75	80	85	90	95	100	100	100	100	100
55	65	65	70	75	80	85	90	95	100	100	100	100	100	100
56	70	70	75	80	85	90	95	100	100	100	100	100	100	100
57	75	75	80	85	90	95	100	100	100	100	100	100	100	100
58	80	80	85	90	95	100	100	100	100	100	100	100	100	100
59	85	85	90	95	100	100	100	100	100	100	100	100	100	100
60	90	90	95	100	100	100	100	100	100	100	100	100	100	100
61	95	95	100	100	100	100	100	100	100	100	100	100	100	100
62–64	100	100	100	100	100	100	100	100	100	100	100	100	100	100
65	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Factors for intermediate ages and service are available from the ORNL Benefits Office.

Table 2—Early Retirement Reduction Factors if Terminated by Company Action

If you are terminated by Company action other than for cause, use this table instead of Table 1 to determine the percentage of your full pension that is payable.

	Years of Service														
Age	**8–9**	**10–18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31 & over**
48	40	40	45	50	50	55	60	65	70	75	80	85	90	95	100
49	40	40	45	50	50	55	60	65	70	75	80	85	90	100	100
50	40	40	45	50	50	55	60	65	70	75	80	85	100	100	100
51	45	45	45	50	55	60	65	70	75	80	85	100	100	100	100
52	50	50	50	55	60	65	70	75	80	85	100	100	100	100	100
53	55	55	55	60	65	70	75	80	85	100	100	100	100	100	100
54	60	60	60	65	70	75	80	85	100	100	100	100	100	100	100
55	65	65	65	70	75	80	85	100	100	100	100	100	100	100	100
56	70	70	70	75	80	85	100	100	100	100	100	100	100	100	100
57	75	75	75	80	85	100	100	100	100	100	100	100	100	100	100
58	80	80	80	85	100	100	100	100	100	100	100	100	100	100	100
59	85	85	85	100	100	100	100	100	100	100	100	100	100	100	100
60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
61	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
62–64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Factors for intermediate ages and service are available from the ORNL Benefits Office.

Table 3—50% Surviving Spouse Reduction Factors

Spouse's Age	Pensioner's Age																									
	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
40	.955	.951	.947	.943	.939	.935	.930	.926	.921	.915	.910	.904	.893	.891	.885	.878	.870	.862	.854	.843	.836	.827	.817	.808	.798	.786
41	.956	.952	.949	.945	.941	.936	.932	.927	.922	.917	.911	.906	.900	.893	.886	.879	.872	.864	.856	.847	.838	.829	.819	.810	.800	.789
42	.957	.954	.950	.946	.942	.938	.933	.929	.924	.919	.913	.908	.901	.895	.888	.881	.874	.866	.858	.849	.840	.831	.821	.812	.802	.792
43	.958	.955	.951	.948	.944	.939	.935	.930	.925	.920	.915	.909	.903	.897	.890	.883	.876	.868	.860	.851	.842	.833	.823	.814	.804	.794
44	.960	.956	.953	.949	.945	.941	.937	.932	.927	.922	.917	.911	.905	.899	.892	.885	.878	.870	.862	.853	.844	.835	.826	.816	.806	.796
45	.961	.958	.954	.950	.947	.943	.938	.934	.929	.924	.919	.913	.907	.901	.894	.887	.880	.872	.864	.856	.847	.838	.828	.818	.808	.798
46	.962	.959	.956	.952	.948	.944	.940	.935	.931	.926	.921	.915	.909	.903	.897	.890	.882	.875	.867	.858	.849	.840	.830	.821	.811	.801
47	.963	.960	.957	.953	.950	.946	.942	.937	.933	.928	.923	.917	.911	.905	.899	.892	.885	.877	.869	.861	.852	.842	.833	.823	.813	.803
48	.965	.962	.958	.955	.951	.948	.943	.939	.935	.930	.925	.919	.914	.908	.901	.894	.887	.879	.872	.863	.854	.845	.836	.826	.816	.806
49	.966	.963	.960	.957	.953	.949	.945	.941	.937	.932	.927	.921	.916	.910	.903	.897	.890	.882	.874	.866	.857	.848	.838	.829	.819	.809
50	.967	.964	.961	.958	.955	.951	.947	.943	.938	.934	.929	.924	.918	.912	.906	.899	.892	.885	.877	.868	.860	.851	.841	.832	.822	.812
51	.969	.966	.963	.960	.956	.953	.949	.945	.940	.936	.931	.926	.920	.915	.908	.902	.895	.887	.880	.871	.863	.854	.844	.835	.825	.815
52	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.928	.923	.917	.911	.904	.897	.890	.882	.874	.866	.857	.847	.838	.828	.818
53	.971	.969	.966	.963	.960	.956	.953	.949	.945	.940	.935	.931	.925	.920	.913	.907	.900	.893	.885	.877	.869	.860	.851	.841	.831	.821
54	.973	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.928	.922	.916	.910	.903	.896	.888	.880	.872	.863	.854	.844	.835	.825
55	.974	.971	.969	.966	.963	.960	.956	.952	.949	.944	.940	.935	.930	.925	.919	.913	.906	.899	.891	.883	.875	.866	.857	.848	.838	.828
56	.975	.973	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.927	.921	.915	.909	.902	.894	.887	.878	.870	.861	.851	.842	.832
57	.976	.974	.972	.969	.966	.963	.960	.956	.953	.949	.944	.940	.935	.930	.924	.918	.912	.905	.898	.890	.882	.873	.864	.855	.845	.836
58	.978	.975	.973	.970	.968	.965	.962	.958	.955	.951	.947	.942	.938	.932	.927	.921	.915	.908	.901	.893	.885	.877	.868	.859	.849	.840
59	.979	.977	.974	.972	.969	.966	.963	.960	.957	.953	.949	.945	.940	.935	.930	.924	.918	.911	.904	.897	.889	.880	.871	.862	.853	.844
60	.980	.978	.976	.973	.971	.968	.965	.962	.959	.955	.951	.947	.943	.938	.933	.927	.921	.914	.907	.900	.892	.884	.875	.866	.857	.848
61	.981	.979	.977	.975	.972	.970	.967	.964	.961	.957	.954	.950	.945	.940	.935	.930	.924	.918	.911	.904	.896	.888	.879	.870	.861	.852
62	.982	.980	.978	.976	.974	.971	.969	.966	.963	.959	.956	.952	.948	.943	.938	.933	.927	.921	.914	.907	.900	.892	.883	.874	.865	.856
63	.983	.981	.979	.977	.975	.973	.970	.968	.965	.961	.958	.954	.950	.946	.941	.936	.930	.924	.918	.911	.903	.895	.887	.879	.870	.861
64	.984	.982	.981	.979	.977	.974	.972	.969	.967	.963	.960	.957	.953	.948	.944	.939	.933	.927	.921	.914	.907	.899	.891	.883	.874	.865
65	.985	.984	.982	.980	.978	.976	.974	.971	.968	.965	.962	.959	.955	.951	.947	.942	.936	.931	.925	.918	.911	.903	.896	.887	.879	.870
66	.986	.985	.983	.981	.979	.977	.975	.973	.970	.967	.964	.961	.958	.954	.949	.945	.940	.934	.928	.922	.915	.908	.900	.892	.883	.875
67	.987	.986	.984	.982	.981	.979	.977	.974	.972	.969	.967	.963	.960	.956	.952	.948	.943	.937	.932	.925	.919	.912	.904	.896	.888	.879
68	.988	.987	.985	.984	.982	.980	.978	.976	.974	.971	.969	.966	.962	.959	.955	.951	.946	.941	.935	.929	.923	.916	.908	.901	.893	.884
69	.989	.987	.986	.985	.983	.981	.980	.978	.975	.973	.971	.968	.965	.961	.957	.953	.949	.944	.939	.933	.927	.920	.913	.905	.897	.889
70	.990	.988	.987	.986	.984	.983	.981	.979	.977	.975	.972	.970	.967	.964	.960	.956	.952	.947	.942	.937	.930	.924	.917	.910	.902	.894

Table 4—Surviving Child Reduction Factors

If you elect to provide your dependent child with a survivor pension, use this table instead of Table 3.

Child's Age	Your Age															
	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
1	.961	.957	.952	.948	.943	.938	.932	.926	.918	.910	.902	.892	.882	.871	.859	.847
2	.964	.960	.956	.952	.947	.943	.937	.931	.924	.917	.908	.899	.890	.879	.868	.855
3	.967	.963	.960	.956	.951	.946	.942	.936	.930	.923	.915	.906	.897	.887	.876	.864
4	.970	.967	.963	.959	.955	.951	.946	.942	.936	.928	.921	.913	.905	.895	.884	.873
5	.973	.970	.967	.963	.960	.955	.951	.946	.941	.935	.928	.920	.912	.903	.893	.882
6	.976	.973	.971	.967	.964	.960	.956	.951	.946	.941	.935	.927	.920	.911	.902	.891
7	.979	.976	.974	.971	.968	.965	.961	.957	.952	.947	.942	.935	.928	.919	.910	.901
8	.981	.979	.977	.976	.972	.969	.966	.962	.958	.953	.948	.943	.936	.928	.920	.911
9	.984	.982	.980	.978	.976	.973	.970	.967	.963	.959	.954	.949	.944	.937	.930	.921
10	.986	.985	.983	.981	.979	.977	.974	.971	.968	.965	.961	.956	.951	.945	.939	.931
11	.988	.987	.985	.984	.982	.980	.978	.976	.973	.970	.966	.962	.958	.952	.947	.941
12	.990	.989	.988	.986	.985	.983	.982	.980	.977	.975	.972	.968	.964	.960	.955	.949
13	.992	.991	.990	.989	.988	.986	.985	.983	.981	.979	.977	.974	.970	.967	.962	.958
14	.993	.993	.992	.991	.990	.989	.988	.986	.985	.983	.981	.979	.976	.973	.969	.965
15	.995	.994	.994	.993	.992	.991	.990	.989	.988	.987	.985	.983	.981	.979	.976	.973
16	.996	.996	.995	.995	.994	.993	.993	.992	.991	.990	.989	.987	.986	.984	.981	.979
17	.997	.997	.996	.996	.996	.995	.995	.994	.993	.993	.992	.991	.989	.988	.986	.984
18	.998	.998	.998	.997	.997	.997	.996	.996	.995	.995	.994	.994	.993	.992	.991	.989
19	.999	.999	.998	.998	.998	.998	.998	.997	.997	.997	.996	.996	.995	.995	.994	.993
20	.999	.999	.999	.999	.999	.999	.999	.999	.998	.998	.998	.998	.997	.997	.997	.996
21	—	—	—	—	—	—	.999	.999	.999	.999	.999	.999	.999	.999	.999	.998
22	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

Factors for intermediate ages are available from the ORNL Benefits Office.

