YOUR BENEFITS SUMMARY PLAN DESCRIPTION

IGUA SPO EMPLOYEES

ORNL BENEFITS

OAK RIDGE National Laboratory

EFFECTIVE 01/01/2024

Contents

1. About Your Benefits

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

All capitalized terms are defined in the Glossary subsection at the end of this section.

Highlights

Your Benefits ...

Provide Eligibility for You and Your Family

As a **Regular Full-Time Employee, Regular Part-Time Employee** you are eligible for coverage under most benefit plans, including Medical, Dental, Life, Legal, and Accident Insurance, the Savings Plan, and the Pension Plan, on your first day of work. Casual Employees are not eligible for Short-Term or Long-Term Disability benefits or Dependent Care Flexible Spending Accounts (FSA).

Offer Coverage Automatically

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

- Employee Assistance Program
- Short-Term Disability and Long-Term Disability (eligible as defined in the “Disability Coverage” and the “Glossary”)
- Business Travel Accident Insurance
- Pension Plan
- On-Site Medical Clinics

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

Let You Choose the Coverage That Is Right for You

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

- Medical (including Prescription Drugs and Vision Care)
- Dental
- Dependent Care FSA
- Health Savings Account
- Basic and Supplemental Life Insurance
- Spouse and Dependent Life Insurance
- Accidental Death & Dismemberment Insurance (AD&D)
- Legal Insurance
- Savings Plan

Offer Tax-Effective Coverage

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

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

Eligibility and Enrollment

Employee

You are eligible to participate in the benefit plans described in this book if you are employed and paid as a Regular Full-Time Employee of the Company working on a regular basis, a Regular Part-Time Employee working a fixed schedule, or a Full-Time Temporary Employee who is hired to work at least 6 months.

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

Individuals who are paid as independent contractors or who are leased from another employer are not employees and are not eligible to participate in the benefit plans described in this benefit summary book.

Dependents

Eligible dependents may include your Spouse, your Children, and Adult Disabled Children (at any age). You may choose to cover your eligible dependents for Medical (including prescription drugs and vision care) and Dental coverage. Your Spouse and Children are eligible for Life, AD&D, and Legal Insurance coverage. All eligible dependents may also use the Employee Assistance Program.

Dependent Verification

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

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

Continuation of Coverage

Medical (including prescription drugs and vision care) Dental, and Legal Insurance coverage may be continued for an unmarried Child who is incapable of self-support due to a physical or mental handicap that began before he or she reached age 26, provided you submit proof of the Child's disability to the insurance company within 30 days after the Child attains age 26 and you remain a participant in the plan. For newly hired employees, an Adult Disabled Child who has been continuously covered under another employer's group health plan since immediately before turning age 26 is treated as satisfying the requirement. Additional proof of the Child's continuing disability will be required periodically.

Administrative Information

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

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

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

Child Life Insurance coverage may be continued for an unmarried Child who is incapable of self-support due to a physical or mental handicap that began before he or she reached age 26.

AD&D coverage may be continued indefinitely for an unmarried Child who is incapable of self-support due to a physical or mental handicap that began before he or she reached age 19.

The terms “Eligible Dependents,” “Spouse,” and “Child” are defined in the Glossary.

Special Eligibility Rules for Families

If you and your spouse both work for the Company or if your spouse is a retiree and you are both 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 an employee, or you may be enrolled as a spouse (either in this plan or the retiree plan). However, you may not enroll for coverage as an employee and as a spouse. In addition, only one of you may enroll your eligible dependent children.

If more than one parent of a dependent child works for the Company, only one of you may enroll your eligible dependent child.

If you are under age 26 and you and one of your parents work for the Company and are eligible to participate in the Company’s benefit plans, you may enroll in the plan as an employee, or you may be enrolled as a dependent. However, you may not enroll for coverage as an employee and as a dependent.

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

Benefits with no enrollment required:

- Employee Assistance Program
- Short-Term Disability
- Long-Term Disability
- Business Travel Accident Insurance
- On-Site Medical Clinics
- Pension Plan

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

- Medical (including Prescription Drugs and Vision Care)
- Dental
- Dependent Care FSA
- Basic and Supplemental Life Insurance
- Spouse and Dependent Life Insurance
- AD&D
- Legal Insurance
- Savings Plan

When You May Enroll

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

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

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

Open Enrollment

All employees may enroll for benefits for which they are eligible during the annual Open Enrollment period held in October or November of each year. Coverage is effective beginning January 1 of the following year.

Enrollment in the Dependent Care FSA is not automatic and must be reelected each year.

Contributions to the Health Savings Account (HSA) must be elected each year. All other benefit elections remain in effect without reenrollment each year.

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

Savings Plan

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

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

You may also call Schwab Retirement Plan Services Company. Hours are 8 a.m.–10 p.m. Eastern time, Monday through Friday (except on days when the New York Stock Exchange is closed).

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

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

Beneficiaries

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

When You May Change Your Elections

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

Other election changes can be made annually, during the Open Enrollment period, or within 30 days of a Qualifying Mid-Year Event.

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

If you would like to request a midyear election change because of a Qualifying Mid-Year Event, you must do so through the ORNL Benefits Service Center website at my.adp.com or by phone at 1-800-211- 3622. This election must be made within 30 days of the event.

When Coverage Begins

New Hires

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

Current Employees

Changes Made During Open Enrollment

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

Changes at Other Times

If you change the elections for your Medical, Dental, or Legal Insurance or your Dependent Care FSA because of a Qualifying Mid-Year Event, or change the elections for your Life or AD&D Insurance, the changes will be effective on the date described in the chart below.

