YOUR BENEFITS SUMMARY PLAN DESCRIPTION

RETIREES

ORNL BENEFITS

OAK RIDGE National Laboratory

EFFECTIVE 01/01/2024

Contents

1. About Your Benefits

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

Highlights

Your Benefits …

… Offer Medical and Dental Coverage for You and Your Family

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

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

… Allow You to Continue Your Life Insurance Coverage

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

… Provide You With Retirement Income

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

Eligibility and Cost

Determining Eligibility and Cost

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

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

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

Company Service Date prior to April 1, 2012

For Salaried and ATLC Bargaining Unit Employees:

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

Benefit Plan	Eligible?	Cost
Medical (including Prescription Drugs and Vision Care) (for retirees under age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	Cost shared by you and the Company
If you were classified as a full-time employee for less than 10 years when you retired	Yes	You pay full cost
Dental (for retirees under age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	Cost shared by you and the Company
If you were classified as a full-time employee for less than 10 years when you retired	Yes	You pay full cost
Over 65 Medicare Supplement Program (for retirees over age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	Cost shared by you and the Company
If you were classified as a full-time employee for less than 10 years when you retired	Yes	You pay full cost
Long-Term Care (for current plan participants)	Yes	You pay full cost

Company Service Date prior to April 1, 2012		
Basic Life Insurance	Limited (cost and eligibility are based on the chart in the Life Insurance chapter)	
Supplemental Life Insurance	Limited (cost and eligibility are based on the chart in the Life Insurance chapter)	
Pension Plan (participation will automatically continue until you die, or until your survivor dies if you have elected a form of payment that provides a survivor benefit; you are not required nor may you make participant contributions after retirement)	Yes	If you retired on or before January 1, 2013, the Company pays the full cost. Employee contributions began on January 1, 2013, for salaried employees and on October 1, 2013, for bargaining unit employees; these contributions are reflected as a non-taxable portion of your monthly pension payment.
Savings Plan (provided you have a deferred account balance, you may retain your account. However, you cannot make contributions to the Savings Plan after retirement)	Yes	NA

Company Service Date on or after April 1, 2012

For Salaried and ATLC Bargaining Unit Employees:

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

Benefit Plan	Eligible?	Cost
Medical (including Prescription Drugs and Vision Care) (for retirees under age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	You pay full cost
If you were classified as a full-time employee for less than 10 years when you retired	No	NA
Dental (for retirees under age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	You pay full cost
If you were classified as a full-time employee for less than 10 years when you retired	No	NA
Over 65 Medicare Supplement Program (for retirees over age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	You pay full cost
If you were classified as a full-time employee for less than 10 years when you retired	No	NA

Company Service Date on or after April 1, 2012		
Basic Life Insurance	Coverage for salaried employees ends at retirement but may be converted (see the Life Insurance chapter). Coverage for Bargaining Unit employees is limited (Cost and eligibility are based on the chart in the Life Insurance chapter).	
Supplemental Life Insurance	Coverage ends at retirement but may be converted (see the Life Insurance chapter).	
Pension Plan (participation will automatically continue until you die, or until your survivor dies if you have elected a form of payment that provides a survivor benefit; you are not required nor may you make participant contributions after retirement)	Yes	If you retired on or before January 1, 2013, the Company pays the full cost. Employee contributions began on January 1, 2013, for salaried employees and on October 1, 2013, for bargaining unit employees; these contributions are reflected as a non-taxable portion of your monthly pension payment.
Savings Plan (provided you have a deferred account balance, you may retain your account. However, you cannot make contributions to the Savings Plan after retirement)	Yes	NA

Company Service Date prior to August 15, 2016		
For IGUA Bargaining Unit Employees If your company service date is prior to August 15, 2016, you retired under the Company's Pension Plan, and you participated in the benefit plan immediately prior to your retirement, then your eligibility and cost are described below.		
Benefit Plan	**Eligible?**	**Cost**
Medical (including Prescription Drugs and Vision Care) (for retirees under age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	Cost shared by you and the Company
If you were classified as a full-time employee for less than 10 years when you retired	Yes	You pay full cost
Dental (for retirees under age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	Cost shared by you and the Company
If you were classified as a full-time employee for less than 10 years when you retired	Yes	You pay full cost
Over 65 Medicare Supplement Program (for retirees over age 65)		
If you were classified as a full-time employee for at least 10 years when you retired	Yes	Cost shared by you and the Company

Company Service Date prior to August 15, 2016		
If you were classified as a full-time employee for less than 10 years when you retired	Yes	You pay full cost
Basic Life Insurance	Limited (cost and eligibility are based on the information in the Life Insurance chapter)	
Supplemental Life Insurance	Limited (cost and eligibility are based on the information in the Life Insurance chapter)	
Pension Plan (participation will automatically continue until you die, or until your survivor dies if you have elected a form of payment that provides a survivor benefit; you are not required nor may you make participant contributions after retirement)	Yes	If you employed before August 15,2016, the Company pays the full cost.
Savings Plan (provided you have a deferred account balance, you may retain your account. However, you cannot make contributions to the Savings Plan after retirement)	Yes	NA

Company Service Date on or after August 15, 2016

For IGUA Bargaining Unit Employees

If your company service date is on or after August 15, 2016, you retired and you participated in the benefit plan immediately prior to your retirement, then your eligibility and cost are described below.

Benefit Plan	Eligible?	Cost
Medical (including Prescription Drugs and Vision Care) (for retirees under age 65)		
If you were age 50 or older and classified as a full-time employee for at least 10 years when you left the company	Yes	You pay full cost
If you were classified as a full-time employee for less than 10 years when you left the company	No	NA
Dental (for retirees under age 65)		
If you were age 50 or older and classified as a full-time employee for at least 10 years when you left the company	Yes	You pay full cost
If you were classified as a full-time employee for less than 10 years when you left the company	No	NA
Over 65 Medicare Supplement Program (for retirees over age 65)		
If you were age 50 or older and classified as a full-time employee for at least 10 years when you left the company	Yes	You pay full cost

Company Service Date on or after August 15, 2016		
If you were classified as a full-time employee for less than 10 years when you left the company	No	NA
Basic Life Insurance	Coverage Ends at retirement but may be converted (see the Life Insurance chapter).	
Supplemental Life Insurance	Coverage ends at retirement but may be converted (see the Life Insurance chapter).	
Pension Plan (participation will automatically continue until you die, or until your survivor dies if you have elected a form of payment that provides a survivor benefit; you are not required nor may you make participant contributions after retirement)	No	NA
Savings Plan (provided you have a deferred account balance, you may retain your account. However, you cannot make contributions to the Savings Plan after retirement)	Yes	NA

Medical and Dental Plans Coverage Rules

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

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

- You must be covered in the plan for a spouse or child to be covered as your dependent.
- If your spouse is an active UT-Battelle employee and eligible for health care benefits you may enroll as a dependent under your spouse's active employee plan. (If you previously carried the coverage for both of you, your spouse has the opportunity to establish coverage under his or her name at the time of your retirement.) If you enroll in your spouse's active plan, you will be eligible to later enroll in this plan (if you are under age 65) within 30 days of your spouse losing coverage.
- If you currently have active employer coverage from another source (such as coverage under your spouse's medical plan), you may later enroll in the Medical and/or Dental Plans if you lose coverage under that employer's plan. You must show proof of loss of coverage and enroll within 30 days of the date you lose coverage.
- If your spouse is over age 65, your spouse (and other eligible dependents) may continue participating in the Medical and/or Dental Plans until you reach age 65. Your spouse must be enrolled in Medicare Part A and Part B **(but not Part D)**. Medicare will pay eligible medical expenses as primary payer for your spouse.
- If you and your spouse both retire from ORNL and you are both under 65, you can either enroll in the plan separately or together. If you are enrolled separately, at the time the older retiree becomes eligible for Medicare, they can be added to the under 65 retiree plan as the spouse of the younger retiree or enroll in the Over 65 Medicare Supplement Program.
- If you and your spouse both work or worked for the Company and are eligible to participate in the Company's benefit plans (whether in the active plan or the retiree plan), you may enroll in the plan as a retiree, or you may be enrolled as a spouse. However, you may not enroll for coverage as a retiree and as a spouse. In addition, only one of you may enroll your eligible dependent children regardless of whether it is in the active or retiree plan.