Table 5—Surviving Dependent Parent Reduction Factors

If you elect to provide you dependent parent with a survivor pension, use this table instead of Table 3.

Parent's Age	Your Age		
	55	60	65
70	.950	—	—
75	.985	.949	—
80	.991	.985	.972
85	.995	.992	.985

Factors for intermediate ages are available from the ORNL Benefits Office.

Table 6—75% Surviving Spouse Reduction Factors

Spouse Age	Pensioner's Age																						
	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
41	.920	.914	.907	.901	.894	.887	.880	.872	.865	.857	.848	.838	.829	.820	.809	.799	.787	.775	.764	.751	.740	.727	.714
42	.921	.915	.910	.903	.897	.890	.883	.875	.868	.859	.850	.841	.832	.822	.812	.801	.789	.778	.766	.754	.742	.730	.717
43	.924	.918	.911	.906	.899	.892	.885	.878	.869	.861	.853	.844	.834	.825	.814	.804	.792	.780	.769	.756	.745	.732	.720
44	.925	.920	.914	.908	.901	.894	.887	.880	.872	.864	.856	.846	.837	.828	.817	.806	.795	.783	.771	.760	.747	.735	.722
45	.927	.923	.917	.910	.904	.897	.890	.883	.875	.867	.859	.849	.840	.830	.820	.809	.799	.787	.775	.762	.750	.737	.725
46	.930	.924	.918	.913	.906	.900	.893	.886	.878	.869	.861	.853	.844	.833	.824	.813	.801	.789	.778	.765	.754	.741	.729
47	.931	.927	.921	.915	.908	.903	.896	.889	.880	.872	.864	.856	.848	.837	.826	.816	.805	.793	.780	.769	.756	.743	.731
48	.934	.928	.924	.917	.911	.906	.899	.892	.883	.878	.868	.859	.849	.840	.829	.820	.808	.797	.784	.773	.760	.747	.735
49	.937	.931	.925	.920	.914	.908	.901	.894	.886	.879	.871	.861	.853	.844	.833	.822	.812	.800	.788	.775	.764	.751	.738
50	.938	.934	.928	.923	.917	.910	.904	.897	.890	.882	.874	.865	.856	.846	.837	.826	.814	.804	.792	.779	.768	.755	.742
51	.941	.935	.931	.925	.920	.913	.907	.900	.893	.885	.878	.868	.860	.850	.840	.830	.818	.808	.796	.783	.771	.756	.748
52	.943	.938	.933	.928	.923	.915	.910	.903	.896	.889	.880	.872	.863	.853	.844	.833	.822	.812	.800	.787	.775	.762	.750
53	.946	.941	.935	.931	.925	.920	.913	.906	.900	.892	.885	.875	.867	.857	.848	.837	.826	.816	.804	.792	.779	.766	.754
54	.947	.943	.938	.933	.928	.923	.915	.910	.903	.896	.887	.879	.871	.861	.852	.841	.830	.820	.808	.796	.783	.771	.759
55	.950	.946	.941	.935	.930	.925	.918	.913	.906	.899	.892	.883	.875	.865	.858	.845	.834	.824	.812	.800	.788	.775	.760
56	.951	.947	.943	.938	.933	.928	.923	.915	.910	.903	.894	.886	.878	.869	.860	.850	.840	.828	.817	.805	.792	.780	.768
57	.954	.950	.946	.941	.935	.931	.925	.918	.913	.906	.899	.890	.882	.874	.864	.854	.844	.833	.821	.809	.797	.784	.773
58	.956	.953	.948	.944	.938	.934	.928	.923	.915	.910	.901	.894	.886	.878	.868	.859	.848	.837	.826	.814	.802	.789	.778
59	.959	.954	.950	.946	.941	.937	.931	.925	.920	.913	.908	.899	.890	.882	.872	.863	.853	.842	.830	.818	.806	.795	.783
60	.960	.957	.953	.948	.944	.940	.934	.928	.923	.917	.910	.903	.894	.886	.876	.867	.857	.846	.836	.824	.812	.800	.788
61	.963	.959	.956	.951	.947	.943	.937	.933	.927	.920	.913	.906	.899	.890	.882	.872	.863	.852	.841	.829	.817	.805	.793
62	.964	.962	.957	.954	.950	.946	.940	.935	.930	.924	.917	.910	.903	.894	.886	.876	.867	.857	.846	.834	.822	.810	.799
63	.966	.963	.960	.956	.953	.948	.943	.938	.933	.927	.921	.914	.907	.899	.890	.882	.872	.861	.850	.840	.829	.817	.805
64	.969	.968	.962	.959	.954	.951	.946	.941	.937	.931	.924	.918	.911	.903	.894	.886	.876	.867	.856	.845	.834	.822	.810
65	.970	.967	.964	.962	.957	.953	.948	.944	.940	.934	.928	.923	.915	.907	.900	.892	.882	.872	.861	.852	.840	.829	.817
66	.972	.969	.966	.963	.960	.956	.951	.947	.943	.938	.933	.925	.920	.913	.904	.896	.887	.878	.868	.857	.846	.834	.824
67	.973	.972	.969	.966	.962	.959	.954	.951	.948	.941	.935	.930	.924	.917	.908	.901	.892	.883	.874	.863	.852	.841	.829
68	.976	.973	.970	.967	.964	.962	.957	.954	.950	.944	.940	.934	.928	.921	.914	.908	.897	.889	.879	.868	.859	.848	.836
69	.978	.975	.972	.970	.967	.963	.960	.957	.953	.948	.943	.937	.931	.925	.918	.911	.903	.894	.885	.875	.864	.853	.842
70	.979	.978	.975	.972	.969	.966	.963	.959	.956	.951	.947	.941	.935	.930	.923	.915	.908	.899	.890	.880	.871	.860	.849

Glossary

Company Service

The total elapsed time between the date you begin employment with the Company and your last day of 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.)

Compensation

For the Pension Plan
Straight-time rate of pay (including certain variable pay, shift differential, and hourly cost of living adjustment) based on regularly scheduled hours.

Credited Service

All the time you work for the Company, from your first hour of service until you sever from service. Credited Service is used for vesting purposes. Refer to the “Pension Plan” chapter for more information on Credited Service.

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.

12. Savings Plan for IGUA Employees at ORNL

Summary Plan Description

This information is not intended to be a substitute for specific individualized tax, legal, or investment planning advice. Where specific advice is necessary or appropriate, you should consult with a qualified tax advisor, CPA, Financial Planner or Investment Manager

Introduction

Type of Plan

Effective January 1, 2019, UT-Battelle LLC established a 401(k) plan for newly hired former employees of National Strategic Protective Services, LLC who are represented under a collective bargaining agreement. The plan is named the Savings Plan for IGUA Employees at ORNL, but it will be referred to in this summary as the *Plan*. The Plan contains a cash or deferred arrangement, and once you're eligible to participate, you can contribute to the Plan on a tax deferred basis by payroll deductions.

Plan Sponsor

UT-Battelle LLC is the sponsor of the Plan, and will sometimes be referred to in this summary as the "Sponsoring Employer," the "Employer," "we," "us" or "our". Our address is 1 Bethel Valley Road, Oak Ridge, TN 37830; our telephone number is (865) 574-8943; and our employer identification number is 62-1788235.

Purpose of This Summary

This booklet is called a Summary Plan Description (the "SPD") and it is meant to describe highlights of the Plan in understandable language. It is not, however, meant to be a complete description of the Plan, nor is it meant to interpret, extend or change the provisions of the Plan in any way. If there is a conflict between this SPD and the Plan, the provisions of the Plan control your right to benefits. A copy of the Plan and related documents are on file with the Plan Administrator and you can read them at any reasonable time. Also, no provision of the Plan or this SPD is intended to give you the right to continued employment or to prohibit changes in the terms or conditions of your employment. If you have any questions that are not addressed in this SPD, you can contact the Plan Administrator (who is described in the next section) during normal business hours.

Who to Contact for Account Questions[1]

Schwab Retirement Plan Services, Inc. is the plan recordkeeper. Participant Services Representatives are available at (**800) 724-7526** Monday through Friday, 7:00 a.m.– 11:00 p.m. ET if you have questions about your account or want to know more about saving.

Account Access

You can check balances, request investment information, choose investments, change how much you save, and more at **(800) 724-7526** or www.workplace.schwab.com.

Plan Administration

Plan Trustee[2]

The Plan is administered under a written plan and trust agreement, with Charles Schwab Bank as the trustee. The trustee can be contacted at 211 Main Street, 14th Floor, San Francisco, CA 94105.