Benefit Plan	Your Coverage Will Begin…
Medical (including Prescription Drugs and Vision Care), Dental, and Legal Insurance	**New Regular Full-Time Employees, and Regular Part-Time Employees:** on your first day of work, provided you enroll within 30 days of that date. If you do not enroll within 30 days after you first become eligible, you will have to wait until the next Open Enrollment to enroll. Your coverage will become effective the first day of the plan year following Open Enrollment, currently January 1.
	Current Employees: Election and enrollment changes made as a result of a Qualifying Mid-Year Event must be made within 30 days of the event. In this case, coverage is effective on the qualifying event date.
Employee Assistance Program	On your first day of work.
Dependent Care FSA	**New Employees:** Payroll deductions begin as soon as administratively possible and in accordance with IRS rules following your election; however, you may claim eligible expenses beginning on your first day of work. Pre-tax and after-tax deductions are made based on IRS rules. Casual Employees are not eligible.
	Current Employees: Election and enrollment changes made as a result of a Qualifying Mid-Year Event must be made within 30 days of the event. Coverage is effective beginning the date the election is made**. For birth or adoption, coverage is effective beginning the date of the event.**
Short-Term Disability	Refer to the “Disability Coverage” chapter.
Long-Term Disability	On your first day of work.
Savings Plan	Your contributions in the form of payroll deductions will begin as soon as administratively possible after you enroll, generally within 30 days.
Pension Plan	On your first day of work.
Basic Life Insurance	**New Employees**: On your first day of work, provided you enroll within 30 days after you become eligible. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
	Current Employees: Satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
Supplemental Life Insurance	**New Employees:** On your first day of work, provided you enroll within 30 days after you become eligible. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
	Current Employees: Satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
Spouse and Dependent Life Insurance	**New Employees:** On your first day of work, provided you enroll within 30 days after you become eligible for guaranteed issue amounts. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
	Current Employees: Satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
AD&D	**New Employees**: On your first day of work, provided you enroll within 30 days after you become eligible.
	Current Employees: If changes are made to the plan using the Life Accident Insurance changes life event, the change is effective the date of the event.
Business Travel Accident Insurance	On your first day of work

Qualifying Mid-Year Events

You may change your pre-tax Medical, Dental, and Legal Insurance elections as well as your Dependent Care FSA contributions during the year only on account of and consistent with a Qualifying Mid-Year Event. A change during the year must be made within 30 days of the Qualifying Mid-Year Event or within 60 days of certain special enrollment events.

Change in Status Events

The IRS permits election changes when an eligible individual experiences certain events, if those events also impact eligibility for benefits. These Qualifying Mid-Year Events due to a change in status include:

- marriage, legal separation, annulment, or divorce
- the death of your Spouse or Child
- the birth or adoption (or placement for adoption) of your Child
- the loss or gain of benefit eligibility of your Child
- the termination or commencement of employment of you, your Spouse, or your Child
- reduction or increase in hours of employment of you, your Spouse, or your Child, including a switch between part-time and full-time employment, a strike or lockout, or commencement of or return from an unpaid leave of absence.

Change in Other Coverage

The IRS also permits election changes in certain scenarios where an eligible individual, their Spouse, or Children experience a change in coverage or eligibility under another plan. These Qualifying Mid-Year Events due to a change in coverage include:

- a change in health coverage due to your Spouse's employment
- a "special enrollment period" under the group health plan as required by law, including loss of coverage for Medicaid or a state Children's Health Insurance Program (CHIP) or gaining eligibility for Medicaid or CHIP
- a qualified medical child support order that requires your Child to be covered under the group medical and/or dental plan
- you, your Spouse or Child becomes eligible (or loses eligibility) for Medicare or Medicaid
- you, your Spouse or Child lose coverage under any group health coverage sponsored by a governmental or educational institution, including: (i) Tricare; (ii) a medical care program of an Indian Tribal government; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

  or
- involuntary loss of other group health plan coverage.

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

Please note that becoming eligible for Tricare is not an allowable Qualifying Mid-Year Event under IRS rules and you, therefore, cannot drop your coverage mid-year due to becoming eligible for Tricare.

Here are a few examples of election changes that are consistent with a Qualifying Mid-Year Event:

Example of Changes Consistent with a Qualifying Mid-Year Event

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

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

For your election to be effective, the Plan Administrator must determine that your requested Qualifying Mid-Year Event change is consistent with the event. If the event does not correspond with a change in benefit eligibility, it is not a Qualifying Mid-Year Event.

REMINDER: Enrollment must be completed within 30 days of any Qualifying Mid-Year Event or a special enrollment period for gaining eligibility or losing coverage, or within 60 days of becoming eligible for premium assistance under Medicaid or CHIP or losing eligibility for Medicaid or CHIP. Otherwise, you will have to wait until Open Enrollment to enroll, and the coverage will not be effective until the next January 1.

Change in Cost of Coverage

In addition to the changes listed above, if there is a **significant** change in the cost of coverage of a benefit option, you may be entitled to make a corresponding change in your election within 30 days of the event. If a new benefit option is added or improved significantly or curtailed by the Company or by your dependent's employer, you may be permitted to make a corresponding new election.