Over Age 65 Medical and Dental Plans

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

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

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

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

Eligibility for Dependents

Medical and Dental Eligibility for Your Dependents

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

For your spouse:

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

For your dependent children:

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

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

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

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

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

When You May Change Your Elections

When You May Change Your Elections

You can drop your medical, dental, or group life coverage at any time by notifying the ORNL Benefits Service Center. If you get divorced, have a spouse or dependent pass away or have a dependent that ceases to meet the eligibility requirements, you must notify us within 30 days. You must have a Qualifying Life Event to add coverage.

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

Qualifying Life Events

An individual may make a mid-year election change to add coverage for a spouse or dependent in very limited circumstances when it is because of and consistent with a Qualifying Life Event. Retirees may add a new spouse or dependent child as a result of marriage or a new child as a result of birth, adoption or placement for adoption. A rehired retiree who is participating in the plan may add a spouse or dependent who has a loss of other group health coverage, becomes eligible for assistance under Medicaid or CHIP, or losses eligibility for Medicaid or CHIP.

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

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

How Changes Affect Your Benefits

Steps to Take If You Get Married

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

Notify the Social Security Administration of any name changes.

Change your benefit elections within 30 days of your marriage.

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

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

Steps to Take If You Get Divorced

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

Notify the Social Security Administration of any name changes.

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

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

Add your eligible dependents to your medical and dental coverage if a court establishes that you must provide coverage for dependent children and you are eligible for a plan that covers dependent children.

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

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

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

Steps to Take If You Are Expecting or Adopting a Child

If You or Your Spouse is Pregnant …

Both men and women should contact the ORNL Benefits Office and ask about the steps you need to take and deadlines you need to meet to add your baby to your coverage. This will help you maximize your available benefits.

Schedule prenatal appointments.

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

When Your Child Arrives

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

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

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

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

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

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

If You Adopt a Child …

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

Steps to Take at Death

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

Steps to Take If You Lose a Spouse or Child

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

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

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

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

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

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

What Happens to Your Benefits If You Die

Here is what happens to your benefits if you die:

Medical (Including Prescription Drug and Vision Care) and Dental

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

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

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

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

Over 65 Medicare Supplement Program

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

Long-Term Care

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

Life Insurance

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

Pension Plan

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

Savings Plan

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

When Coverage Begins

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

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

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

When Coverage Ends

Coverage will end on the earliest of the following dates:

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

  or
- the date the plan is terminated.

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

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

- pension benefits will end the month of your death

  and
- Savings Plan benefits will be paid to your beneficiary.

Administrative Information

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

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

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

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

Glossary

Adult Disabled Child

A Child prior to attaining age 26 and thereafter was and remains:

- unmarried, and
- physically, mentally, or developmentally disabled, and
- incapable of self-support, and
- fully dependent of the Eligible Employee/Retiree for support; and
- the child is certified by the claims administrator for the Plan as incapacitated due to disability.

For current employees or retirees' dependent(s), the certification process must be started within 30 days of the dependent reaching age 26. If the employee is a new hire, the certification process must be started within 30 days of the date of hire, the dependent must have been disabled prior to attaining age 26, and continuously covered under another employer group medical plan.

Child

For Medical, Dental, and Employee Assistance Program Coverage

- your own child,
- your legally adopted child (or an individual who is lawfully placed with you for legal adoption),
- a child of the person who is recognized under applicable law as your Spouse (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.

Company

The term Company refers to UT-Battelle, LLC

Eligible Dependents

For Medical and Dental Coverage and Employee Assistance Program
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.
- Adult Disabled Child dependent over age 26 that is unmarried and has been disabled prior to age 26 with no gap in employer provided group health plan coverage.

Retiree

A Retiree is a former employee who at the time of termination of employment was eligible to receive a retirement benefit.

2. Medical Plans

Consumer Choice and Prime Select Medical Plans Overview

How The Consumer Choice Plan And Prime Select 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 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.

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 non-Network Benefits.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, “certain Network facility” is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider’s contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 the Claims Administrator 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 the Claims Administrator determines that the Plan will pay for Benefits.

For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

For non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.

- For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for

amounts in excess of your Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.

- For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
    - The reimbursement rate as determined by a state *All Payer Model Agreement*.
    - The reimbursement rate as determined by state law.
    - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
    - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD**.**

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.

For Air Ambulance transportation provided by a non-Network provider, the Eligible Expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Coinsurance or Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

For Emergency ground ambulance transportation provided by a non-Network provider, the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable coinsurance.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- Ancillary Services received at certain Network facilities on a non-Emergency basis;
- non-Ancillary Services received at certain Network facilities on a non-Emergency basis;
- Emergency Health Services;
- Air Ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or it's designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, and Deductible.

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 or the Recognized Amount when applicable, 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.

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.

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. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

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?
Copayments applies only to the Prime Select Plan	Yes	N/A
Payments toward the Annual Deductible - Consumer Choice Plan	Yes	Yes
Payments toward the Annual Deductible – Prime Select Plan	N/A	No
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

Travel and Lodging – (For Travel and Lodging related to complex medical conditions see Clinical Programs and Resources).

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service that is not available in the Covered Person's state of residence due to law or regulation when such services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year during the entire period of time a Covered Person is enrolled under the Plan, will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per day for the Covered Person, or $100 per day for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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** - Personal Health Support Nurses 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 Personal Health Support 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.

- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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 the *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

Plan Highlights – Consumer Choice Plan

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum. The deductible and out-of-pocket maximum consist of both medical and prescription drug eligible expenses.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible		
Individual	$1,600	$2,500
Family (cumulative Annual Deductible). The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.	$3,200	$5,000
Annual Out-of-Pocket Maximum		
Individual (single coverage)	$2,500	$5,000
Family (cumulative Out-of-Pocket Maximum). The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.	$5,000	$10,000
The Annual Deductible applies toward the Out-of-Pocket Maximum for all 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 – Consumer Choice 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.	Ground Ambulance 90% after you meet the Annual Deductible Air Ambulance 90% after you meet the Annual Deductible	Ground Ambulance Same as Network Air Ambulance Same as Network
• Non-Emergency Ambulance. Ground Ambulance, as the Claims Administrator determines appropriate. • Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.	Ground Ambulance 90% after you meet the Annual Deductible Air Ambulance 90% after you meet the Annual Deductible	Ground Ambulance Same as Network Air Ambulance Same as Network
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.	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	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
COVID-19	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only See *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Non-Accidental	90% 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**
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.	90% 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 Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. • Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described in the Eligible Expenses will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.	90% after you meet the Annual Deductible	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 $750 per 36 months. No maximum for children up to age 18.	90% after you meet the Annual Deductible	Non-Network Benefits are not available

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Home Health Care • Network Benefits are unlimited. • Non-Network Benefits are 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.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• **Hospital - Inpatient Stay**	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Infertility Services *Note:* Limited to $20,000 combined with Network and Non-Network.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient		
Lab Testing - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
X-Ray and Other Diagnostic Testing - Outpatient	90% 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	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• **Mental Health Services**		
• Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
• Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery Network Benefits include services received at a Network facility and performed by a Network Physician that is not 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.	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.
• **Ostomy Supplies**	90% 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**
Pharmaceutical Products - Outpatient Medical Setting • *Note:* Does not include prescriptions dispensed by Express Scripts.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	90% 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
• Private Duty Nursing – Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• Prosthetic Devices	90% 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.	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: • 180 visits per calendar year for physical, occupational, pulmonary rehabilitation, cardiac rehabilitation, cognitive rehabilitation and speech therapy combined. • Unlimited visits per calendar year for post-cochlear implant aural therapy. • 25 visits per calendar year for Manipulative Treatment.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• **Scopic Procedures - Outpatient Diagnostic and Therapeutic**	90% 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.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
• Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
• Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Surgery - Outpatient	90% 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**	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation 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.	
Urgent Care Center Services	90% after you meet the Annual Deductible	Same as Network

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
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.	90% after you meet the Annual Deductible	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 – Prime Select Plan

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copayments 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.		
• Dental Services – Accident Only	$20 PCP/$35 Specialist	Not Applicable
• Emergency Health Services	$75	$75
• Hospital – Inpatient Stay	$250	Not Applicable
• Physician's Office Services – Primary Care Physician	$20	Not Applicable
• Physician's Office Services - Specialist	$25	Not Applicable
• Rehabilitation Services	$20 PCP/$35 Specialist	Not Applicable
• Urgent Care Center Services	$25	$25
• Virtual Visits.	$20	Not Applicable

Plan Features	Network Amounts	Non-Network Amounts
Copays do not apply toward the Annual Deductible. Copays apply toward the Out-of-Pocket Maximum.		
Annual Deductible		
• Individual	No Annual Deductible	$200
• Family (not to exceed the applicable Individual amount for all Covered Persons in a family)	No Annual Deductible	$400
Annual Out-of-Pocket Maximum		
• Individual (single coverage)	$9,450	Unlimited
• Family (not to exceed the applicable Individual amount for all Covered Persons in a family)	$18,900	Unlimited
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 – Prime Select 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 Services1	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%	Same as Network
• Emergency Ambulance.	Ground Ambulance 90% after you meet the Annual Deductible Air Ambulance 90% after you meet the Annual Deductible	Ground Ambulance Same as Network Air Ambulance Same as Network

Covered Health Services1	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Network	Non-Network
• Non-Emergency Ambulance. Ground Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.	Ground Ambulance 90% after you meet the Annual Deductible Air Ambulance 90% after you meet the Annual Deductible	Ground Ambulance Same as Network Air Ambulance Same as Network
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.	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 $250	80% after you meet the Annual Deductible
COVID-19 Testing	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.
Dental Services - Accident Only See *Additional Coverage Details*, for limits.	100% after you pay a per visit Copayment of $20 PCP or $35 Specialist	Same as Network
Dental Services - Non-Accidental	100% after you pay a per visit Copayment of $20 PCP or $35 Specialist	80% after you meet the Annual Deductible
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.