Plan Administrator

All matters that concern the operation of the Plan are the responsibility of the Administrator. The Administrator is UT-Battelle LLC, whose address is 1 Bethel Valley Road, Oak Ridge, TN 37830, and whose telephone number is (865) 241-6215. The Administrator has the power and discretionary authority to interpret the terms of the Plan based on the Plan document and existing laws and regulations, as well as the power to determine all questions that arise under the Plan. Such power and authority include, for

[1] Schwab Retirement Plan Services, Inc. provides recordkeeping and related services with respect to retirement plans and has provided this communication to you as part of the recordkeeping services it provides to the Plan.
[2] Trust, custody, and deposit products and services are available through Charles Schwab Bank.

example, the administrative discretion necessary to resolve issues with respect to an Employee's eligibility for benefits, credited service, Disability, and retirement, or to interpret any other term contained in the Plan and related documents. The Plan Administrator's interpretations and determinations are binding on all Participants, employees, former employees, and their beneficiaries.

Plan Number

For identification purposes, we have assigned number 003 to the Plan.

Plan Year

The Plan Year is the 12-month accounting year of the Plan, and it begins each January 1st and ends the following December 31st.

Service of Legal Process

If you have to bring legal action against the Plan for any reason, legal process can be served on the Manager of Pension & Savings at UT-Battelle LLC, 1 Bethel Valley Road, Oak Ridge, TN 37830. Legal process can also be served on the trustee or on the Administrator. You must exhaust the Plan's claims procedure (see the Section titled *Claims Procedure)* before you can bring legal action against the Plan.

Service Crediting

Your Service refers to the portion of your employment with us that is used to determine the Vested Interest in your Account and to determine whether you are entitled to a contribution allocation for an Allocation Period. The way your Service is determined is described in more detail below.

Hour of Service

You are credited with an Hour of Service for each hour that you have a right to be paid by us for the performance of your duties. This includes the actual number of hours that you work and hours for which you are paid but are not at work, such as paid vacation, paid holidays, or paid sick leave.

Year of Vesting Service

A Year of Vesting Service is a period of time used to determine your Vested Interest in one or more of your Accounts. You will be credited with a Year of Vesting Service for each Vesting Computation Period during which you are credited with at least 1,000 Hours of Service. The Vesting Computation Period is the Plan Year.

Break in Vesting Service

You will incur a Break in Vesting Service if you are not credited with more than 500 Hours of Service during a Vesting Computation Period. However, in certain circumstances, such as taking time off to give birth to a child or to adopt a child, or taking time off to care for a child following the birth or adoption, you will be credited with 501 Hours of Service even though you did not actually work 501 hours in order to prevent you from incurring a Break in Eligibility Service (but this type of special credit will not be used to determine your Years of Vesting Service or to determine your entitlement to a contribution for any Allocation Period).

Period of Service

A Period of Service, in general, is a period of time that begins on your date of hire and ends on the date you terminate employment or incur a Break in Eligibility Service or a Break in Vesting Service. The rules for determining your Period of Service are more complex than the explanation described in this section, especially the rules that apply if you terminate employment and are then rehired. For more information, you can check with the Administrator.

401(k) Contributions

How the Contribution Is Determined

Once you become a Participant, you can begin making 401(k) Contributions. 401(k) Contributions are amounts that you elect to contribute to the Plan through payroll withholding, and they can be made on a pre-tax basis (that is, they are deducted from your Compensation free of current income taxes but are fully taxable when they are subsequently distributed from the Plan).

Your 401(k) Contributions for any calendar year can't be less than 1% of your Compensation, and can't be more than 40% of your Compensation, or if less, the dollar limit on 401(k) Contributions announced annually by the IRS (which is $19,000 for the 2019 calendar year). 401(k) Contributions are allocated to your 401(k) Contributions Account. In addition, for any calendar year in which you are age 50 or older, you can also make additional "catch-up" 401(k) Contributions in excess of the annual dollar limit on 401(k) Contributions described above. The catch-up contribution limit is also announced annually by the IRS (and is $6,000 for the 2019 calendar year). Please note that the $19,000 and $6,000 annual limits apply with respect to your total 401(k) Contributions you make to all 401(k) plans.

How You Become a Participant

To become a Participant in this part of the Plan, you must satisfy the following criteria (described in more detail below): (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable entry date.

- **Eligible Employees.** All employees are Eligible Employees for this part of the Plan except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Individuals who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; and (e) employees covered by a collective bargaining agreement which does not allow for their participation in the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant as soon as administratively feasible after the date that you are hired.

Salary Deferral Agreements

You must file a Salary Deferral Agreement with the Administrator before you can begin making 401(k) Contributions to the Plan. Your Salary Deferral Agreement is where you indicate the amount that you want us to withhold from your Compensation and contribute to the Plan on your behalf. You can elect to contribute a percentage of your Compensation as your 401(k) Contribution.

After your initial election, you can change your Salary Deferral Agreement by filing a new agreement with the Administrator at any time. If your employment terminates, your Salary Deferral Agreement will expire.

You can also cancel your Salary Deferral Agreement at any time by giving written notice to the Administrator. Your cancellation will be implemented as soon as administratively possible after your notice is received. If you do cancel your agreement, you will not be permitted to make a new election until the first available date that you would otherwise be entitled to change an existing agreement as described in the preceding paragraph.

The Administrator from time to time may establish additional administrative procedures (or change existing procedures) concerning deferral elections, in which case you will be appropriately notified. The Administrator can also temporarily suspend your deferral agreement if you reach the maximum deferral amount that is permitted by law or by the Plan, or if the Administrator believes the Plan may fail certain required non-discrimination tests. You will be notified if your deferral agreement is temporarily suspended.

How Your Compensation Is Determined

In general, you can make 401(k) Contributions from all of the compensation that is paid or made available to you during the Plan Year, excluding any compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the

Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) as shift differential.

How Your Vested Interest Is Determined

Your Vested Interest in your 401(k) Contribution Account is 100% at all times.

Matching Contributions

How the Contribution Is Determined

We may also make Matching Contributions to the Plan in order to match all or a portion of a Participant's 401(k) Contributions. The amount of this matching contribution for any pay period will be equal to the amount required under the terms of the Contract Between WSI Oak Ridge, Oak Ridge National Laboratory Site, Oak Ridge, Tennessee and International Guards Union of America Local No. 3, Oak Ridge, Tennessee August 15, 2012 – August 15, 2018, and its successor Agreements and the Contract Between National Strategic Protective Services, Oak Ridge, Tennessee and International Guards Union of America Local No. 3 (CAS Operators located at ORNL and ORPF), Oak Ridge, Tennessee September 8, 2014- September 8, 2019, and its successor Agreements. However, no Matching Contribution will exceed 100% of a Participant's 401(k) Contributions that do not exceed 6% of his or her Compensation. Matching Contributions are based on a Participant's 401(k) Contributions during the applicable payroll period only, and not based on total 401(k) Contributions during the overall Plan Year (i.e., Matching Contributions are not "trued-up" at the end of the Plan Year).

How You Become a Participant

To become a Participant in this part of the Plan, you must satisfy the following criteria (described in more detail below): (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable entry date.

- **Eligible Employees.** All employees are Eligible Employees for this part of the Plan except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Individuals who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; and (e) employees covered by a collective bargaining agreement which does not allow for their participation in the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant as soon as administratively feasible after the date that you are hired.

How You Qualify for a Contribution Allocation

Once you become a Participant in this part of the Plan, you are eligible for a Matching Contribution for any Allocation Period (i.e., payroll period) in which we make one if you are employed by us during any portion of the applicable pay period.

How Your Compensation Is Determined

In general, the amount of any Matching Contributions made on your behalf is based on all of the compensation that is paid or made available to you during the Allocation Period, excluding any compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) as shift differential. However, no contributions will be made with respect to Compensation in excess of the annual dollar limit on Compensation, which is announced annually by the IRS (and is $280,000 for the 2019 calendar year).

How Your Vested Interest Is Determined

1 Year of Vesting Service	0% Vested
2 Years of Vesting Service	0% Vested
3 Years of Vesting Service	100% Vested

Your Vested Interest in your Matching Contribution Account is determined by the schedule following this paragraph, based on your Years of Vesting Service (including Service with us; with Wackenhut Service, Inc. (Oak Ridge, TN) to the extent that such service was counted as service under the NSPS OR-BU 401(k) Retirement Plan, but only for Employees whose first date of employment with the Employer is December 31, 2018; and with National Strategic Protective Services, LLC, but only with respect to former employees of National Strategic Protective Services, LLC who became Employees of the Employer on December 31, 2018). Any part of this account which is not Vested will be forfeited when you receive a distribution (or after you incur 5 consecutive Breaks in Vesting Service, if earlier).

Nonelective Contributions

How the Contribution Is Determined

We will also make Nonelective Contributions to the Plan. The amount of such contribution for any Allocation Period will be equal to the amount required under the terms of the Contract Between WSI Oak Ridge, Oak Ridge National Laboratory Site, Oak Ridge, Tennessee and International Guards Union of America Local No. 3, Oak Ridge, Tennessee August 15, 2012 – August 15, 2018, and its successor Agreements and the Contract Between National Strategic Protective Services, Oak Ridge, Tennessee and International Guards Union of America Local No. 3 (CAS Operators located at ORNL and ORPF), Oak Ridge, Tennessee September 8, 2014- September 8, 2019, and its successor Agreements.

How You Become a Participant

To become a Participant in this part of the Plan, you must satisfy the following criteria (described in more detail below): (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable entry date.