If you contribute to the Dependent Care Flexible Spending Account, and there is an increase or decrease in the cost of services by a day care provider who is not your relative, you can make a corresponding change to your contribution election for your Dependent Care Spending Account by submitting a new election within 30 days of the change. If your dependent care provider changes or services are significantly curtailed, you may be able to change your election within 30 days. For example, if mid-year, your mother will begin taking care of your Child at no cost and you no longer need your current dependent care center, you can revoke your election to contribute to the dependent care spending account due to a change in coverage. However, if your mother wants a payment mid-year, you cannot increase your contributions to this account due to a change in cost because she is your relative.

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

Change in Employment Status

In addition, if you were working 30 or more hours per week and experience a change in employment such that you are now expected to work less than 30 hours per week, you may prospectively revoke your Medical, Dental, and/or Vision coverage. This change is permissible under IRS rules even though you may remain eligible for coverage after the change in employment status. To be eligible to drop your coverage mid-year for this reason, you must certify that you and any Spouse or Child whose coverage you wish to drop have enrolled or intend to enroll in another plan providing minimum essential health coverage no later than the first day of the second month following the date you will no longer have coverage in this Plan. You must elect to drop your coverage within 30 days of your change in employment status.

How Changes Affect Your Benefits

Steps to Take If You Get Married or Divorced

If You Get Married …

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

Make any changes to your benefit elections within 30 days of your marriage on the Benefits Enrollment website at my.adp.com or call the ORNL Benefits Service Center at 1-800-211-3622.

Review your Spouse's benefits so you can coordinate coverage to your best advantage. If you are adding your Spouse to your medical and/or dental coverage, a copy of your marriage license must be submitted within the 30-day enrollment window.

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

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

To update your Savings Plan beneficiary information, request a Savings Plan beneficiary form from the Savings Plan website or by calling Charles Schwab Retirement Plan Services. Keep in mind that if you have been married for at least 1 year and you want to designate someone other than your Spouse as your beneficiary, you must have your Spouse's written and notarized consent. Contact Charles Schwab Retirement Plan Services or the ORNL Benefits Office for more information.

If You Get Divorced …

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

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

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

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

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

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

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

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

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

Steps to Take If You Are Expecting or Adopting a Child

If You or Your Spouse Is Pregnant ...

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

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

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

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

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

If You Adopt a Child ...

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

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

When Your Child Arrives

For Medical 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.

Consider beginning or increasing your contributions to the Health Savings Account and/or Dependent Care FSA, so you can pay for your Child's unreimbursed medical expenses and child care expenses with pre-tax dollars.

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

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

You must provide a copy of the birth certificate or adoption papers by the date on the Dependent Verification Services (DVS) Notice.

Steps to Take If You Become Disabled

If You Become Disabled …

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

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

For IGUA CAS

Receive Short-Term Disability benefits for up to 6 months of disability (if eligible). If your disability continues longer than 6 months, you can apply for Long-Term Disability benefits.

Contact the claims administrator and file forms for Long-Term Disability benefits if your disability will continue longer than 6 months.

For IGUA SPO

Receive Short-Term Disability benefits for up to 26 weeks of disability (if eligible). If your disability continues longer than 26 weeks, you can apply for Long-Term Disability benefits.

Contact the claims administrator and file forms for Long-Term Disability benefits if your disability will continue longer than 26 weeks.

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

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

What Happens to Your Benefits If You Become Disabled

Here is what happens to your benefits during a disability:

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

During Short-Term Disability

Coverage continues. Contributions are deducted from your disability benefits.

During Long-Term Disability

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

Employee Assistance Program

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

Dependent Care FSA

During Short-Term Disability

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

During Long-Term Disability

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

Short-Term and Long-Term Disability

Short-Term Disability provides benefits for up to 6 months of disability, depending on your length of service. Long-Term Disability benefits provide a percentage of your annual Pay, up to a maximum of 60% of your annual Pay, not to exceed $5,000 per month, offset by Social Security and other benefits payable. Eligibility for benefits is defined in the “Disability Coverage” chapter.

Basic Life Insurance and Supplemental Life Insurance

During Short-Term Disability and Long-Term Disability

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

Spouse and Dependent Life Insurance

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

Business Travel Accident Insurance

During Short-Term Disability and Long-Term Disability

Coverage ends. However, if within 365 days of a covered accident, you become Totally and Permanently Disabled as a result of an injury sustained in the accident, you will receive a lump-sum payment of four times your annual pay to a maximum of $500,000, subject to the maximum amount, after you have been Totally and Permanently Disabled for 12 consecutive months.

AD&D

During Short-Term Disability and Long-Term Disability

Coverage continues during Short-Term Disability and during Long-Term Disability, provided you pay the premiums.

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

During Short-Term Disability and Long-Term Disability

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

Savings Plan

During Short-Term Disability

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

During Long-Term Disability

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

Steps to Take If You Leave the Company

If You Leave the Company …

Notify your supervisor.

Apply for COBRA within 60 days from the date your coverage ends if you wish to continue Medical (including prescription drugs and vision care) or Dental coverage.

Convert your Life, Spouse and Dependent Life, and Accident Insurance to a private policy within 30 days of your termination if you wish to continue this type of coverage. Metropolitan Life Insurance will send you

a conversion notice. For AD&D conversion, you may request a form from the ORNL Benefits Service Center.

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

Decide whether to leave your account balance in the Savings Plan or take a distribution. Notify the ORNL Benefits Office if your address changes.

What Happens to Your Benefits If You Leave the Company

Medical (Including Prescription Drugs and Vision Care)

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

Dental

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

Employee Assistance Program

Coverage ends 18 months after employment terminates.