Covered Health Services1	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
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	80% 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 Copayment. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described in the Eligible Expenses will be determined as described in the Eligible Expenses Section of How the Prime Select Plan Works.	100% after you pay a Copayment of $75 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*.	
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%	80% after you meet the Annual Deductible
Hospice Care	100%	80% after you meet the Annual Deductible
Hospital - Inpatient Stay	100% after you pay a Copayment of $250	80% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient		
• Lab Testing - Outpatient	100%	80% after you meet the Annual Deductible
• X-Ray and Other Diagnostic Testing - Outpatient	100%	80% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100%	80% after you meet the Annual Deductible
Mental Health Services		
• Inpatient	100% after you pay a Copayment of $250	80% 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 per visit Copayment of $20 PCP or $35 Specialist	80% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
• Inpatient	100% after you pay a Copayment of $250	80% after you meet the Annual Deductible
• Outpatient	100% after you pay a per visit Copayment of $20 PCP or $35 Specialist	80% after you meet the Annual Deductible
Obesity Surgery Network Benefits include services received at a Network facility and performed by a Network Physician that is not 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.	
Ostomy Supplies	100%	80% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient Medical Setting ***Note:*** Does not include prescriptions dispensed by Express Scripts.	100%	80% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in the Eligible Expenses Section of How the Prime Select Plan Works.	100%	80% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
• Office Visit	100% after you pay a per visit Copayment of $20 PCP or $35 Specialist	80% after you meet the Annual Deductible
Pregnancy – Maternity Services A Copayment 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%	80% after you meet the Annual Deductible
• Lab, X-ray or Other Preventive Tests	100%	80% after you meet the Annual Deductible
• Breast Pumps	100%	80% after you meet the Annual Deductible
Private Duty Nursing – Outpatient	100%	80% after you meet the Annual Deductible
Prosthetic Devices See *Additional Coverage Details*, for limits.	100% after you meet the $200 Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
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. • 25 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. • Unlimited visits per calendar year for post-cochlear implant aural therapy.	100% after you pay a per visit Copayment of $20 PCP or $35 Specialist	80% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100%	80% 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%	80% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
• Inpatient.	100% after you pay a Copayment of $250	80% after you meet the Annual Deductible
• Outpatient.	100% after you pay a per visit Copayment of $20 PCP or $35 Specialist	80% after you meet the Annual Deductible
Surgery - Outpatient	100% after you meet the Annual Deductible	80% 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%	80% 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 $25 per visit	100% after you pay a Copayment of $25 per visit

Covered Health Services1	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Virtual Care Services 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.

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

Information For The Consumer Choice And Prime Select 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 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.
- When a Physician is unable to visit the patient at the facility;
- When the patient requires special equipment handing that requests medical assistance.

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. For Non-Network Benefits, if you are requesting non-Emergency ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), 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 by 20% of Eligible Expenses.

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

For Non-Network Benefits you must obtain prior authorization 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 by 20% 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 as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% 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.

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 limited to charges for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth.

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.

Dental Services – Non-Accidental

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 of the 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 for which careful monitoring is required during and immediately following the planned procedure.
- Individuals in whom conscious sedation would be inadequate or contraindicated for any 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 by 20% 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.
- Custom molded cranial orthotics (helmets), when prescribed by 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 generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these 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 by 20% 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 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.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* are Covered Health Services only in connection with gender dysphoria services rendered by a Designated Provider that are not available in proximity to the covered person's residence.

Prior Authorization Requirement

For Non-Network Benefits 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 by 20% 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 – This Benefit Only Applies To The Consumer Choice Plan

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 through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.

- A fitting by an audiologist.
- A written prescription.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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. Benefits are limited to $750 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.

- Network Benefits are unlimited and Non-Network Benefits are limited to 60 visits per calendar year for the Consumer Choice Plan
- Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year for the Prime Select Plan
- 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 and Private Duty Nursing, or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% 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 by 20% 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 facility.

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 by 20% 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).

Infertility Services – This Benefit Only Applies To The Consumer Choice Plan

Therapeutic services for the treatment of Infertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.

- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty.
- Electroejaculation.
- Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Criteria to be eligible for Benefits

To be eligible for the Infertility services Benefit you must have a diagnosis of infertility.

- To meet the definition of Infertility you must meet one of the following:
  - You are not able to become pregnant after the following periods of time of regular unprotected intercourse or Therapeutic Donor Insemination:
    - One year, if you are a female under age 35.
    - Six months, if you are a female age 35 or older.
  - You are female and have failed to achieve or maintain a Pregnancy due to impotence/sexual dysfunction;
  - You are female and have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
  - You are male and have a diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- You are a female under age 44 and using own oocytes (eggs).
- You are a female under age 55 and using donor oocytes (eggs).
- You have Infertility that is not related to voluntary sterilization.
- You are male and have a diagnosis of a male factor causing Infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- Not a Child Dependent.

Any combination of Network Benefits and Non-Network Benefits are limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.

Only charges for the following apply toward the infertility lifetime maximum:

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.

- Specific injections.

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 medical treatment 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.

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, 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 by 20% 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 medical treatment 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 by 20% 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/or procedures.
- Medication management.
- 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 by 20% 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/or porccedures.
- Medication management.
- 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 by 20% of Eligible Expenses.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40.
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria the following must also be true:

- You have a minimum Body Mass Index (BMI) 35-39.9 with at least one clinically significant obesity-related co morbidity, including but not limited to the following:
  - Mechanical arthropathy in a weight-bearing joint.
  - Type 2 diabetes mellitus.
  - Poorly controlled hypertension (systolic blood pressure at least 140 mm Hg or diastolic blood pressure 90mm Hg or greater, despite optimal medical management).
  - Hyperlipidemia.
  - Coronary artery disease.
  - Lower extremity lymphatic or venous obstruction.
  - Obstructive sleep apnea.
  - Pulmonary hypertension.
- You have documentation from a Physician of active participation within the last 12 months in a weight management program that is supervised either by a physician or a registered dietician for a minimum of three consecutive months.
- The weight-management program must include monthly documentation of ALL of the following components:
  - Weight.
  - Current dietary program.
  - Physical activity (e.g., exercise program).
- The surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by a Network surgeon even if there are no BRS Designated Provider near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in the *Glossary* and are not Experimental or Investigational or Unproven Services.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in the *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling 1-888-936-7246.

If you receive obesity surgery services that are not performed as part of the Bariatric Resource Services program, 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.

Prior Authorization Requirement

For Non Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of obesity surgery arises.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% 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).

It is important that you provide notification 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.

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 by 20% 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 Committee on 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.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

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 Class III and Class IV prosthetic devices. An evaluation by an orthopedic surgeon or a physical and rehabilitation physician is required, in addition to a prescription, to provide the clinical justification for advanced prosthetic devices and myoelectric limbs.

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 by 20% 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 by 20% 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals is not a habilitative service.

The Plan may require the following be provided:

- medical records
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, Claims Administrator may request additional medical records.

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*.

Benefits are limited to:

- 180 visits per calendar year for physical, occupational, pulmonary rehabilitation, cardiac rehabilitation, cognitive rehabilitation and speech therapy combined for the Consumer Choice Plan.

- 20 visits per calendar year for physical, occupational, pulmonary rehabilitation, cardiac rehabilitation, cognitive rehabilitation and speech therapy combined for the Prime Select Plan.
- 25 visits per calendar year for Manipulative Treatment for both Plans.
- Unlimited visits per calendar year for post-cochlear implant aural therapy for both Plans.