- **Eligible Employees.** All employees are Eligible Employees for this part of the Plan except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Individuals who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; (e) employees covered by a collective bargaining agreement which does not allow for their participation in the Plan; and (f) Unit employees with a NSPS company service date prior to August 15, 2016 who are eligible to participate in the Pension Plan for Employees at ORNL.
- **Entry Date.** You will enter this part of the Plan as a Participant as soon as administratively feasible after the date that you are hired.

How You Qualify For a Contribution Allocation

Once you become a Participant in this part of the Plan, you are eligible for a Nonelective Contribution for any Plan Year in which we make one if you satisfy the requirements (if any) described below for that Plan Year. Nonelective Contributions are allocated to your Nonelective Contribution Account.

- **Active Participants.** If you are still employed by us on the last day of a Plan Year, you will be eligible to receive an allocation if you are credited with at least 1,000 Hours of Service during the Plan Year.
- **Terminated Participants.** If you terminate employment for any reason before the last day of the Plan Year, you will not be eligible to receive an allocation regardless of your service during that Plan Year.

How the Contribution Is Allocated

Nonelective Contributions are allocated in accordance with the terms of the collective bargaining agreement.

How Your Compensation Is Determined

In general, the amount of any Nonelective Contributions made on your behalf is based on all of the compensation that is paid or made available to you during the Plan Year, excluding any compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) as shift differential. However, no contributions will be made with respect to Compensation in excess of the annual dollar limit on Compensation, which is announced annually by the IRS (and is $280,000 for the 2019 calendar year).

How Your Vested Interest Is Determined

1 Year of Vesting Service	0% Vested
2 Years of Vesting Service	0% Vested
3 Years of Vesting Service	100% Vested

Your Vested Interest in your Nonelective Contribution Account is determined by the schedule following this paragraph, based on your Years of Vesting Service (including Service with us; with Wackenhut Service, Inc. (Oak Ridge, TN) to the extent that such service was counted as service under the NSPS OR-BU 401(k) Retirement Plan, but only for Employees whose first date of employment with the Employer is December 31, 2018; and with National Strategic Protective Services, LLC, but only with respect to former employees of National Strategic Protective Services, LLC who became Employees of the Employer on December 31, 2018). Any part of this account which is not Vested will be forfeited when you receive a distribution (or after you incur 5 consecutive Breaks in Vesting Service, if earlier).

Top Heavy Requirements

Under certain circumstances, you may be entitled to a minimum allocation for any Plan Year in which the Plan is considered "top heavy." The Plan is considered top heavy for any Plan Year in which more than 60% of Plan assets are allocated to the Accounts of Participants who are Key Employees. However, the Plan automatically satisfies this requirement in any Plan Year for which we make a contribution on your behalf to any other qualified retirement plan that we sponsor. If the Plan is not exempt, then for each Plan Year in which the Plan is considered top heavy and in which you are a non-Key Employee who is employed by us on the last day of the Plan Year, you will receive a minimum allocation equal to the lesser of 3% of your Compensation or the highest percentage of Compensation allocated for that Plan Year to the Accounts of Participants who are key employees.

Maximum Allocation Limitations

The amount of contributions and forfeitures that can be allocated to your Account for any Plan Year is limited by law to the lesser of 100% of your Compensation or the annual dollar limit (which is announced annually by the IRS and is $56,000 for the 2019 calendar year). However, this dollar limit does not apply to the amount of earnings that can be allocated to your Account, to the "catch-up" contributions you can make to the Plan, to the amount of any Rollover Contributions you can make to the Plan, or to any other funds transferred to this Plan on your behalf from another qualified plan.

Rollover Contributions

If you participated in another retirement plan, you may be permitted to roll over any distribution you receive from the other plan to this Plan if all legal requirements (and any requirements imposed by the Administrator) on such rollovers are satisfied. If you do decide to make a rollover contribution and it is accepted by the Administrator, it will be kept in a separate Rollover Account established on your behalf. Your Vested Interest in your Rollover contributions will be 100% at all times.

Specifically, if you are an eligible employee, you may roll over amounts from the following retirement plans:

- qualified plans excluding after-tax contributions
- 403(a) and 403(b) annuity plans excluding after-tax contributions
- governmental plans (Code Sec. 457(b) plans)
- Individual Retirement Accounts (IRAs) and individual retirement annuities
- participant loans from such plans as permitted by the Administrator

Distribution of Benefits

Distributions for Reasons Other Than Death

If your employment is terminated for any reason other than death, your Vested Interest will be distributed within an administratively feasible time after you request payment. Your Vested Interest will be distributed in a lump sum which can be paid to you or, at your election, can be rolled over to another qualified retirement plan or to an individual retirement account. You can also elect not to receive a lump sum and instead elect partial payments in amounts that you request from time to time.

In addition to the payments described above, there are rules which require that certain minimum distributions be made from the Plan. Generally, these minimum distributions must begin by the later of (a) the April 1st following the end of the calendar year in which you reach age 70½ or (b) the April 1st following the end of the calendar year in which you retire. However, if you are a 5% owner, you must begin receiving these distributions by the April 1st following the end of the calendar year in which you reach age 70½ even if you are still employed by the Employer.

Distributions Upon Death

Your Vested Interest will be distributed to your beneficiary as soon as administratively feasible after your death. If you are not married, you can name anyone to be your beneficiary. If you are married, your spouse by law is your beneficiary unless he or she waives the death benefit in writing and witnessed by a notary on an official Plan beneficiary designation form. Your beneficiary can elect to receive (a) a lump sum; or (b) installment payments in the minimum amount legally required to be distributed each year.

If you fail to designate a beneficiary, or if the beneficiary is not alive at the time of your death, the death benefit will be paid in the following order of priority to:

- your spouse;
- your children and any descendants of deceased children (i.e., “per stirpes”); and
- your estate.

If you designate your spouse as beneficiary and later become divorced, the designation of your spouse as beneficiary will no longer be valid. Under these circumstances, you should submit a new beneficiary designation.

If your death occurs *before* the date minimum distributions must begin (as described in the preceding section), the distribution to your beneficiary must be made within certain legal timeframes that are dependent upon several factors, including (a) whether you have a designated beneficiary, (b) your relationship to the beneficiary (spousal or non-spousal beneficiary), and (c) certain elections that your beneficiary may make after your death. However, if your death occurs *after* the date that minimum distributions must begin, the minimum death benefit that must be paid to your beneficiary each year after your death is based on the longer of your remaining life expectancy (had you survived) or the remaining life expectancy of your beneficiary. Your beneficiary may also choose to accelerate the payment rate. Contact the Administrator for more information regarding payments to beneficiaries.

Any death benefit received by your spouse can be rolled over to an IRA. A non-spouse beneficiary may establish a special IRA (an "Inherited IRA") that can receive a direct rollover of all (except for any required minimum distributions) or a portion of the death benefit distributed upon your death to that non-spouse beneficiary.

Certain portions of a death benefit may not be eligible to be rolled over into an Inherited IRA. If you (a deceased Participant) needed to take a required minimum distribution in the year of your death (but you have not yet taken that required minimum distribution), then that required minimum distribution cannot be rolled over from the Plan into an Inherited IRA. Similarly, if the non-spouse beneficiary needs to take any required minimum distribution from the Plan for the year in which the direct rollover occurs (or any prior year), then the non-spouse beneficiary cannot roll over that required minimum distribution into an Inherited IRA.

If the non-spouse beneficiary elects to roll over the death benefit to an Inherited IRA, then the inherited IRA will be subject to complicated required minimum distribution rules. You should inform your non-spouse beneficiary that (a) he or she is designated to receive your death benefit, and (b) your death benefit can be rolled over to an Inherited IRA. The non-spouse beneficiary should discuss any planning issues and tax consequences with their professional tax advisor with respect to a direct rollover of your death benefit into an Inherited IRA.

Cash-Outs of Small Accounts

If your employment is terminated for any reason and your Vested Interest is $5,000 or less (including your Rollover Account balance) it will be distributed in a lump sum, or, at your election, will be rolled over to another qualified retirement plan or to an individual retirement account (IRA) of your choosing. However, if you do not make an election, then the distribution (a) will be made in a lump sum if your Vested Interest is $1,000 or less; or (b) if your Vested Interest is more than $1,000, will be rolled over to an individual retirement account (IRA) that we establish for you at Charles Schwab Bank ("IRA provider"). The IRA provider will charge your IRA for any expenses associated with the establishment and maintenance of the IRA and with the investments of the IRA. You will be given more information at the time of distribution regarding the IRA provider and any associated fees or expenses.

In-Service Distributions

Even if you have not terminated your employment with us, you can elect to take a lump sum distribution of up to 100% of the following accounts:

- **401(k) Contribution Account.** You can request a distribution from your 401(k) Contribution Account if you have reached age 59½. You may also take an in-service distribution at any time after you reach Normal Retirement Age (age 65).
- **Qualified Matching Contribution Account.** You can request a distribution from your Qualified Matching Contribution Account if you have reached age 59½. You may also take an in-service distribution at any time after you reach Normal Retirement Age. This account is one to which we may elect to make contributions in order to pass certain Plan testing requirements.
- **Qualified Non-Elective Contribution Account.** You can request a distribution from your Qualified Non-Elective Contribution Account if you have reached age 59½. You may also take an in-service distribution at any time after you reach Normal Retirement Age. This account is one to which we may elect to make contributions in order to pass certain Plan testing requirements.
- **Matching Contribution Account.** You can request a distribution from your Matching Contribution Account if you have reached age 59½. You can also take an in-service distribution at any time after you reach Normal Retirement Age.
- **Nonelective Contribution Account.** You can request a distribution from your Nonelective Contribution Account if you have reached age 59½. You can also take an in-service distribution at any time after you reach Normal Retirement Age.
- **Rollover Contribution Account.** You can request a distribution from your Rollover Contribution Account at any time.