Dependent Care FSA

Coverage ends. You may submit Dependent Care FSA claims for expenses incurred before your termination.

Disability

Coverage ends.

Life and Accident Insurance

Coverage ends on the last day of the month in which your employment terminates. You may convert your Basic Life, Supplemental Life, and Spouse and Dependent Life to individual whole life policies. You may choose the portability option under Supplemental Life Insurance, which allows you to continue this coverage under a term life policy. Metropolitan Life Insurance will send you a conversion notice. You may also convert your AD&D policy if you are under age 70. You may not convert Business Travel Accident Insurance.

Legal Insurance

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

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

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

Savings Plan

Contributions end. You may choose to receive a payout of your full vested account balance, or you may leave it in the Savings Plan. Any outstanding loans must be paid within 90 days of termination.

Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

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

What Happens to Your Benefits When You Turn Age 65

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

Medical (Including Prescription Drugs and Vision Care)

Coverage for you and your dependents continues.

Medicare

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

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

Consumer Choice Medical Plan with Health Savings Account

If you are enrolled in the Consumer Choice medical plan, you may continue to make contributions to your HSA as long as you are not enrolled in Medicare Part A or B. However, if you apply for Social Security, you should stop all contributions to your HSA up to 6 months before you collect Social Security. When you apply for Social Security, Medicare Part A will be retroactive for up to 6 months (as long as you were eligible for Medicare during those 6 months). If you do not stop contributing to the HSA 6 months before you apply for Social Security, you may incur a tax penalty on your excess contributions.

See the "Medical Plan" chapter for more information.

At Age 70½ …

You may begin your pension benefit.

See the "Pension" chapter for more information.

Steps to Take When You Retire

If You Are About to Retire …

Visit the ORNL Benefits website to generate a calculation of your estimated pension benefit. Attend a retirement planning seminar to understand your retirement options.

Notify your supervisor.

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

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

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

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

What Happens to Benefits When You Retire

Medical (Including Prescription Drugs and Vision Care) and Dental

For IGUA employees hired prior to August 15, 2016

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

For IGUA employees hired on or after August 15, 2016

- If you have at least 10 years of full-time Company service, you will pay the full cost.

If you retire prior to age 65, you may continue coverage under the medical and/or dental plans offered to retirees under age 65 until the first of the month in which you reach age 65. At age 65, coverage ends, and you may become eligible for the Over Age 65 Medicare Supplement program. You may elect to continue coverage under the medical plan for a Spouse under age 65 and eligible dependents until your Spouse reaches age 65, as long as you are enrolled in the Over Age 65 Medicare Supplement program. Your under age 65 Spouse and dependents may continue enrollment in the Dental Plan until your Spouse reaches age 65, regardless of whether or not you are enrolled in the Over Age 65 Medicare Supplement program. In any case, when your coverage ends at age 65, eligible dependents may be able to continue coverage for up to 36 months under COBRA. rules are based on when you were hired and the number of years you were classified as a full-time employee.

For IGUA employees hired on or after August 15, 2016

- If you have less than 10 years of Company service, you will be offered COBRA.

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

Employee Assistance Program

Coverage ends 18 months after employment terminates.

Dependent Care FSA

Participation in the Dependent Care FSA ends. You may submit claims for eligible dependent care expenses incurred before you retire.

Disability Coverage ends. Legal Insurance

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

For IGUA Employees Hired Prior to August 15, 2016

Basic Life Insurance

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

Supplemental Life Insurance

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

For IGUA employees Hired on or after August 15, 2016

Basic and Supplemental Life Insurance

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

Spouse and Dependent Life Insurance

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

Business Travel Accident Insurance

Coverage ends.

AD&D

Coverage ends. You may convert your AD&D coverage to an individual policy if you are under age 70.

Pension Plan

You will receive monthly pension benefits at the time and according to the payment option you have selected.

Savings Plan

Contributions end. You may choose from a variety of payout methods or you can leave your account balance in the Savings Plan until you reach your required beginning date. Mandatory minimum distribution rules apply after your required beginning date if you have retired from the Company. Any outstanding loans must be paid within 90 days of your retirement. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

Steps to Be Taken If You or a Family Member Dies

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

Notify the ORNL Benefits Office of the death.

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

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

If You Die, Your Survivors May…

Convert any family AD&D coverage to a private policy within 30 days of your death if they wish to continue this coverage.

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

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

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

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

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

Complete a AD&D claim form if you are enrolled for family AD&D coverage and the death was accidental. Send the completed form(s), along with a certified death certificate and other supporting information, to the ORNL Benefits Office.

Change your Medical (including prescription drugs and vision care), Dental, Dependent Care FSA, Life, and AD&D elections within 30 days of the death, if coverage changes are appropriate.

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

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

What Happens to Your Benefits If You Die

Medical (Including Prescription Drugs and Vision Care) and Dental

Your eligible dependents who were enrolled in the Plan at the time of your death may elect to continue Medical (including prescription drugs and vision care) and Dental coverage for 3 months at the appropriate active employee contribution rate.

Administrative Information

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

If you were not eligible to retire under the

Pension Plan when you died, your enrolled dependents may continue coverage after the initial 3-month period for an additional 33 months through COBRA.

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

For IGUA employees hired prior to August 15, 2016

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

For IGUA employees hired on or after August 15, 2016

- If you have at least 10 years of full-time Company service, you will pay the full cost.

- If you have less than 10 years of Company service, you will be offered COBRA.