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 by 20% 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/or procedures.
- Medication management.
- Individual, family, and group therapy.
- 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 assistance in locating 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 by 20% 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 and orthognathic surgeries 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 by 20% 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 by 20% 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 may be received by a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

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).

For Non-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). For non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator, Benefits will be reduced by 20% 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).

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*.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health care specialist, 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 contacting the Claims Administrator at www.myuhc.com or by calling the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

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 do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Services

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury.*

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.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

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 to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs. Conditions for which this program is available include:
- 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 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 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 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 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.

Complex Medical Conditions Programs and Services

Bariatric Resource Services (BRS)

Your Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Participants and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation’s leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Cancer Support Program

UnitedHealthcare provides a program that identifies and supports a Covered Person who has cancer. You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. 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 and 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 your ID card or call the program directly at 1-866 936-6002.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the Travel and Lodging Assistance Program, refer to the provision below.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services below

Your Plan Sponsor may provide you with Travel and Lodging assistance for certain Covered Health Services. 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 requisite distance from your home address to the facility is at least 50 miles. 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 number on your ID card.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Covered Person and a travel companion, provided the Covered Person is not covered by Medicare as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.

- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offer an 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.

Lodging Reimbursement Assistance

- A per diem rate, up to $50.00 per day, Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem is limited to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Women's Health/Reproductive

Maternity Support Program

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 your ID card.

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

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

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. Acupuncture
3. Aromatherapy.
4. Hypnotism.
5. Massage therapy.
6. Rolfing.
7. 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*.
8. 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).

   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. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
5. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
6. Devices and computers to assist in communication and speech except for dedicated speech aid generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Additional Coverage Details*.
7. Oral appliances for snoring.
8. Powered and non-powered exoskeleton devices.

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 that an 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.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports.

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 lessons and voice therapy.
- Voice modification surgery.

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 for which Benefits are provided as described under *Urinary Catheters* in *Additional Coverage Details*.
   - Elastic/compression stockings unless prescribed by a physician and used for a medical condition as described under *Durable Medical Equipment* in *Additional Coverage Details*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Additional Coverage Details*.

3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. 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, pyromania, kleptomania, 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.
8. Non-Medical 24-Hour Withdrawal Management; and
9. high intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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.2
- Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Additional Coverage Details*.

3. 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).
    - Sclerotherapy treatment of veins.
    - 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.
    - Skin abrasion procedures performed as a treatment for acne.
    - Treatments for hair loss.
    - 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 or therapies for the purpose of general well-being or condition in the absence of a disabling condition.
5. Speech therapy to treat stuttering, stammering, or other articulation disorders.
6. Rehabilitation services for speech therapy, except when required for treatment of a speech impairment 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*.
7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

8. 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.
9. Chelation therapy, except to treat heavy metal poisoning.
10. 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.
11. The following treatments for obesity:
    a. Non-surgical treatment of obesity, even if for morbid obesity; unless the services are provided as part of the medical weight loss program managed by the WellOne Clinic.
    b. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in *Additional Coverage Details*.
12. Medical and surgical treatment of excessive sweating (hyperhidrosis).
13. 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.
14. 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*.
15. Helicobacter pylori (H. pylori) serologic testing.
16. Intracellular micronutrient testing.

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. The following treatment-related services:
    - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility.

- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
- Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease.
- Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
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. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under *Infertility Services* including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
   - Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under *Infertility Services* including thawing and insemination.
4. The reversal of voluntary sterilization.
5. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
6. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
7. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
8. Infertility treatment following unsuccessful reversal of voluntary sterilization.
9. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

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*. 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 for acute 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 licensed hospice 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 to work or to prepare a person for specific work).

Vision and Hearing

1. Routine vision examinations, including refractive examinations to determine the need for 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. Bone anchored hearing aids except when either of the following applies:
   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

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 HIV and 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 under the 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 Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the 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 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 meeting the Annual Deductible and paying any 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 at the 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 benefit determination. 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 that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may 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**
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
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 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 meets the definition of a Covered Health Service under this Plan.

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 Spouses age 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 any third 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 the Plan 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 (1) 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 any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding 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.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by UT-Battelle, LLC. The BRS program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI - see Body Mass Index (BMI).

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

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.

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 *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in *Introduction*.

- 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 Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 in Chapter 1, *About Your Benefits.*

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 - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

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.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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 by way of their participation in the Shared Savings Program. 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-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 the *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 the *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.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided in an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

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.

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.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a 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.

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 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 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. 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.

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.

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. To obtain a prior authorization your doctor can call 1-800-753-2851 or they can use the electronic prior authorization form.

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 coinsurance. These charges will not apply towards the deductible or out-of-pocket maximum. 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.

Smart 90 Exclusive

This program requires you to fill your maintenance medications at any network retail pharmacy or through the Express Scripts home delivery pharmacy, **AND** at a 90-day supply. You can get up to three 30-day courtesy fills before you must make the switch. After courtesy fills are spent, maintenance medications you do not fill at a preferred location or that you do not fill for 90-days will not be covered by the Plan and you will be required to pay the full cost of the medication. As a non-covered drug, these charges will not apply towards your 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 at Home Delivery

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. The prescription must be written for more than a 56 day-supply.

Express Scripts reminds you about 2 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 1 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 can also purchase specialty medications at an in-network retail pharmacy.

Copayment/Patient Assistance Programs and Accredo

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

Example under Prime Select:	
Cost of medication	$3500
Copayment Assistance	$2500
Copayment	$200
Plan Pays	$800
Applied to Out-of-Pocket	$200

Example under Consumer Choice	
Assumes the Deductible has not been met:	
Cost of medication	$3500
Copayment Assistance	$2500
Deductible	$1000
Plan Pays	$0
Applied to Out-of-Pocket	$1000

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
- Bowel Preps
- Breast Cancer Prevention
- Contraceptives
- Statins
- HIV PrEP

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 the Prime Select prescription plan.

Administrative Information

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

What happens to your benefits when ...

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

Summary of Benefits

Prescription Drugs, Provided by Express Scripts				
Covered Services	**Consumer Choice with HSA In-Network**	**Prime Select In-Network**	**Consumer Choice with HSA Out-of-Network**	**Prime Select Out-of-Network**
Retail Prescription Drugs (Up to a 30 day supply) for new prescriptions and non-maintenance medications. After three 30-day fills of a maintenance medication, if you do not fill for a 90-day supply, you will be responsible for the full cost of the medication. This cost will not apply towards your deductible or out-of-pocket maximum.	Member pays 100% until the plan deductible[1] of $1,600 is met for individual coverage and $3,200 all other for coverage levels Then 20% coinsurance **Generic:** minimum $10/ maximum $75 **Preferred Brand:** minimum $25/ maximum $150 **Non-Preferred Brand:** minimum$40/ maximum $250 If actual cost is under the minimum, you pay actual cost Plan out-of-pocket maximum[2] is $2500 for individual coverage and $5000 for all other coverage levels	**Generic:** $5 co-pay Then 30% **Preferred Brand:** minimum $20 maximum $100 **Non-preferred Brand:** minimum $40 maximum $200 If actual cost is under the minimum, you pay actual cost	Member pays 100% until the plan deductible[1] of $2,500 is met for individual coverage and $5,000 all other for coverage levels 50% after plan deductible is met. Member must file a claim Plan out-of-pocket maximum[2] is $5,000 for individual coverage and $10,000 for all other coverage levels	50% after $200 pharmacy deductible. Member must file a claim Plan out-of-pocket maximum is unlimited

[1] The Plan Deductible consists of medical and prescription expenses.
[2] The Plan Out-of-Pocket Maximum consists of medical and prescription expenses.