Hardship Distributions

As long as you are an employee, you can take a distribution to pay for a financial hardship caused by one or more of the following circumstances:

- Unreimbursed expenses for medical care (or unreimbursed expenses necessary to obtain medical care) incurred by you, your spouse, your dependents, or the person named as your primary Plan

beneficiary, provided the expenses are the type that are considered tax deductible under the Internal Revenue Code.
- Costs related to the purchase of your principal residence (excluding mortgage payments).
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage of your principal residence.
- Tuition, related educational fees, and room and board, for up to the next 12 months of post-secondary education for you, your spouse, your children, other eligible dependents, or the person named as your primary Plan beneficiary.
- Funeral expenses for your parent, your spouse, your children, other eligible dependents, or the person named as your primary Plan beneficiary.
- Expenses for repair of damage to your principal residence that would qualify for a casualty deduction (without regard to whether the loss exceeds 10% of your adjusted gross income).

If you have one of the above expenses, a hardship distribution can only be made if the following rules are also satisfied:

- The hardship distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the hardship distribution.
- You must have taken any other distribution or participant loans available under this or any Plan maintained by us.

Hardship distributions can be taken from your 401(k) Contributions Account (excluding earnings).

You cannot make any 401(k) Contributions to the Plan for 6 months after you take a hardship distribution.

Loans to Participants

You are permitted to borrow from the Plan using an electronic authorization system available by contacting a Participant Services Representative at 800-724-7526 or on the website at www.workplace.schwab.com (see page 1). Loans will be made only to actively-employed participants in accordance with the Loan Policy established by the Administrator. Your vested account balance is used as security for the loan.

Loans will be made pursuant to the following terms:

- You may have a maximum of two loans outstanding at any time;
- The minimum amount of a loan is $1,000;
- The maximum amount of the loan, when added to the outstanding balance of all other loans from the Plan, is generally the *lesser* of 50% of your vested account balance or $50,000 (reduced by the excess of your highest outstanding loan balance during the prior 1-year period over the outstanding loan balance as of the day the loan is made);
- The loan term may not exceed 5 years, except that any loan used to purchase your principal residence may be repaid over a 20-year period;
- Loans are available from the vested portion of all of your accounts;
- The following loan fee will be charged to your account - $50.00 to establish the loan.

You will be charged a reasonable rate of interest on any loan that you take from the Plan. Loan proceeds are generally taken pro rata from investment funds in which your account balance is invested. All payments of principal and interest that you make on a loan will be credited to your account. Loan payments generally must be made through payroll deduction. If you fail to make payments when they are due under the loan terms, you will be considered to be in “default.” A loan in default may be treated as a distribution from the Plan, thus resulting in taxable income to you. In any event, your failure to repay a loan will reduce the benefit that you would otherwise be entitled to from the Plan.

Note that if you have an unpaid leave of absence or go on military leave while you have an outstanding loan, you may qualify for a suspension of loan payments. Upon termination of employment, all loans will

immediately become due and payable. If a loan is not repaid within a reasonable time following termination, it will be offset against your vested account balance.

The Administrator may periodically revise the Plan's loan policy. For further details on Plan loans, you may request a copy of the Loan Policy from the Administrator.

Investment of Accounts

Subject to an investment policy established by the Administrator, you can direct how your Account will be invested. You can choose from any investment options offered by the Plan. You can switch between investments as often as is permitted under the investment options you choose. All earnings and losses on your directed investments will be credited directly to your Account. Investment results will reflect any fees and investment expenses for the investments you select. You may request more information on fees associated with an investment option from the Administrator. At the appropriate time, we will provide you with more detailed information about the investment options offered by the Plan.

We intend to comply with Section 404(c) of the Employee Retirement Income Security Act of 1974. This means that if you are permitted to exercise independent control over the investment of your Account and you are offered a reasonably diverse selection of well managed investment options, then the fiduciaries of the Plan, including the Administrator and us, may be relieved of certain liabilities for any losses which occur because you exercise control.

Generally, you will receive a quarterly statement that contains information regarding your investment choice(s), any contributions received by the Plan during that quarter, your investment gains or losses, ending fund balances and your vested percentage.

Tax Withholding on Distributions

Due to the complexity and frequency of changes in the federal laws that govern benefit distributions, penalties and taxes, the following is only a brief explanation of the law and IRS rules and regulations as of the date this summary is issued. You will receive additional information from the Administrator at the time of any benefit distribution, and you should consult your tax advisor to determine your personal tax situation before taking the distribution.

Direct Rollovers Not Subject to Tax

Any eligible distribution that is directly rolled over to another eligible retirement account (either another qualified retirement plan or an individual retirement account) is not subject to income tax withholding. Generally, any part of a distribution from this Plan can be directly rolled over to another eligible retirement account unless the distribution (1) is part of a series of equal periodic payments made over your lifetime, or over the lifetime of you and your beneficiary, or over a period of 10 years or more; or (2) is a minimum benefit payment which must be paid to you by law. There are other distributions that are not eligible for direct rollover treatment, and you should contact the Administrator if you have questions about a particular distribution.

20% Withholding on Taxable Distributions

If you have your benefit paid to you and it's eligible to be rolled over, you only receive 80% of the benefit payment. The Administrator is required to withhold 20% of the benefit payment and remit it to the Internal Revenue Service as income tax withholding to be credited against your taxes. If you receive the distribution before you reach age 59½, you may also have to pay an additional 10% tax. You can still rollover all or a part of the 80% distribution that is paid to you by putting it into an IRA or into another qualified retirement plan within 60 days of receiving it. If you want to rollover 100% of the eligible distribution to an IRA or to another qualified retirement plan, you must find other money to replace the 20% that was withheld. You cannot elect out of the 20% withholding (1) unless you are permitted (and elect) to leave your benefit in this Plan, or (2) unless you have 100% of an eligible distribution transferred directly to an IRA or to another qualified retirement plan that accepts rollover contributions.

Claims Procedure

If you feel that you are entitled to a benefit that you are not receiving from the Plan, you can make a written request to the Administrator (or its delegate) for that benefit. Plan Benefits fall into two categories – Disability related benefits and non-Disability related benefits. A Disability-related benefit means a benefit that is available under the Plan and that becomes payable upon a determination of a Participant's Disability by the Administrator. A Disability-related benefit does not include a benefit that, under the terms of this Plan, becomes payable upon a determination of a Participant's Disability by the Social Security Administration or under a long term Disability plan sponsored by the Employer. The claims procedure for Disability-related benefits and non-Disability benefits are similar, but there are differences. While the claims procedure for each benefit is described below, this is just a summary, and the Administrator can supply you with a more detailed claims procedure.

Exhaustion of Remedies

No civil action for benefits under the Plan will be brought unless and until you have (1) submitted a timely claim for benefits in accordance with the provisions of this Section; (2) been notified by the Administrator that the claim has been denied; (3) filed a written request for a review of the claim in accordance with the applicable provisions of paragraphs (e) or (f) below; and (4) been notified in writing of an adverse benefit determination on review.

Grounds for Judicial Review

Any civil action will be based solely on your advanced contentions in the administrative review process, and the judicial review will be limited to the Plan document and the record developed during the administrative review process as set forth in this Section.

Written Claims

Any claim for benefits must be filed in writing with the Administrator, but the Administrator may permit the filing of a claim for benefits electronically as the Administrator complies with certain Department of Labor requirements.

Any Employee, Participant or Beneficiary who files a claim for benefits under the Plan is a "Claimant" under these claims procedures.

As a Claimant, you may authorize a representative to act on your behalf with respect to any claim under the Plan. The representative must provide satisfactory evidence to the Administrator of its authority to act on your behalf, such as a letter of authority with your notarized signature. To the extent consistent with the authority you grant to your representative, references to “you” or to "Claimant" in these claims procedures include your representative.

The Administrator may review claims under the Plan or may delegate that authority to an appropriate claims adjudicator. References in these claims procedures to the Administrator include any claims adjudicator acting on behalf of the Administrator. Benefit claim determinations shall be made based on the applicable provisions of the Plan document and any documents of general application that interpret the Plan provisions and are maintained by the Employer or the Administrator for purposes of making benefit determinations. The Administrator shall take such steps as are necessary to ensure and verify that benefit claim determinations are made in accordance with such documents and that the Plan provisions are being applied consistently with respect to similarly situated Claimants. All notices to Claimants will be written in a manner calculated to be understood by the Claimant.

Review of Non-Disability Benefit Claims

The provisions of this paragraph will apply if your claim for a benefit does not require a determination as to whether or not you are disabled or if a claim requires a Disability determination, but that determination is made outside the Plan for reasons other than determining eligibility for a Plan Benefit. Examples of this are where the Disability determination is based solely on whether you are entitled to disability benefits under either the Social Security Act or the Employer’s long term disability plan.