Employee Assistance Program

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

Dependent Care FSA

Coverage ends. Dependents may submit Dependent Care FSA claims for expenses incurred before your death.

Life and Accident Insurance

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

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

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

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

Legal Insurance

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

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

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

Savings Plan

Your beneficiary may receive your full account balance in a lump sum or as a rollover to an individual retirement account. However, your spousal beneficiary may choose either a lump-sum payment or monthly installments. Your spousal beneficiary may also elect to defer payment until the latest date permitted by the tax laws.

Paying for Your Benefits

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

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

For elections made within 30 days of the birth or adoption or placement for adoption of a Child, all payments required for coverage from the date of such event will be deducted on a pre-tax basis if elected within

30 days. Pre-tax payroll deductions can be changed only if you have a Qualifying Life Event and you contact the ORNL Benefits Service Center within 30 days of the Qualifying Life Event. Therefore, if you have a Qualifying Life Event and drop a dependent but do not notify the ORNL Benefits Service Center within

30 days of the Qualifying Life Event, you may have a change in coverage level but no change in premium until the following year.

Rights and Responsibilities

The Company may—but is not required to—share in the cost of the benefits offered to you. You must enroll in a timely manner and pay your share of any cost. To participate in the plans, you must allow the Company to use your individual information (such as address and phone numbers, including private phone numbers, or whatever is minimally necessary to fully administer any and all benefit plans).

The Company will share your individual information with third-party vendors only to the extent minimally necessary to support the administrative processes and features of the benefit plan. Vendor and service contracts will be maintained that exclusively limit the use of your individual information to the operation of the specific benefit program for which the vendor provides service. Benefit plans such as medical and prescription drugs may include managed care, disease or wellness management, and utilization management programs, which are incorporated programs of the benefit plan. The Company reserves the right to incorporate these management programs into the benefits plans offered.

Pre-Tax Contributions

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

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

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

When Coverage Ends

Coverage for You

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

- the date your employment terminates, with these exceptions:
  - for Medical (including prescription drugs and vision care) Dental, and Legal Insurance coverage, the last day of the month in which your employment terminates
  - for Long-Term Disability coverage, the date your employment terminates for any reason, unless you are totally disabled at the time of distribution
  - for Basic Life Insurance coverage, the last day of the month in which your employment terminates for any reason other than retirement after you become eligible for an immediate pension benefit or total disability (see the "Life and Accident Coverage" chapter for more information)
- coverage under the Company's benefit plans will end on the last day of the month in which you have not actively returned to work and either (i) your Short-term Disability benefits end and you are not approved for Long-Term Disability benefits or (ii) your Long-Term Disability benefits end.
- the date you are no longer considered eligible because of a change in your employment status
- the last day of the period for which your last contribution was made (if you fail to make any required contribution)

  or
- the date the plan is terminated.

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

If your coverage ends, you may be eligible to extend Medical coverage (including prescription drugs and vision care) and Dental coverage under COBRA.

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

Coverage for Your Dependents

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

When your dependent Child turns age 26, coverage for Medical (including prescription drugs and vision), Dental, and Legal Insurance will end at the end of the month of their 26th birthday, unless the child has been certified as an Adult Disabled Child.

Administrative Information

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

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

AD&D coverage for a dependent Child will end when they turn age 19 or age 26 if enrolled full-time in a college, university or trade school. Coverage can be extended for a dependent if prior to the age they would have lost coverage they became incapable of self-sustaining employment by reason of mental retardation or physical handicap.

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 for support; and
- the child is certified by the claims administrator for the Plan as incapacitated due to disability.

For current employees dependents, 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.

Casual Employees

An employee working on an intermittent or on-call basis under no declared schedule, or a full-time temporary employee working for less than 6 months.

Casual Retiree

Limited to ORNL retirees who return to work on an intermittent or on-call basis. Casual Retirees are not eligible for any benefits (except the Savings Plan) other than the benefits they elected when they retired.

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.

For Business Travel and AD&D Coverage
Your natural child, stepchild, foster child, legally adopted child, or child of adopting parents, pending adoption, who relies on you for more than 50% of their support and maintenance.

For Life Insurance
Your unmarried children from birth to age 26.

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.

For Medical and Dental Coverage and Employee Assistance Program (continued)

- Disabled Adult 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.

For Dependent Care FSA

Your eligible dependents are:

- the person who is recognized under applicable law as your Spouse, Child or other qualifying relative (if such relative lives with you for at least half the year and regularly spends at least 8 hours per day in your house during the period of time dependent care is being provided) and who is mentally or physically disabled and unable to provide care for himself or herself
- a Child who is less than 13 years old.

For Business Travel Accident Insurance and AD&D Coverage

Your eligible dependents are your Spouse and your Dependent Child(ren). The Dependent will only be a Covered Dependent if a Plan covering Dependents is selected.

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

For Spouse and Dependent Life Insurance

Your eligible dependents are your Spouse and your unmarried Children from birth to 26 years.

Full-Time Temporary Employee

A non-exempt employee who is scheduled to work at least 40 hours per week or an exempt employee who is scheduled to work at least 173.3 hours per month for 6 months up to a maximum of three years. This includes postdocs.

Long-Term Disability

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

6 months.

Regular Full-Time Employee

A non-exempt employee who is scheduled to work at least 40 hours per week on a regular basis or an exempt employee who is scheduled to work at least 173.3 hours per month on a regular basis.