Prescription Drugs, Provided by Express Scripts

Covered Services	Consumer Choice with HSA In-Network	Prime Select In-Network	Consumer Choice with HSA Out-of-Network	Prime Select Out-of-Network
Mail Order—Home Delivery and Retail (Up to a 90 day supply)	Member pays 100% until the plan deductible[3] of $1,600 is met for individual coverage and $3,200 for all other coverage levels Then 20% coinsurance **Generic:** minimum $20/ maximum $150 **Preferred Brand:** minimum $60/maximum $300 **Non-Preferred Brand:** minimum $100/maximum $500 **Specialty Medications:** minimum $60/maximum $300 If actual cost is under the minimum, you pay actual cost Plan out-of-pocket maximum[4] is $2500 for individual coverage and $5000 for all other coverage levels	**Generic:** $12 co-pay 30% coinsurance **Preferred Brand:** minimum $50 maximum $200 **Non-preferred Brand:** minimum $100 maximum $400 **Specialty Medications:** minimum $50 maximum $200 except medications in the SaveonSP Program the cost is $0. If the member chooses not to enroll in SaveonSP Program the cost could be the full program copay If actual cost is under the minimum, you pay actual cost	Member pays 100% until the plan deductible[1] of $2,500 is met for individual coverage and $5,000 all other for coverage levels 50% after plan deductible is met. Member must file a claim Plan out-of-pocket maximum[2] is $5,000 for individual coverage and $10,000 for all other coverage levels	50% after $200 pharmacy deductible. Member must file a claim Plan out-of-pocket maximum is unlimited

Examples of Prescription Drug costs

CONSUMER CHOICE with HSA:
Retail Brand Preferred Coinsurance Examples

Drug Cost	20% Coinsurance	Member Pays
$60	$12	$25 (minimum payment)
$150	$30	$30 (20% of covered cost)
$800	$160	$150 (maximum payment)

[3] The Plan Deductible consists of medical and prescription expenses.
[4] The Plan Out-of-Pocket Maximum consists of medical and prescription expenses.

PRIME SELECT: Retail Brand Preferred Coinsurance Examples		
Drug Cost	**30% Coinsurance**	**Member Pays**
$60	$18	$20 (minimum payment)
$150	$45	$45 (30% of covered cost)
$400	$120	$100 (maximum payment)

Other Important Information

Prescription Drug Claims Review and Appeal Procedures

Coverage Review

Description

You have the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Initial Coverage Review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at www.express-scripts.com/PA.

To request an initial administrative coverage review, you or your representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St Louis, MO 63166-6587. Fax 877 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1 800-753-2851.

How a Coverage Review is Processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, you must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours**	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

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.

How to Request a Level 1 Appeal or Urgent Appeal after an Initial Coverage Review has been Denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by you or your authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

  Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the

patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: phone 1 800-753-2851 fax 1 877- 852-4070

Administrative appeal requests: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a Level 1 Appeal or Urgent Appeal is Processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, or trained prior authorization staff member.

Appeal decisions and notifications are made as follows:

<table>
<tr><td>Type of Appeal</td><td>Decision Timeframe

Decisions are completed as soon as possible from receipt of request but no later than:</td><td colspan="2">Notification of Decision</td></tr>
<tr><td></td><td></td><td>Approval</td><td>Denial</td></tr>
<tr><td>Standard Pre-Service*</td><td>15 days</td><td rowspan="2">Patient: automated call (letter if call not successful)

Prescriber: Electronic or Fax (letter if fax not successful)</td><td>Patient: letter

Prescriber: Electronic or Fax (letter if fax not successful)</td></tr>
<tr><td>Standard Post-Service*</td><td>30 days</td></tr>
<tr><td>Urgent*#</td><td>72 hours</td><td>Patient: automated call and letter</td><td>Patient: live call and letter</td></tr>
<tr><td></td><td></td><td>Prescriber: Electronic or Fax (letter if fax not successful)</td><td>Prescriber: Electronic or Fax (letter if fax not successful)</td></tr>
</table>

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

#The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

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).

How to Request a Level 2 Appeal After a Level 1 Appeal has been Denied

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by you or your authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

  Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

  Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St Louis, MO 63166-6587 Fax 1 877-328-9660

How a Level 2 Appeal is Processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist or Physician.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days	Patient: automated call (letter if call not successful)	Patient: letter
Standard Post-Service*	30 days	Prescriber: Electronic or Fax (letter if fax not successful)	Prescriber: Electronic or Fax (letter if fax not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

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.

When and How to Request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The request must be received within 4 months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

To submit an external review, the request must be mailed or faxed to Express Scripts.

Express Scripts
Attn: External Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Phone: 1 800-753-2851
Fax: 1 877-852-4070

How an External Review is Processed

Standard External Review: Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

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

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

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 Attn: Benefit Coverage Review Department PO Box 66587 St Louis, MO 63166-6587. Fax 877 328-9660

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, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

  Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

  Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

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, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient

- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

  Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

  Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

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 Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Phone: 1 800-753-2851
Fax: 1 877-852-4070

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	No charge for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal, or polycarbonate (for dependent children) Frames allowance of up to $120 plus 20% off excess of $120 every 24 months; **OR** Contact lens every 12 months covered up to $120 allowance; allowance applies to cost of contacts. Contact lens exam (evaluation and fitting fee) subject to nor more than $60 patient copay.	Allowance of up to: • Exam: $45 • Single vision: $30 • Bifocals: $50 • Trifocals: $65 • Frames: $70 **OR** • Elective contacts: $105
Lens Enhancements	20–25% discount on lens enhancements and upgrades. Standard progressive lenses no charge.	
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)(l)(B)], the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

Time of Action

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

5. Over 65 Medicare Supplement Program

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

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

Highlights

Your Over 65 Medicare Supplement Program Benefits …

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

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

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

What happens to your benefits when ...

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

How the Over 65 Medicare Supplement Program Works

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

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

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

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

You must enroll in a Supplement plan through Via Benefits when first eligible and maintain continuous coverage through Via Benefits to be eligible to participate in this program.

The following are circumstances that you (or your spouse, if applicable) can lose eligibility to participate in ORNL's Medicare Supplement Program:

- enroll in a Medicare Supplement plan outside of Via Benefits
- lose continuous enrollment in a Medicare Supplement plan through Via Benefits
- enroll in a Medicare Advantage plan
- enroll in a Medicare Part D prescription drug plan outside of ORNL's Prescription Drug Plan

If any of the above occur, you (or your spouse, if applicable) will no longer be eligible to participate in the ORNL Prescription Drug Plan, forfeit the HRA funding, and won't be able to re-enroll in the future. This also applies to those who lose eligibility or elect to cancel the ORNL Prescription Drug Plan.

If the retiree loses eligibility to participate in this program, their spouse automatically loses eligibility, including spouses enrolled in ORNL's under age 65 retiree medical plans.

These eligibility rules apply to retirees and eligible spouses of retirees In order for a spouse to participate in this plan, the retiree must participate. A surviving spouse may be able to participate in the plan if enrolled or eligible to enroll prior to the retiree's death.

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

Your Prescription Drug Benefits ...

… Provides Comprehensive Drug Coverage

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

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

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

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

… Offers a Convenient Home Delivery Option

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

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

ORNL Prescription Drug Plan, Administered by Express Scripts

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

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

Health Reimbursement Arrangement

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

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

HRA Account and Benefit Credits

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

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

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

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

Casual Retiree

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

Taxation

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

Eligible Medical Expenses

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

- Medications (in reasonable quantities), but only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin;
- Dental expenses;
- Dermatology;
- Physical therapy;

- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision, or long-term care insurance.

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

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

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

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

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

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

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

What Happens Upon Your Death

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

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

Continuation of Coverage

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

Other Important Information

Prescription Drug Claims Review and Appeal Procedures

Claims and appeal for benefit coverage claims

Urgent Care Claims (Expedited Reviews)

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

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

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

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

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

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

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

Appeals Procedure

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

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

This information should be mailed to:

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

Level-One Appeal

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

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

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

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

organization, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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

Level-Two Appeal

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

To initiate a second level appeal, provide in writing:

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

This information should be mailed to:

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

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

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

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

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

External Review Procedure

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

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

Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030
Phone: 1-800-753-2851
Fax: 1-888-235-8551

Non-Urgent External Review

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

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

Urgent External Review

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

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

Direct Reimbursement Claims and Appeals

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

To request reimbursement, send your claim to:

Express Scripts
PO Box 14711
Lexington, KY 40512

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

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

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

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

Appeals Procedure

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

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

This information should be mailed to:

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

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

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

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

This information should be mailed to:

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

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

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

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

about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and also are described below.

External Review Procedures

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

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

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030
Phone: 1-800-753-2851
Fax: 1-888-235-8551

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

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

HRA Claims Procedures

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

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

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

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

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

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

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

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

Appeals Procedure

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

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

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

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

Medicare Supplement Plan Claims

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

6. Dental Plans

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

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

Highlights

Your Dental Plans …

Encourage Preventive Care

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

Offer Protection for More Extensive Treatment

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

Provide Orthodontic Benefits for Your Children

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

What Happens to Your Benefits When ...

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

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

Some Facts to Remember About Your Dental Plans ...