- **Initial Denial.** Whenever the Administrator decides for any reason to deny a claim in whole in part, the Administrator will give you a written or electronic notice of its decision within 90 days of the date the claim was filed, unless an extension of time is necessary or you voluntarily agree to an extension. If special circumstances require an extension, the Administrator will notify you before the end of the initial review period that additional review time is necessary. The notice for an extension (a) will specify the circumstances requiring a delay and the date that a decision is expected to be made; and (b) will describe any additional information needed to resolve any unresolved issues. Unless the Administrator requires additional information from you to process the claim, the review period cannot be extended beyond an additional 90 days unless you voluntarily agree to a longer extension or the Administrator determines that special circumstances require a further extension. If special circumstances require a further extension, the Administrator will notify you before the end of the extended review period that further additional review time is necessary and such notice will describe the special circumstances requiring a further delay and specify the date a decision is expected to be made. The Administrator cannot extend the review period beyond an additional 90 days unless you voluntarily agree to a longer extension. If the Administrator requires additional information from you to process the claim and a timely notice requesting the additional information is transmitted to you, it must be provided within 90 days of the date that the notice is provided by the Administrator.
- **Notice of Denial.** If your claim is denied, the notice will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; (e) a description of the Plan's review (i.e., appeal) procedures, the time limits applicable to such procedures, and in the event of an adverse review decision, a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (f) a statement that if you request a review of the Administrator's decision and the reviewing fiduciary's decision on review is adverse to you, there is no further administrative review following the initial review, and that you then have a right to bring a civil action under ERISA §502(a). The notice will also include a statement advising you that, within 60 days of the date on which you receive such notice, you may obtain review of the decision as explained in the next paragraph.
- **Right to Appeal.** Within the 60-day period beginning on the date you receive notice regarding disposition of your claim, you may request that the claim denial be reviewed by filing with the Administrator a written request for such review. The written request must contain the following information: (a) the date on which your request was received by the Administrator; (b) the specific portions of the denial of your claim which you request be reviewed; (c) a statement setting forth the basis upon which you believe the Administrator's denial of your claim should be reversed and your claim should be accepted; and (d) any other written information (offered as exhibits) which you want to be considered to explain your position, without regard to whether such information was submitted or considered in the initial benefit determination.
- **Review on Appeal.** In general, your appeal will be reviewed within 60 days of the date it is received by the Administrator (unless special circumstances require an extension to 120 days and you are so notified before the end of the 60-day review period). The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial determination. The decision on review will contain the following: (a) the specific reasons for the denial on review; (b) reference to specific Plan provisions on which the denial is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; (d) a statement describing any voluntary review procedures and your right to obtain copies of them; and (e) a statement that there is no further administrative review of decision and that you have a right to bring a civil action under ERISA §502(a).

Participants Absent Because of Military Duty

Participants Who Die During Military Absence

If you are absent from employment with us because of military service and you die on or after January 1, 2007 while you are performing "qualified" military service (as defined under the Internal Revenue Code), you will be treated as having returned to employment on the day before your death for Vesting purposes. However, you will not be entitled to any additional benefits or contributions with respect to your period of military leave.

Qualified Reservist Distributions

A Qualified Reservist Distribution may be made to a Participant who is a Qualified Reservist under any circumstance and/or for any reason. A Qualified Reservist Distribution is any distribution of 401(k) Contributions to a Qualified Reservist that is made during the period beginning on the date the Qualified Reservist is ordered or called to active duty and ending on the last day of active duty. A Qualified Reservist is an individual who is a member of a reserve component and is called to active duty after September 11, 2001 either for a period in excess of 179 days or for an indefinite period.

A Participant who is a Qualified Reservist may request a Qualified Reservist Distribution on or after the date of the order or call to active duty and before the last day of the Plan Year during which the order or call to active duty occurred. The Administrator must receive a copy of the order or call to active duty prior to any amounts being distributed. The Administrator may rely on the order to determine the period that the Qualified Reservist has been ordered or called to active duty. The Qualified Reservist is eligible for a Qualified Reservist Distribution if the order specifies a period of 180 or more days. It does not matter if the actual period of active duty is less or otherwise changed. A Qualified Reservist will be eligible for a Qualified Reservist Distribution if the original order or call is less than 180 days and subsequent calls or orders increase the total period of active duty to 180 or more days.

Qualified Reservist Distributions are not subject to the 10% early withdrawal penalty tax. In addition, at any time during the two-year period beginning on the day after the last day of the Qualified Reservist's active duty, a Qualified Reservist who has received one or more such distributions may make one or more repayment contributions to an IRA, up to the total amount of the Qualified Reservist Distributions, and the dollar or compensation limitations that apply to contributions to an IRA do not apply to these repayments. However, you will not receive any tax deduction for repayment of Qualified Reservist Distributions to an IRA.

Active Duty Severance Distributions

If you are absent from employment with us while you are on active military duty for a period of more than 30 days, you are considered to have terminated employment with us and you can therefore elect to take a distribution of some or all of your vested Contribution Accounts. Some restrictions apply (for example, if you take a distribution from your 401(k) Contributions Account, you cannot make additional 401(k) Contributions for a period of 6 months after the distribution), and you should consult the Plan Administrator in the event you are interested in taking such a distribution.

Other Information

Addition of Dividend or Income Payment Allocated Among Participants

When dividends or income payments are allocated among Participant accounts, and the pro rata allocation of such payment would result in the allocation of less than $25 to a Terminated Participant who had previously taken a final distribution, then such Terminated Participant will not receive the allocation. Such amount will be deposited to the Trust and the Plan Administrator (or its delegate) will allocate all such amounts on a pro rata basis to the other Participants receiving such dividend or income payment.

Attachment of Your Account

Your creditors cannot garnish or levy upon your Account except in the case of a proper IRS tax levy, and you cannot assign or pledge your Account except as collateral for a loan from the Plan or as directed through a Qualified Domestic Relations Order (QDRO) as part of a divorce, child support or similar proceeding in which a court orders that all or part of your Account be transferred to another person (such as your ex-spouse or your children). The Plan has a procedure for processing QDROs, which you can obtain free of charge from the Administrator.

Amendment or Termination of the Plan

Although we intend for the Plan to be permanent, we can amend or terminate it at any time. If we do terminate the Plan, all Participants will have a 100% Vested Interest in their Accounts as of the Plan termination date, and all Accounts will be available for distribution at the same time and in the same manner as would have been permissible had the Plan not been terminated.

Accounts Are Not Insured

Your Account is not insured by the Pension Benefit Guaranty Corporation (PBGC) because the insurance provisions of ERISA do not apply to 401(k) plans. For more information on PBGC coverage, ask the Administrator or contact the PBGC. Written inquiries to the PBGC should be addressed to: Technical Assistance Division, PBGC, 1200 K Street NW, Suite 930, Washington, D.C. 20005-4026. You can also call them at (202) 326-4000.

Payment of Plan Expenses

The Plan routinely incurs expenses for the services of lawyers, actuaries, accountants, third party administrators, and other advisors. Some of these expenses may be paid directly by us while other expenses may be paid from the assets of the Plan. The expenses that are paid from Plan assets will be shared by all Participants either on a pro-rata basis or an equal dollar basis. If the expense is paid on a pro-rata basis, an amount will be deducted from your Account based on its value as compared to the total value of all Participants' Accounts. For example, if the Plan pays $1,000 of expenses and your Account constitutes 5% of the total value of all Accounts, $50 would be deducted from your Account ($1,000 x 5%) for its share of the expense. On the other hand, if the expense is paid on an equal dollar basis, the expense is divided by the number of Participants and then the same dollar amount is deducted from each Participant's Account.

Statement of ERISA Rights

Your Right To Receive Information

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants are entitled to (a) examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration; (b) obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Administrator. The Administrator may make a reasonable charge for the copies; (c) receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report; and (d) obtain a statement telling you whether you have a right to receive a pension at Normal Retirement Age (which is defined elsewhere in this summary plan description) and if so, what your benefits would be at Normal Retirement Age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Duties of Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 and 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 pension benefit or exercising your rights under ERISA.

Enforcement of Rights

If your claim for a pension 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 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 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, you may file suit in Federal 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 U.S. 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, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Administrator. If you have questions about this statement or about your ERISA rights, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or contact them at http://www.dol.gov/ebsa/aboutebsa/org_chart.html or at the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You can call the Employee Benefits Security Administration (the EBSA) at (866) 444-3272; **TTY/TDD users:** (877) 889-5627. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. You may also obtain additional pension-related information at the Department of Labor's website at http://www.dol.gov/ebsa/publications/wyskapr.html where you can review a publication called "*What You Should Know About Your Retirement Plan*."

Other Account Questions?

Call 800-724-7526 to talk to a Participant Services Representative Monday through Friday, 7:00 a.m. – 11:00 p.m. ET.

Glossary

Many definitions are used in this summary and most are defined in the section in which they appear, but the following terms have broader application and are used throughout the summary:

Account

Your Account represents the aggregate value of the contributions made to the Plan on your behalf, as well as the net earnings on those contributions. Your Account may include (but is not limited to) the following sub-accounts: the 401(k) Contribution Account; the Matching Contribution Account; and the Nonelective Contribution Account.

Allocation Period

The Allocation Period is the period of time for which a contribution to the Plan is allocated. The Allocation Period is generally the Plan Year but can be a shorter period of time.

Disability

Disability is a physical or mental impairment you suffer after you become a Participant in the Plan (and while you are still an employee) which, in the opinion of the insurance company, qualifies you for benefits under an Employer-sponsored long-term disability plan which is administered by an independent third party (or qualifies you for disability benefits under the Social Security Act if no such long-term disability plan exists on the date you suffers the mental or physical impairment).

Foreign Compensation

Foreign Compensation, in general, is compensation paid to a Non-Resident Alien Employee who is not a Participant in the Plan.

Fringe Benefit Payments

Fringe Benefit Payments, in general, are reimbursements or other expense allowances, cash and noncash fringe benefits, moving expenses, deferred compensation, and welfare benefits.

Key Employee

A Key Employee is an Employee who satisfies certain executive, ownership, or compensation requirements as set forth in the Internal Revenue Code.

Merger and Acquisition Employee

A Merger and Acquisition Employee is, generally, an individual who becomes, or ceases to be, an Employee as a result of a merger of acquisition.

Nonelective Contribution

A Nonelective Contribution is an additional type of contribution we may elect to make to the Plan for any Plan Year. Nonelective Contributions are generally made as a percentage of pay.