Regular Part-Time Employee

A non-exempt employee who is scheduled to work at least 20-36 hours per week on a regular basis or an exempt employee who is scheduled to work at least 87-156 hours per month on a regular basis. (Hired either to work 50% up to 90% of a declared schedule, in 10% increments)

Short-Term Disability

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

Spouse

An individual to whom you are lawfully married, whether the individual is the opposite sex or the same sex. Individuals of the same sex will be considered to be lawfully married for purposes of the plans as long as they were married in the United State, in a US territory, or in a foreign jurisdiction whose laws authorize the marriage of two individuals of the same sex.

2. Medical Plans

Consumer Choice Plan

All Capitalized terms are defined in the Glossary subsection at the end of this section.

How The Consumer Choice Plan Works

What this section includes:

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

Accessing Benefits

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

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

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

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

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 <u>not</u>:

- 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.

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 or the Recognized Amount that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

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

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

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non- Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses or the Recognized Amount when applicable.	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

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	$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	$5,000	$10,000

Plan Features	Network Amounts	Non-Network Amounts
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.		
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.	Unlimited	
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).		

Schedule of Benefits

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services, as described in the definition of Recognized Amount in the Glossary.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Ambulance Services		
• 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.	

Congenital Heart Disease (CHD) Surgeries	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
COVID-19 Testing	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
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 Services[1]	**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.	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
Home Health Care	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**
• 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.		
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.	
Ostomy Supplies	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient *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	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**
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.		
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.	
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	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Any combination of Network Benefits and Non-Network Benefits is limited to: • 60 days per calendar year.		
Substance-Related and Addictive Disorders Services		
• Inpatient.	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**
• 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
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.	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.*

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Did you know…

You generally pay less out-of-pocket when you use a Network provider?

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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 generating 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

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods 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, 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

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.

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

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

Services include the following:

Diagnostic evaluations, assessment and treatment, 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 a provider 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, 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 treatment, 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 a provider 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, 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

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.
- You have a 3-month physician supervised diet documented within the last 2 years.

See *Bariatric Resource Services (BRS)* under *Clinical Programs and Resources* for more information on the BRS program.

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.

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.

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.
- 25 visits per calendar year for Manipulative Treatment.

Unlimited visits per calendar year for post-cochlear implant aural therapy. These visit limits apply to Network Benefits and Non-Network Benefits combined. Visit limits for Manipulative Treatment applies to Network Benefits only.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

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

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

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

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

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

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If authorization is not obtained as required, or notification is not provided, Benefits will be reduced 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.

Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, 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 a 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, 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 *Complex Medical Conditions 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.

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 Management Services.
- Complex Medical Conditions Programs and Services.
- Women’s Health/Reproductive.

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

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, animal assisted 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. This exclusion does not apply to non-accident-related dental services for which Benefits are provided as described under *Dental Services – Non-Accidental* in *Additional Coverage Details.*
   - 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 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.
- 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.

Medical Supplies

- Disposable medical supplies, including ace bandages, gauze, dressings, tubing, masks are covered when used for the effective use of Durable Medical Equipment or prosthetics only.
- 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*.
- Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
- 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 or behavioral/mental health related 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.
- 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*.
- Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
- Oral vitamins and minerals.
- Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
- Other dietary and electrolyte supplements.

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:

- 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.
- 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 Infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
   - 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 or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to a Gestational Carrier or Surrogate:
    - Fees for the use of a Gestational Carrier or Surrogate.
    - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
    - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
    - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
    - Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
    - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
5. InVitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
6. Assisted Reproductive Technology procedures 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).
10. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

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 *Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services* described above under *Clinical Programs and Resources* and, except as identified under *Travel and Lodging* in Section 3, *How the Plan Works.* Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Additional Coverage Details*.

Types of Care

1. Custodial Care or maintenance care as defined in the *Glossary* or maintenance care.
2. Domiciliary Care, as defined in the *Glossary.*
3. Multi-disciplinary pain management programs provided on an inpatient basis 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, Copayments, Coinsurance, and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.
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

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of

other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section *Coordination of Benefits*.

Eligible Expenses due to a Non-Network provider for Covered Health Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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.

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 and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. 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* agrees with UnitedHealthcare's determination, 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**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
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**
Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
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**
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

Post-Service Claims Type of Claim or Appeal	Timing
	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

*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.

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. Any claim that you may have relating to or arising under the Plan may only be brought in the U.S. District Court for the Eastern District of Tennessee. No other court is a proper venue or forum for your claim. The U.S. District Court for the Eastern District of Tennessee will have personal jurisdiction over you and any other participant or beneficiary named in the action.

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 Services 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 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 an Opt-out provider or one that does not participate in the Medicare program or 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 the Claims Administrator will use Medicare's Allowable Expense or Medicare's limiting charge for covered services as the Allowable Expense for both the Plan and Medicare.

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.

Anti-Assignment Provision

You may not assign, alienate, pledge, sell, encumber, or transfer benefits for which you may become eligible under this Plan without the Plan's written consent. Any assignment by you will be void. To the extent allowed by law, the Plan will not accept an assignment to a health provider or facility for any reason, including but not limited to, an assignment of:

- The benefits due under the Plan.
- The right to receive payments due under the Plan.
- Any claim you make for damages resulting from a violation or alleged violation of the terms of the Plan, including any breach of fiduciary duties under the ERISA.

Any payments made by the Plan to a health provider do not grant the health provider rights under the Plan or ERISA.

Plan benefits may not be subject to attachment or garnishment by any of your creditors or to legal process.

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.

Incentives to Providers

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

Bundled payments- certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Coinsurance as described in your Schedule of Benefits.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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.