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

Administrative Information

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

MetLife Dental Plan

How the MetLife Dental Plan Works

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

Network Provider

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

Non-Network Provider

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

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

Briefly, the plan covers four types of dental services:

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

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

Annual Deductible

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

Maximum Benefits

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

Summary of Benefits

MetLife Dental Plan Summary of Benefits	
Refer to the “Covered Expenses” section, provided on the following page, for details.	
Services Covered	**Amount of Coverage Per Member***
Calendar Year Maximum	$1,500
Lifetime Orthodontic Maximum	$1,500
Lifetime Maximum	NA
Annual Deductible (applies to Type B and Type C services)	$50 per member
TYPE A—Preventive and Diagnostic Services	Covered 100%
• Oral Examinations	Two in a calendar year
• Prophylaxis (cleanings)	Two in a calendar year
• Periodontal Maintenance	If approved, treatment is covered in addition to routine oral exams
• Full Mouth X-rays	Once every 24 months
• Bite-wing X-rays	Two in a calendar year
• Fluoride	Under age 19, two in a calendar year
• Space Maintainers	No age limit
TYPE B—Oral Surgery and Restorative Services • Restorative (fillings, including composites on posterior teeth • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics • Endodontics (root canal therapy)	Covered 80% after deductible
• Sealants	Covered 80% after deductible, under age 16; chewing surfaces for permanent first and second molars only—one benefit per tooth
TYPE C—Prosthodontic Services	Covered 50% after deductible
• Crowns, Inlays, and Onlays (includes porcelain crowns on molar teeth) • Bridges, Partial Dentures, and Full Dentures	Covered once every 60 months, no age limit
• Implants (Subject to Benefit Consultant Review)	Covered once every 60 months per tooth

MetLife Dental Plan Summary of Benefits	
Refer to the “Covered Expenses” section, provided on the following page, for details.	
Services Covered	**Amount of Coverage Per Member***
TYPE D—Orthodontic Services for dependents up to age 26: • Braces, surgical repositioning to correct malocclusion, surgical extractions, x-rays, retention checking	$300 initial payment and $49.50 for each month following (paid quarterly) up to the lifetime orthodontic maximum
*Reasonable and customary charges apply for non-network providers. The PDP network fee schedule applies for PDP providers.	

Covered Expenses

Type A—Preventive and Diagnostic Services

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

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

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

Type B—Oral Surgery and Restorative Services

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

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

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

Type C—Prosthodontic Services

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

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

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

Type D—Orthodontic Services

No deductible applies to Type D covered expenses.

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

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

Covered expenses for orthodontic services include charges for:

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

Predetermination of Benefits

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

Here is how it works:

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

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

Alternative Course of Treatment

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

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

Exclusions

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

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

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

Extended Dental Care Benefits

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

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

Exceptions to this 30 day extension include treatment involving:

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

Treatment in Progress

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

Claiming Benefits

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

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

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

Coordination of Benefits

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

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

Other Company Benefits

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

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

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

Claims Review and Appeal Procedures

Initial Determination

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

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you

as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

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

Appeals Procedure

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

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

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

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

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

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

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

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

Delta Dental Plan

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.”

Choosing a Dentist

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

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

Participating vs. Nonparticipating

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

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

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

Annual Deductible

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

Maximum Benefits

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

Emergency Dental Care

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

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
CLASS I—Preventive and Diagnostic Services *Note: Members with certain high-risk medical conditions, such as diabetes, heart conditions, and high-risk pregnancies, may be eligible for additional prophylaxes (cleanings) or fluoride treatment*	Covered 100%
• Oral Examinations	Two in a calendar year
• Prophylaxis (cleanings)—includes periodontal maintenance	Two in a calendar year
• Full Mouth X-rays	Once every 3 years
• Bite-wing X-rays	Two in a calendar year
• Fluoride	Two in a calendar year, under age 19
• Space Maintainers	Under age 14
CLASS II—Basic Services: • Restorative (fillings, including composites on posterior teeth) • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics • Endodontics (root canal therapy)	Covered 80% after deductible

Delta Dental Plan Summary of Benefits	
Refer to the "Schedule of Benefits" section on the following pages for details.	
Services Covered	**Amount of Coverage**
• Emergency palliative treatment	
• 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 3 years, unless special need is shown.

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

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

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

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

Limitations and Exclusions on Basic Benefits

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

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

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

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

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

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

g) Gold foil restorations are an Optional Service.

h) metal inlays are Optional Services.

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

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

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

Crown

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

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.

7. Life Insurance

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

Highlights

Your Benefits …

… Provide Security for Your Family Through Basic Life Coverage

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

… Offer the Opportunity for Added Protection Through Supplemental Coverage

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

What happens to your benefits when ...

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

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

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

If You Retired Before Age 65

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

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

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

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

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

If You Retired at Age 65 or After

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

Reduced Coverage Amount

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

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

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

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

Basic Life Insurance IGUA Bargaining Unit Employees hired before 8/15/2016

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

If You Retired Before Age 65

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

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

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

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

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

If You Retired at Age 65 or After

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

Reduced Coverage Amount

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

If you had Basic Life Insurance coverage for at least 5 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.

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

Supplemental Life Insurance for ATLC Bargaining Unit Employees and Salaried Employees hired prior to 4/1/2012

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

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

Supplemental Life Insurance

Retirees may be eligible for supplemental life insurance, depending on retirement date

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

Supplemental Life Insurance for IGUA Bargaining Unit Employees hired before 8/15/2016

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

If You Retired Before Age 65

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

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

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

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

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

If You Retired at Age 65 or After

If you retired at age 65 or after, a reduced amount of supplemental life insurance coverage 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 currently is provided at no cost to you.

Reduced Coverage Amount

If you had supplemental life insurance coverage for at least 1 year but less than 5 years immediately preceding your retirement, your reduced insurance 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 your Supplemental Life Insurance at one times your salary 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.

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

Other Important 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.

Naming Your Beneficiary

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

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

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

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

Tax Consequences

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

Accelerated Benefit Option

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

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

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

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

When Coverage Ends

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

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

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

Conversion and Portability

Conversion Privileges

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

Portability

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

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

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

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

If Your Benefits Terminate

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

Administrative Information

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

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

8. Pension Plan

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

Highlights

The Pension Plan …

… Provides a Benefit Which Adds to Your Other Retirement Income

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

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

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

What happens to your pension benefits when …

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

Receiving Benefit Payments

If You are Receiving Benefit Payments

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

If Your Benefit Has Not Started

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

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

Pension Benefit Amount

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

Employee Contributions

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

Normal Forms of Payment

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

For Married Employees

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

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

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

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

For Single Employees

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

Optional Forms of Payment

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

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

Life Annuity Option for Married Employees

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

50% Survivor Benefit Option

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

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

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

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

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

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

Level Income Option

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

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

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

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

Social Security

Social Security retirement benefits are entirely in addition to benefits paid from the Pension Plan. Social Security provides retirement benefits to you and your eligible spouse based on earnings covered under the law. If you were born before 1938, full Social Security retirement benefits can start at age 65. Your spouse is eligible for an additional 50% of your benefit—or a benefit based on his or her own covered

earnings, if greater—when he or she reaches age 65. Disability benefits may also be provided for you and eligible family members, as well as survivor's benefits.

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

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

Reemployment After Retirement

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

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

Other Important Information

Withholding Taxes

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

Change of Address

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

Direct Deposit of Payments

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

Administrative Information

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

Glossary

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.

Average Straight-Time Monthly Earnings

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

8.A. Pension Plan – For Grandfathered Former Employees from the National Strategic Protection Services Plan (NSPS)

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

Highlights

The Pension Plan …

… Provides a Benefit Which Adds to Your Other Retirement Income

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

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

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

What happens to your pension benefits when …

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

Receiving Benefit Payments

If You are Receiving Benefit Payments

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

If Your Benefit Has Not Started

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

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

Pension Benefit Amount

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

Employee Contributions

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

Normal Forms of Payment

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

For Married Employees

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

If your spouse dies before you, this form of payment will "pop up" to the amount that would be paid to single employees, upon receipt of required documentation. For a table of reduction factors, contact the ORNL Benefits Office.

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

Married participants may also elect a 75% survivor annuity option. Under this form of payment, your pension is reduced and, after your death, 75% of that benefit is continued to your surviving spouse for the rest of his or her life. If your spouse dies before you, this form of payment will "pop up" to the amount that would be paid to a single employee, upon receipt of required documentation. (For a table of 75% Surviving Spouse reduction factors effective for the date you commence your benefit, contact the ORNL Benefits Office.)

For Single Employees

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

Optional Forms of Payment

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

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

Life Annuity Option for Married Employees

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

50% Survivor Benefit Option

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

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

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

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

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

Your election of a survivor benefit cannot be changed after your pension begins. If your named survivor should die before you, this payment form will automatically "pop up" to the amount that would be paid to single employees.