Non-Resident Alien Employee

A Non-Resident Alien Employee is an individual who is neither a citizen of the United States of America nor a resident of the United States of America and who does not receive earned income from the Employer which constitutes income from sources within the United States.

Normal Retirement Age

Normal Retirement Age is the date you reach age 65.

Spouse

The term “spouse” or “marriage” should be read to include either opposite or same-gender couples legally married in any state, U.S. territory or foreign jurisdiction that recognizes such marriages, regardless of where you currently live. However, a registered domestic partnership, civil union or similar relationship recognized under state law is not considered a “marriage” for purposes of this retirement plan.

Vested Interest

Your Vested Interest is the percentage of your Account to which you are entitled at any point in time. This percentage, in turn, is the aggregate of your Vested Interest in your various sub-accounts. However, notwithstanding any vesting schedule set forth in other sections of this summary, you will have a 100% Vested Interest in your Account upon reaching Normal Retirement Age, or upon your death or Disability while you are still a Participant but before you terminate employment.

Appendix A. Additional Nonelective Contributions

With respect to Participants who are employed by UT-Battelle LLC, we may make another Nonelective Contribution in addition to the one previously described in this summary for each Participant who is eligible, as described below.

How the Contribution Is Determined

These contributions are totally discretionary on our part, as is the amount should we decide to make them.

How You Become a Participant

To become a Participant with respect to this contribution, you must satisfy the following criteria (described in more detail below): (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable entry date.

- **Eligible Employees.** All employees of UT-Battelle LLC are Eligible Employees with respect to this contribution except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Individuals who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; and (e) employees covered by a collective bargaining agreement which does not allow for their participation in the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant as soon as administratively feasible after the date that you are hired.

How You Qualify for a Contribution Allocation

Once you become a Participant with respect to this contribution, you are eligible for a contribution for any Plan Year in which we make one if you satisfy the requirements (if any) described below for that Plan Year. These contributions are allocated to your Nonelective Contribution Account.

- **Active Participants.** If you are still employed by us on the last day of a Plan Year, you will be eligible to receive an allocation if you are credited with at least 1,000 Hours of Service during the Plan Year.
- **Terminated Participants.** If you terminate employment for any reason before the last day of the Plan Year, you will not be eligible to receive an allocation regardless of your service during the Plan Year.

How the Contribution Is Allocated

This contribution is allocated in the ratio that your Compensation for the Plan Year bears to the total Compensation of all Participants eligible to receive an allocation for the Plan Year. This means that the amount allocated to each eligible Participant's Nonelective Contribution Account will, as a percentage of Compensation, be the same. For example, if the contribution is equal to 5% of all eligible Participants' Compensation, then that is the amount that will actually be allocated to each eligible Participant's Nonelective Contribution Account.

How Your Compensation Is Determined

In general, the amount of any contribution described in this Appendix that is made on your behalf is based on all of the compensation that is paid or made available to you during the Plan Year, excluding any compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) as shift differential. However, no contributions will be made with respect to Compensation in excess of the annual dollar limit on Compensation, which is announced annually by the IRS (and is $280,000 for the 2019 calendar year).

How Your Vested Interest Is Determined

1 Year of Vesting Service	0% Vested
2 Years of Vesting Service	0% Vested
3 Years of Vesting Service	100% Vested

Your Vested Interest in your Nonelective Contribution Account is determined by the schedule following this paragraph, based on your Years of Vesting Service (including Service with us; with Wackenhut Service, Inc. (Oak Ridge, TN) to the extent that such service was counted as service under the NSPS OR-BU 401(k) Retirement Plan, but only for Employees whose first date of employment with the Employer is December 31, 2018; and with National Strategic Protective Services, LLC, but only with respect to former employees of National Strategic Protective Services, LLC who became Employees of the Employer on December 31, 2018). Any part of this account which is not Vested will be forfeited when you receive a distribution (or after you incur 5 consecutive Breaks in Vesting Service, if earlier).

13. Administrative Information

This chapter contains information on the administration and funding of the plans described in this book as well as your rights as a plan participant. 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.

Participation in any of the Company's benefit plans should not be viewed as a contract of employment.

Plan Sponsor and Administrator

UT-Battelle, LLC, is the sponsor, the named fiduciary, 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 terms of the plans; determine eligibility for entitlement to plan benefits; and 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, which 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 employees of the Company, including those represented by collective bargaining units to the extent 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 Plans” chapter.

For information on review and appeal procedures for dental plan claims, see the “Dental Plans” chapter.

Disability Claims Review and Appeal Procedures

This subsection applies to disability claims filed under the Long-Term Disability Plan and Short-Term Disability Plan. For any claims or appeals relating to a disability determination under another plan under the Employee Retirement Income Security Act of 1974 (ERISA), please contact the carrier for a detailed summary of its disability claims procedures.

Disability Claims Appeal

You or an authorized representative may file claims for plan benefits and appeal adverse claim decisions. An “authorized representative” is 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. You must exhaust all administrative remedies before filing an action to recover benefits.

Notice of Adverse Benefit Determination for a Disability Claim

You will be notified of the plan’s benefit determination not later than 45 days after the plan’s receipt of the claim. The period may be extended up to an additional 30 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 45 day period. If a decision cannot be made within this 30 day extension period due to circumstances outside the plan’s control, the period may be extended up to an additional 30 days, in which case you will be notified of the additional extension before the end of the initial 30 day extension. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

Notification of Disability Claim Decision

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;
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);
5. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   - the views presented by you to the plan of health care professional treating you and vocational professionals who evaluated you;
   - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
   - a disability determination regarding you presented by you to the plan made by the Social Security Administration;

6. either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;(Applies only if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit);
7. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
8. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit.

Disability Claim Appeal of an Adverse Benefit Determination

To have your claim reconsidered, you must file an appeal of an adverse benefit determination for a disability claim. The appeal must be submitted in writing to the Claims Administrator. You will have 180 days following receipt of an adverse benefit determination to appeal the decision.

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 to you, free of charge, copies of all documents, records, and other information relevant to the claim.

The plan's review on appeal shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The appeal will be conducted by an "Appeals Fiduciary" appointed by the Claims Administrator to review your claim. The Appeals Fiduciary shall not be the individual or committee who made the initial Adverse Benefit Determination or a subordinate of that individual or committee.

The assigned Appeals Fiduciary will not give deference to the initial benefit determination and will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. If the Adverse Benefit Determination on the initial claim determination was based on a medical judgment, the Appeals Fiduciary will consult with a health care professional who has appropriate training and experience in the medical field. This health care professional will not be an individual who was consulted in connection with the initial benefit determination, nor will it be the subordinate of any such individuals.

Before the plan can issue an adverse benefit determination on review, the plan shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the plan can issue an adverse benefit determination on review based on a new or additional rationale, the plan shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

You ordinarily will be notified of the decision no later than 45 days *after the appeal is received.* If special circumstances require an extension of up to an additional 45 days, you will be notified of such extension during the 45 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.

Notification of Disability Claim Decision on Appeal

If your appeal seeking reconsideration of the denied claim under the plan is denied again 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. information indicating 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;
3. your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (where applicable);
4. notification of your option to have a second--level appeal review;
5. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   - the views presented by you to the plan of health care professional treating you and vocational professionals who evaluated you;
   - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
   - a disability determination regarding you presented by you to the plan made by the Social Security Administration,
6. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request, and
7. either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist.

Second Disability Claim Appeal of an Adverse Benefit Determination in the Disability Plans

To file an appeal of an adverse first Appeal Benefit Determination, you must, within 60 days of receiving the determination, notify the Plan Administrator that you wish to appeal again. This level of appeal is optional. You have the right to submit written comments, documents, records, and other pertinent information with your second-level appeal. You also will be given, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The Plan Administrator will notify you of the benefit determination on the second appeal within 45 days, unless special circumstances require an extension of up to 45 additional days for processing the appeal. If an extension is required, the Plan Administrator will notify you before the expiration of the initial 45 day period and will indicate the special circumstances that require an extension of time and will include the date by which the Plan Administrator will make its determination on appeal.

Notification of Disability Claim Decision on Second Appeal

If your appeal seeking reconsideration of the denied claim under the plan is denied again in whole or in part, you will receive written or electronic notification that will include ~~:~~similar information to what was received on the first appeal.

Other Claims Review and Appeal Procedures (Non-Health and Non-Disability Claims)

Other Claims Appeal

You or an authorized representative may file claims for plan benefits and appeal adverse claim decisions. An "authorized representative" is 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 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 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 ordinarily will be notified of the decision no later than 60 days *after the appeal is received.* If special circumstances require an extension 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.

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 with reference to the specific plan provisions on which that decision is based;
2. information indicating 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. an explanation of 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 also may 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 while you are an employee of the Company, you will become immediately vested 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

A few special provisions apply only to the Savings Plan and Pension Plan.

Maximum Benefits

Federal tax laws impose certain limitations on the benefits and contributions under qualified retirement plans. These limitations generally apply only to highly compensated employees. You will be notified if these limitations apply to you. More information is available from the ORNL Benefits Office.

Top-Heavy Provisions

Under current tax law, the Pension Plan and Savings Plan are required to contain provisions that apply in the event a significant portion of the plan's benefits are payable to highly compensated employees. These provisions—called "top-heavy" rules—provide for accelerated vesting of plan benefits and certain minimum benefit accruals in the event the plans become top-heavy. The plans are not top-heavy now. Therefore, the top-heavy rules are not likely to affect your benefits under the plans.

A more detailed explanation of the provisions will be provided if and when these plans become top-heavy.