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

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

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 or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in How the Consumer Choice 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.

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 –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. See the Eligible Expenses Section of How the Consumer Choice Plan Works.

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 the UnitedHealthcare as stated below and as detailed in Eligible Expenses Section of How the Consumer Choice Plan Works.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. 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 accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 as appropriate for the proposed use in any of the following:
  AHFS Drug Information (AHFS DI) under therapeutic uses section;
  Elsevier Gold Standard's Clinical Pharmacology under the *indications* section;
  DRUGDEX System by Micromedex under the therapeutic uses *section* and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* under, *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 their 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 diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and

- Provides Emergency Health Services.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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.

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. 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 - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. See the Eligible Expenses Section of How the Consumer Choice Plan Works.

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 - this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. See the Eligible Expenses Section of How the Consumer Choice Plan Works.

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 - 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.

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:

- Services exceed the scope of Intermittent Care in the home.
- 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.

Recognized Amount – the amount which Coinsurance and applicable Deductible is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by 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 Service Act. 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.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
    - 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.

Secretary – as that term is applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

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 and devices, regardless of *U.S. Food and Drug Administration (FDA*) approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

On-Site Medical Services: Occupational Medical Division

Introduction

The ORNL Occupational Medical Division (“ORNL Medical”) manages ORNL’s occupational medical program to help provide for the safety and health of workers at ORNL facilities through the delivery of medical and other occupational health-related services by qualified personnel who possess appropriate licensing, certification, and training. The scope and nature of these medical services rendered are based on regulatory requirements for occupational medical monitoring and surveillance necessary to support the diverse research and operational activities of ORNL. All components of the occupational medical program are evaluated and prioritized with respect to regulatory compliance, their impact on our workers’ health and safety at the site, and their benefit/effectiveness in relation to cost to help contain health care expenditures and to allocate funds in the most judicious manner. For purposes of the reporting and disclosure obligations of the Employee Retirement Income Security Act of 1974, it is a component of the Medical Plan.

Eligibility

You are eligible to receive occupational medical services from ORNL Medical if you are employed and paid as a Regular Full-Time Employee of the Company working on a regular basis, a Regular Part-Time Employee working a fixed schedule, a Full-Time Temporary Employee or a Casual Employee working on an ad hoc or intermittent basis. Casual Retirees are eligible to receive occupational medical services.

Individuals who are paid as independent contractors or who are leased from another employer are not employees and are not eligible to participate in the benefit plans described in this Summary Plan Description.

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

Enrollment

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

Cost of Services

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

Services Provided

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

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

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

Accessing Services

ORNL Medical is open Monday through Friday, 7:00 a.m. to 4:30 p.m. The telephone number is 574-7431, email address is medical@ornl.gov, and website is https://portal09.ornl.gov/sites/hrd/onsitemed/medical.html. If you need care after hours, call 911 (land line only) or the Laboratory Shift Supervisor (LSS) at 576-4LSS or 574-6606.

How Changes Affect Your Benefits

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

Glossary

Employee

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

- **Casual Employee**—An employee who works on an intermittent or on-call basis.
- **Full-Time Temporary Employee**—An employee who is scheduled to work on a full-time basis not to exceed 3 years.
- **Regular Full-Time Employee**—A non-exempt employee who is scheduled to work at least 40 hours per week on a regular basis or an exempt employee who is scheduled to work at least 173.3 hours per month on a regular basis.
- **Regular Part-Time Employee**—A Regular Part-Time employee must work a declared schedule equal to or greater than 50% of a regular, full-time schedule. Schedules are declared in 10% increments (50%, 60%, 70%, 80%, or 90%). Certain benefits are prorated based on the declared schedule, not the actual hours worked.

On-Site Medical Services: The WellOne Clinic

Introduction

The WellOne Clinic assists in achieving and maintaining the highest physical and emotional health of all employees so that optimal job performance may be achieved with minimal stress. This will reduce absenteeism, enhance productivity, and prolong the employee's productive years. The WellOne Clinic is a self-insured, self-administered workplace-based medical services facility that provides outpatient health care to those with access to ORNL facilities. For purposes of the reporting and disclosure obligations of the Employee Retirement Income Security Act of 1974, it is a component of the Medical Plan.

Eligibility

You are eligible to receive benefits and services from the WellOne Clinic if you are authorized to access ORNL facilities. No enrollment is necessary for employees.

You are eligible to receive telehealth services from TeleOne if you are a UT-Battelle employee, TN based DOE employee, on-site subcontractor, or a dependent of a UT-Battelle employee. Dependents much be at least two (2) years of age or older, enrolled in UT-Battelle's Consumer Choice or Prime Select Plan, and reside in Tennessee.

Cost of Services

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

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

When you use telehealth services through TeleOne, no payments are made at the time of service. All services are billable to insurance plans or directly to you if you are not insured. All patients, regardless of insurance status, will be billed for telehealth services.