Level Income Option

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

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

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

Social Security

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

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

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

Reemployment After Retirement

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

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

Other Important Information

Withholding Taxes

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

Change of Address

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

Direct Deposit of Payments

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

Administrative Information

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

Glossary

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.

Average Straight-Time Monthly Earnings

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

9. Savings Plan

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

Highlights

The Savings Plan …

… Lets Your Account Grow Tax-Deferred

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

… Gives You the Opportunity to Invest in Your Future

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

… Provides 24-Hour Access to Account Information

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

What happens to your benefits when ...

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

Your Savings Plan Account

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

If your Savings Plan account has been deferred, your savings will remain invested in the Savings Plan funds as you direct. In any event, Savings Plan required minimum distribution payments will begin no later than December of the year in which you reach age 73.

The Savings Plan Information Sources

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

- check your account balance and investment performance
- transfer between investment funds
- request a withdrawal
- update or change beneficiary information

When you call Participant Services, you will need your web ID. If you do not have your web ID, you may speak to a Participant Services representative and provide the necessary security information.

To Reach Participant Services

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

International:
1-330-908-4777

TTY Service:
1-800-345-2550

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

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

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

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

Working With the Plan

After you log on, you will see the market value of your account as of a particular date. Remember, our plan investment funds are valued daily, and the amount shown on the screen is the market value as of the close of business of the previous business day. This value is updated once a day, so the value you see in the morning will be the same value for that entire day.

Call Participant Services or use the Internet for …

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

Your Investment Options

You can transfer existing balances—in 1% increments—among the investment options at any time. Transfers completed before 4 p.m. Eastern time will be effective that day, assuming it is a business day and the New York Stock Exchange is open; otherwise, changes will be effective the next business and market trading day. Confirmation of your transaction will be mailed within 3 business days.

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

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

Investment Earnings

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

Investment Option Summary

Transaction Processing

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

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

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

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

Reward vs. Risk

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

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

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

When will you need the money in your accounts?

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

What are your investment goals?

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

Are your investments sufficiently diversified?

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

In-Plan Roth Rollovers

If you have money in a non-Roth Account (e.g., Before-Tax Account, Matching Account, Non-Roth After-Tax Account), you may rollover all or a portion of the vested non-Roth Account balance to a Roth (after-tax) Account under this Plan. Any qualified distributions from a Roth Account (including earnings) will not be subject to tax at distribution. If you rollover the payment to a designated Roth Account in this Plan, the amount of the payment rolled over will be subject to taxes for you to pay outside of the Plan.

However, the 10% additional tax on early distributions will not apply (unless you take the amount rolled over or transferred out of the designated Roth Account within the 5-year period that begins on January 1 of the year of the rollover or transfer). Any amount you roll over will retain the same restrictions on distributions the Account had before such rollover.

Withdrawals from Your Deferred Account

If you choose to defer your total account value, you may make partial withdrawals of your savings during retirement, within certain plan limits. To request a withdrawal, call Participant Services. You may not defer payment beyond December 31 of the year in which you reach age 73 or the date you retire if you work for the Company beyond age 73.

Plan Payouts

You may elect to receive:

- a single lump-sum payment of your total account value

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

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

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

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

If you die, your beneficiary may receive the full amount of your Savings Plan account balance in a lump sum. Your spousal beneficiary or Eligible Designated Beneficiary may elect a lump sum payment, monthly installment payments, or may request a rollover to an IRA. If your beneficiary is not your spouse, your beneficiary will receive a lump sum payment or may request a rollover to an IRA account.

Request a Payout

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

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

Mandatory Distributions

If your vested account balance is $1,000 or less when you leave the Company and you do not request a payout method or rollover, your vested account balance will be distributed to you in a single lump sum payment. If your vested account balance is greater than $1,000 but does not exceed $7,000 when you leave the Company and you do not request a payout method or rollover, your vested account balance will be distributed to an individual retirement account (IRA) established in your name. Your benefits will be paid-out through the IRA and you will no longer participate in the Savings Plan.

Naming Your Beneficiary

Your beneficiary is the person you name to receive benefits from the Savings Plan if you die with a vested Your beneficiary is the person you name to receive benefits from the Savings Plan if you die with a vested balance remaining in your Savings Plan account. Your beneficiary can be anyone you wish. However, if you wish to name someone other than your spouse, you must have your spouse's written and notarized consent. Be sure to keep your beneficiary designation up to date. If you do not make a valid beneficiary designation, your spouse will receive the value of your vested Savings Plan account.

If you do not name a beneficiary, your vested Savings Plan account will be paid to the person or persons in the first surviving class of beneficiaries listed below:

(1) your surviving spouse;
(2) your surviving children and issue of deceased children, per stirpes; and
(3) your estate.

After your death, unless you had previously submitted a written designation to the contrary, your Beneficiary may name his or her own Beneficiary to receive benefits from the Savings Plan if the Beneficiary dies with a vested balance remaining in your Savings Plan account.

You may change your beneficiary at any time (subject to the spousal consent rules described above). Simply call the Participant Services information line or use the Internet to complete the form online. Your beneficiary election will be effective when Participant Services receives your completed form.

Taxation of Withdrawals and Final Payouts

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

Before Age 59½

If you receive a distribution before age 59½, you will pay a 10% additional tax in addition to ordinary income tax on the taxable portion of the payment unless you qualify for one of the exceptions to this 10% penalty listed in the "Special Tax Information Notice." You can avoid the income tax and additional tax if you roll over the taxable portion of your payment into an IRA or other eligible retirement plan within the period permitted by law. Your beneficiaries are never subject to the additional 10% tax penalty, regardless of your age at death.

At Age 59½ or Later

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

Roth Contributions

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

Rollovers and Withholding

Withdrawals and lump sum distributions of your pre-tax contributions and Company matching contributions, your after-tax contributions, or your Roth contributions as adjusted for investment earnings and losses, can be rolled over to an IRA, a Roth IRA, or other eligible retirement plan. Required minimum distributions to employees who have terminated and reached age 73 or retired from the Company after age 73, and distributions paid out in installments are not eligible for such a rollover.

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

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

- Mandatory 20% tax withholding will apply to the taxable portion of the distribution when the payout is made to you.
- Your rollover must be made within 60 days of the day you receive your payout.
- Any portion of the taxable part of your payout not rolled over will be subject to income and penalty taxes (if applicable).

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

To be sure you are using your benefits to their full advantage, you should check with a tax advisor regarding the specific requirements for using these and other forms of favorable treatment that may apply to your payout. Neither the ORNL Pension and Savings Office nor Participant Services can give you tax advice.

Transfer of Assets for ORNL Participants

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

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

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

Your Quarterly Statement

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

You also have access to your account statement any time by visiting workplace.schwab.com.

Claiming Benefits

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

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

Other Important Information

Change of Address

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

Voting Your Shares

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

Investment Fees and Expenses

The Savings Plan incurs administrative fees and investment management fees. The administrative fees are the costs to the Savings Plan and your Savings Plan Account, including recordkeeping, accounting, trustee functions, and legal services. The Company pays some of these fees. Some fees are paid by the Savings Plan and charged to all Participant accounts. Fees for items directly related to your account—such as the

processing of loans, hardship withdrawals, or domestic relations orders—may be charged to your account. Administrative fees will be shown on your quarterly statement.

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

Responsibility for Investment Decisions

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

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

Confidentiality of Investment Directions

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

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

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

ORNL Savings and Retirement Investment Committee
c/o Division Director, Pension & Savings Administration
P. O. Box 2008
Oak Ridge, TN 37831

Plan Funding

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

Tax Treatment

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

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

Administrative Information

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

Glossary

Eligible Designated Beneficiary

Any designated beneficiary who is: (i) your surviving spouse; (ii) your child who has not reached the age of majority; (iii) disabled; (iv) a chronically ill individual; or (v) an individual who is not more than 10 years younger than you. The determination of whether a designated beneficiary is an Eligible Designated Beneficiary shall be made as of the date of your death.

Participant Services

Charles Schwab Retirement Plan Services; contact information is provided on page 9-3.

Recordkeeper

Charles Schwab Retirement Plan Services; contact information is provided on page 9-3.

10. Administrative Information

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

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

Plan Sponsor and Administrator

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

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

In carrying out its responsibilities under the plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the Plan Administrator are final, conclusive, and binding on all persons.