Loss of Retirement Benefits

Other than failing to meet the age and service requirements for a benefit, there are no plan provisions that would cause you to forfeit your Pension Plan benefits. Under the Savings Plan, you are always 100% vested in your own contributions, and you become 100% vested in Company matching contributions after

you complete 3 years of credited service. After 3 years of credited service, you are fully vested in your Company matching contributions in the Savings Plan, but the investment choices you make will affect that balance.

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

1. benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
2. 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;
3. benefits that are not vested because you have not worked long enough for the Company;
4. benefits for which you have not met all of the requirements at the time the plan terminates;
5. 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
6. non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your 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.

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 QDRO to someone else.

A domestic relations order must meet specific requirements to be recognized by the Plan Administrator as a QDRO, and specific procedures regarding the amount and timing of payments must be followed. 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 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 for 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	Company	Benefits are funded through group annuity contracts and assets in separate investment

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
						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	Employee/ Retiree and Company	Benefits are paid from an insurance contract
Business Travel Accident	511	Welfare	Calendar	Zurich	Company	Benefits are paid from an insurance contract
Special Accident Insurance	511	Welfare	Calendar	Life Insurance Company of North America	Employee	Benefits are paid from an insurance contract
Health Benefits (Medical, Dental, Vision)	510	Welfare	Calendar	UnitedHealthcare—Medical MetLife—Dental Delta Dental Plan of Ohio—Dental Vision Service Plan (VSP)—Vision Care	Employee/Retiree and Company	Benefits are paid (through a claims administrator) from employee contributions and general assets of the Company
Prescription Drug Plan	510	Welfare	Calendar	Express Scripts	Employee/Retiree and Company	Benefits are paid (through the Express Scripts claims administrator) from employee contributions and general assets of the Company
Cafeteria Plan – including the Flexible Spending Plans	510	Welfare	Calendar	Dependent Care Flexible Spending Account Health Care Flexible Spending Account Pre-tax Medical and Dental Premium Programs	Employee (Pre-tax Contributions)	Benefits are paid (through a claims administrator) from employee contributions and general assets of the Company
Long-Term Disability Plan	511	Welfare	Calendar	Hartford	Company	Benefits are paid (through the Aetna claims administrator) from general assets of the Company

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Short-Term Disability Plan	511	Welfare	Calendar	Hartford	Company	Benefits are paid (through the Aetna claims administrator) from general assets of the Company
Employee Assistance Plan	510	Welfare	Calendar	Magellan Behavioral Health	Company	Company
Education Assistance Program	511	Welfare	Calendar	Company	Company	Company
Legal Insurance	511	Welfare	Calendar	ARAG	Employee	Benefits are paid from an insurance contract

Your Rights Under COBRA

You and your Qualified Beneficiaries covered under a group health plan (one of the Medical or Dental plans) or the health care spending account 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 your 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 Cobra Continuation Period chart later in this section causes you or an eligible dependent to lose coverage under one of the group health plans, you and/or the eligible dependent, as the case may be, are a “Qualified Beneficiary” with respect to such group health plan.

Each Qualified Beneficiary independently may elect to continue coverage under such a group plan. Covered employees 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 also is a Qualified Beneficiary entitled to COBRA coverage.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the Qualifying Event outlined in the COBRA Continuation Period chart that follows. You may continue to participate in the health care spending account only through the end of the year in which the Qualifying Event occurs.

When the Qualifying Event is the death of an employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child’s loss of eligibility as an eligible dependent child, COBRA continuation coverage lasts for up to 36 months. When the Qualifying Event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which the 18 month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under a group health plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of the disability determination and before the close of the initial 18 month period of continuation coverage, each Qualified Beneficiary is entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18 month period of continuation coverage.

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and other eligible dependents in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. These exceptions are valid only if the event would have caused the spouse or dependent child to lose coverage under the group health plan had the first Qualifying Event not occurred.

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 if 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.

COBRA Continuation Period

Qualifying Event (if accompanied by a loss of coverage)	Maximum Continuation Period		
	You	**Spouse**	**Child**
Your hours of employment are reduced	18 months	18 months	18 months
You terminate for any reason (except gross misconduct)	18 months	18 months	18 months
You or any Eligible Dependent who is a Qualified Beneficiary is determined to be disabled at any time during the first 60 days of COBRA coverage	29 months	29 months	29 months
You die	N/A	36 months*	36 months*
You and your spouse legally separate or divorce	N/A	36 months	36 months
You become entitled to Medicare (Part A or B, or both)	N/A	36 months	36 months
Your child no longer qualifies as an Eligible Dependent	N/A	N/A	36 months

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

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 makeup contributions you missed from the first day of the COBRA coverage.

- If COBRA is elected, the coverage previously in effect generally will be continued, including the amount of health care spending account contributions.
- 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 during annual enrollment or if you experience a Qualifying Event, as described in the "About Your Benefits" chapter.

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.
- Health care spending account contributions can be continued on an after-tax basis, plus the 2% administrative charge.
- 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%.

The Trade Act of 2002 created a 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 this tax provision, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance including continuation coverage.

If you have questions about these 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

The ORNL Benefits Office will notify you by mail of your COBRA election rights when the Qualifying Event is a reduction in hours or termination of employment. You will receive instructions on how to continue your health care benefits under COBRA.

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 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.

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 after you elect COBRA (providing the other plan does not have preexisting

condition limitations affecting the covered person; if the other plan has such limitations, COBRA coverage will end when those limitations expire);
- you or your eligible dependent becomes entitled to Medicare after you elect COBRA;
- 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 Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment concerning an Employee's military leave. These requirements apply to medical and dental coverage for you and your dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death and Dismemberment coverage you may have.

A military leave is a leave due to performance of duty on a voluntary or involuntary basis; military leave includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

For military leaves of less than 31 days, coverage will continue, and you are not required to pay more than the active contribution rate. For military leaves of 31 days or more, you may continue coverage for yourself and your dependents by paying 102% of the total premium, until the earliest of the following:

- 24 months from the last day of employment with the Employer,
- the day after you fail to return to work, or
- the date the policy cancels.

Regardless of whether you continue your health coverage, if you return to your position of employment, your health coverage and that of your eligible dependents (if any) will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

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 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 Administration;
- obtain copies of all plan documents and other plan information, including insurance contracts and 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); and
- 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.

In addition, once every 12 months, you may request information concerning the total value of your Savings Plan accounts and a statement as to what amount (if any) of the Company contributions to your Savings Plan account is then vested (or the earliest date on which it will become vested).

Similarly, once each year, you may request information concerning your vested rights under the Pension Plan (or, if you are not vested, the earliest date on which you become vested), and what your benefit would be at normal retirement age if you stopped working under the plan now. This information is free, but you must address a written request for it to the Plan Administrator or, for Savings Plan information, call the information line.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse, and/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 free certificate of creditable coverage 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 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 and 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. To file suit in a state or federal court concerning: (1) a claim for a benefit, (2) the qualified status of a domestic relations order or medical child support order, or (3) your service credit, you must file the 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 the suit within this 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 (for example, if 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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. Contact Information

For all your benefit questions, call ...	
ORNL Benefits Service Center https://portal.adp.com 1-800-211-3622	ORNL Benefits PO Box 2008, MS 6465 Oak Ridge, TN 37830-6465 1-865-574-7474 Toll Free: 1-865-576-7766 Fax: 1-865-241-3213 E-mail: ornlbenefits@ornl.gov

Benefit	Plan Provider	Contact Information
Medical—UnitedHealthcare Plans	UnitedHealthcare	**Member Services** 1-844-234-7925
		To file a claim, mail your completed claim form to the address shown on your UnitedHealthcare ID card.
		Website www.myuhc.com
Hospital Precertification (for the UnitedHealthcare Indemnity Plan)	UnitedHealthcare	**Member Services** 1-844-234-7925
Prescription Drugs	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
Vision	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

Benefit	Plan Provider	Contact Information
Dental	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
Employee Assistance Program	Magellan	**Member Services** 1-800-888-2273 TTY Service 1-800-456-4006
		Website www.Magellanascend.com
Disease Management Program Clinical support for specific chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure	UnitedHealthcare	**Disease Management Program** 1-844-234-7925
Flexible Spending Accounts	WageWorks	**Member Services** 1-888-557-3156
		To file a claim for reimbursement, mail your claim to: WageWorks Spending Accounts PO Box 34700 Louisville, KY 40232
		Fax Number 1-866-643-2219
		Website https://myspendingaccount.WageWorks.com/
		To order a comprehensive list of deductible expenses, contact: Internal Revenue Service 1-800-829-3676 or www.irs.gov
Long-Term and Short-Term Disability	Hartford	**Member Services** 1-800-882-2894
		Mailing Address Hartford PO Box 14560 Lexington, KY 40512-4560
		Fax Number 1-866-667-1987

Benefit	Plan Provider	Contact Information
Life Insurance	MetLife	**Statement of Health Unit** 1-800-638-6420, prompt 1
		For Life Insurance Conversion Information 1-877-275-6387
Legal Insurance w/ Identity Theft Protection	ARAG	**Member Services** 1-800-247-4184 Website www.ARAGLegalCenter.Com Access Code 18095or
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, MS 6434 Oak Ridge, TN 37831
		Member Services United States: 1-800-724-7526 International: 1-330-908-4777 TTY Service: 1-800-345-2550
		Website www.workplace.schwab.com
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	WageWorks	**Member Services** 1-800-526-2720
		Mailing Address WageWorks, Inc. P.O. Box 34740 Louisville, KY 40232-4740
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 Benefit Billing Department P.O. Box 2239 Omaha, NE 68103-2239
Social Security Administration		**Toll-Free Number** 1-800-772-1213
		Oak Ridge Office 1-800-999-1118