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

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

Employer Identification Number

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

Plan Documents

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

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

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

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

Claiming Benefits

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the plans, as described throughout this book. All forms required to take any action under the plans are available through the ORNL Benefits Office. All completed forms must be submitted to the appropriate office, as described throughout this book.

Health Claims Review and Appeal Procedures

For information on review and appeal procedures for medical, prescription drug, or vision plan claims, see the “Medical Plans”, “Prescription Drug Plan” or “Vision Care” chapter.

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

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

Other Claims Appeal

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

Notice of Adverse Benefit Determination for Other Claims

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

Notification on Other Claim Decisions

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

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

Other Claim Appeal of an Adverse Benefit Determination

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

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

Notification of Other Claims Decision on Appeal

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

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

Legal Process

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

Agent for Service of Legal Process

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

Plan Termination and Amendment

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

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

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may result in the transfer of plan assets and debts to another plan or may split a plan into two or more parts. If the Company does terminate or amend a plan, it may decide to set up a different plan providing similar or identical benefits, but it is under no obligation to do so.

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

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

Special Pension and Savings Provisions

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

Assets Upon Termination

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

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

Pension Benefit Guaranty Corporation

Your pension benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all

benefits, PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

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

The PBGC guarantee generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- some or all benefit increases and new benefits-based plan provisions that have been in place for fewer than 5 years at the time the plan terminates
- benefits that are not vested because you have not worked long enough for the Company
- benefits for which you have not met all of the requirements at the time the plan terminates
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age

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

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

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

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

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

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

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

Assignment or Alienation of Benefits

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

Qualified Domestic Relations Order

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

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

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

Qualified Medical Child Support Order

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

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

Health Insurance Portability and Accountability Act (HIPAA)

This plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) with respect to protected health information (PHI). For purposes of the plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information that relates to your or their eligibility for all group health benefits under the plan. Additional information about your rights under HIPAA is provided separately in a Notice of Privacy Practices.

Other Administrative Facts

UT-Battelle, LLC

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Pension Plan for Employees at ORNL	001	Defined Benefit	Calendar	Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Employee (as of 1/1/2013) and Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
Savings Plan for Employees at ORNL	002	Defined Contribution and 401(k) Plan	Calendar	Charles Schwab Retirement Plan Services Charles Schwab Trust Company serves as Trustee 12401 Research Blvd. 02-130 Austin, TX 78759	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Group Life Insurance	511	Welfare	Calendar	Metropolitan Life Insurance Company	Retiree and Company	Benefits are paid from an insurance contract
Health Benefits—*Under age 65 Retiree* (Medical, Dental, Vision)	510	Welfare	Calendar	UnitedHealthcare—Medical MetLife—Dental Delta Dental Plan of Ohio—Dental Vision Service Plan (VSP)—Vision Care	Retiree and Company	Benefits are paid (through a claims administrator) from retiree contributions and the general assets of the Company
Health Reimbursement Arrangement for Retirees of ORNL (Post-65 Plan)	510	Welfare	Calendar	Via Benefits	Company	Benefits are paid (through a claims administrator) from the general assets of the Company
Prescription Drug Plan	510	Welfare	Calendar	Express Scripts	Retiree and Company	Benefits are paid (through a claims administrator, Express Scripts) from Retiree contributions and general assets of the Company
Long-Term Care Plan	511	Welfare	Calendar	MetLife	Retiree	Benefits are paid from an insurance contract

Your Rights Under COBRA

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

COBRA Participation

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

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

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

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

COBRA Continuation Period		
Qualifying Event (if accompanied by a loss of coverage)	Maximum Continuation Period	
	Spouse	**Child**
You die	36 months*	36 months*
You and your spouse legally separate or divorce	36 months	36 months
Your child no longer qualifies as an eligible dependent	N/A	36 months
*If your dependent is eligible for extended coverage under the Medical Plan, as described in the "Medical Plan" chapter, the maximum COBRA period will be reduced by the length of that extended coverage.		

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to a plan sponsor, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and other eligible dependents also will become Qualified Beneficiaries if bankruptcy results in their loss of coverage under the group health plan.

Choosing COBRA

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

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

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

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

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

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

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

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

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

Notification

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

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

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

or

- the Company's group health plans are terminated.

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

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

Your Rights Under ERISA

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

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

Assistance With Your Questions

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

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

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

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

11. Contact Information

For all your benefit questions, call ...	
ORNL Benefits Service Center PO Box 32290 Louisville, KY 40232 Website: https://portal.adp.com Phone: 1-800-211-3622 TTY Service: 1-800-855-2880 (http://relayservices.att.com) Fax: 1-866-265-8283 E-mail: ORNL.BenefitsSupport@ADP.com	ORNL Benefits Office PO Box 2008 MS 6465 Oak Ridge, TN 37831-6465 Website: http://benefits.ornl.gov 1-865-574-7474

Benefit	Plan Provider	Contact Information
Medical—UnitedHealthcare Plans (Under age 65 retirees)	UnitedHealthcare	**Member Services** 1-844-234-7925
		To file a claim, mail your completed claim form to the address shown on your ID card
		Website www.myuhc.com
Hospital Precertification (for the UnitedHealthcare Indemnity Plan)	UnitedHealthcare	**Member Services** 1-844-234-7925
Prescription Drugs (Under age 65 retirees)	Express Scripts	**Member Services** 1-866-749-0097
		To mail order forms for new prescriptions: Express Scripts PO Box 650322 Dallas, TX 75265-0322
		To order or manage your prescriptions online: www.express-scripts.com
		For the automated refill system: 1-800-473-3455
		For instructions on how to fax your prescription, have your doctor call: 1-888-327-9791
Vision (Under age 65 retirees)	Vision Service Plan	**Member Services** 1-800-877-7195
		To file a claim, mail your claim to: Vision Service Plan Attn: Out-of-Network Provider Claims PO Box 385018 Birmingham, AL 35238-5018
		Website www.vsp.com

Benefit	Plan Provider	Contact Information
Dental (Under age 65 retirees)	MetLife	**Member Services** 1-800-942-0854
		To file a claim, mail your claim to: MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282
		Website www.metlife.com
Dental (Under age 65 retirees)	Delta Dental	**Member Services** 1-800-524-0149
		To file a claim, mail your claim to: Delta Dental PO Box 9085 Farmington Hills, MI 48333-9085
		Website www.deltadentaloh.com
Disease Management Program (Under age 65 retirees) *Clinical support for specific chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure*	UnitedHealthcare (UHC)	**Disease Management Program** 1-844-234-7925
Over 65 Medicare Supplement Program, including the Health Reimbursement Arrangement (HRA) (Over age 65 retirees)	Via Benefits	**Member Services** 1-888-592-8348 TTY: 1-866-508-5123
		Mailing Address Via Benefits PO Box 2396 Omaha, NE 68103-2396
		Website https://myviabenefits.com/ornl
Prescription Drugs (Over age 65 retirees)	Express Scripts	**Member Services** 1-877-701-9946 TTY: 1-800-716-3231
		To mail order forms for new prescriptions: Express Scripts PO Box 30493 Tampa, FL 33633-0561
		To order or manage your prescriptions online: www.express-scripts.com
		Telephone refills 1-877-701-9946

Benefit	Plan Provider	Contact Information
		For instructions on how to fax your prescription, have your doctor call: 1-888-327-9791
Long-Term Care Current participants only	MetLife	**Member Services** 1-800-438-6388
		Mailing Address Metropolitan Life Insurance Company PO Box 937 Westport, CT 06881-0937
		Website http://utbattelle.metlife.com
Life Insurance	MetLife	**Statement of Health Unit** 1-800-638-6420, prompt 1
		For Life Insurance Conversion Information 1-877-275-6387
Savings Plan	ORNL Savings, Retirement, and Investment Committee Charles Schwab Savings Information Line	**Mailing Address** UT-Battelle c/o Plan Administrator's Office PO Box 2008 Oak Ridge, TN 37831
		Participant Services United States: 1-800-724-7526 International: 1-330-908-4777 TTY Service: 1-800-345-2550
		Website https://workplace.schwab.com
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	HealthEquity/WageWorks	Member Services 1-855-556-5737 Fax: 1-866-450-5634 Mybenefits.wageworks.com
		Mailing Address WageWorks PO Box 223684 Dallas, Texas 75222-3684
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*	Inspira Financial on behalf of ADP	**Member Services** 1-855-899-5049
		Billing Address **Inspira Financial** Benefit Billing Department PO Box 953374 St. Louis, MO 63195-3374
Social Security Administration		**Toll-Free Number** 1-800-772-1213
		Oak Ridge Office 1-800-999-1118