Services Provided

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

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

Primary Care Services

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

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

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

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

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

Acute Care Services

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

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

Telehealth Services

TeleOne provides many of the same types of services as you would receive through a visit to the WellOne clinic, only virtually. TeleOne is a scheduled clinician appointment, just like making an appointment with a doctor or nurse practitioner. While the visit is conducted through a secure virtual video platform, your TeleOne doctor or nurse practitioner can order imaging, labs and set you up for referrals when necessary. TeleOne provides treatment for the following types of issues:

- Diabetes management
- Hypertension management
- Sore throat
- Cough without shortness of breath
- Mental health concerns
- Medical weight loss
- Allergies
- Review of imaging and laboratory results
- Pre-screening for COVID-like Illnesses (fever, body aches, cough, shortness of breath)
- Routine management and follow-up for chronic disease management
- Sinus congestion
- Dysuria, urinary frequency
- Insect bite, rash, first-degree burn (without blisters)

NOTE: Some services are more appropriately provided in-person. As such, TeleOne staff will only provide those services which may be appropriately provided via telehealth in their professional judgment and may ask you to visit the WellOne clinic in-person and/or to seek in-person

Accessing Services

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

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

TeleOne is open the same hours as the WellOne clinic and may be accessed by calling the same number as the clinic, (865) 574-WELL or (865) 574-9355.

How Changes Affect Your Benefits

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

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.
- You can contact Accredo at 1-800-803-2523 for your Specialty Medications or any network pharmacy.

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, the plan will only cover 90-day supplies, which can be filled at Express Scripts home-delivery or at any network retail pharmacy. If you use the Express Scripts mail-order pharmacy to get up to a 90-day supply, you will 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 you 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

You can purchase specialty medications at a network retail pharmacy or Accredo, the Express Scripts specialty pharmacy. If your doctor prescribes a specialty medicine, you can contact a network retail pharmacy or you can call Accredo at 1-800-803-2523 to confirm your coverage and buy your medicine.

Copayment/Patient Assistance Programs and Accredo

If you qualify for a copayment/patient assistance for your specialty medication and purchase your medication from Accredo, 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.

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

Preventive Care Drugs

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

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 Pre-exposure Prophylaxis

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.

Administrative Information

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

What happens to your benefits when ...

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

Summary of Benefits

Covered Services	Consumer Choice In-Network	Consumer Choice 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	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 the claim. Plan out-of-pocket maximum[2] is $5,000 for individual coverage and $10,000 for all other coverage levels
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	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 the claim. Plan out-of-pocket maximum[2] is $5,000 for individual coverage and $10,000 for all other coverage levels

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

Examples of Prescription Drug costs		
CONSUMER CHOICE with HSA: Retail Brand Preferred Coinsurance Examples After the Deductible is Met		
Drug Cost	**20% Coinsurance**	**Member Pays**
$60	$12	$25 (minimum payment)
$150	$30	$30 (20% of covered cost)
$800	$160	$150 (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)	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)
		Patient: automated call and letter	Patient: live call and letter
Urgent	72 hours**	Prescriber: Electronic or Fax (letter if fax not successful)	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><th rowspan="2">Type of Appeal</th><th rowspan="2">Decision Timeframe
Decisions are completed as soon as possible from receipt of request but no later than:</th><th colspan="2">Notification of Decision</th></tr>
<tr><th>Approval</th><th>Denial</th></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 rowspan="2">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 no 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 your provider. Prior review and approval by VSP are required for you 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 if you 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 an Out-of-Network Provider are subject to the same time limits and co-payment arrangements as described above for an In-Network Provider. If you choose to go out-of-network, you must pay the provider and submit the claims for reimbursement in accordance with an amount not to exceed what VSP would pay an In-Network Provider 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 participants 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. You can self-refer, visit your 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. 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 ...

- 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 $200.

Administrative Information

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

All capitalized terms are defined in the Glossary subsection at the end of this section.

MetLife Dental Plan

For more information on …	See Page …

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 MetLife Dental 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 MetLife Dental 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 MetLife Dental 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 MetLife Dental 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 MetLife Dental Plan. The deductible does not apply to Type A (preventive and diagnostic) or Type D (orthodontic) services.

Maximum Benefits

The MetLife Dental 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 MetLife 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 MetLife Dental 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 MetLife Dental 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 MetLife Dental 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 MetLife Dental 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 coverage 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 coverage 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 MetLife Dental 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 MetLife 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.”

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

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:	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**
• Restorative (fillings, including composites on posterior teeth) • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics • Endodontics (root canal therapy) • Emergency palliative treatment	
• 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 30% 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 your coverage. The dentist and the participant 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 Delta Dental Plan Summary of Benefits. All charges for the following services will be the responsibility of the participant (though the participant's payment obligation may be satisfied by

insurance or some other arrangement for which the participant 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 participant 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

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: To the extent that the Delta Dental Plan provides or pays for covered services, Delta Dental is subrogated to any right you and/or your dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans. To the extent that Delta Dental has a subrogation right, you and/or your dependent must: 1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the covered services that were paid for by Delta Dental; 2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement; 3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount); 4. Sign any document that Delta Dental

determines is relevant to protect Delta Dental's subrogation and reimbursement rights; and 5. Provide relevant information when requested.

d) 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. 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.

e) 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. Non-coordinating Plan
    - If you have another plan that does not coordinate benefits, it will always be primary.
2. Employee
    - The plan that covers you as an employee (neither laid off nor retired) is always primary.
3. 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 (see 4 below).
    - If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.
4. 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.
5. 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 participant 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, your 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.

Full Denture

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

Nonparticipating Dentists

Dentists who have not contracted with Delta Dental.

Orthodontic Treatment

Science of the movement of teeth in the correction of malocclusion.

Participating Dentists

Dentists who have contracted with Delta Dental to accept certain fees for services they provide.

Partial Denture

An appliance supporting artificial teeth less than the full number of teeth in one jaw.

Periodontics

The treatment of disease of the gum and tissues surrounding the teeth.

Prosthodontic Services

The making of artificial devices for replacement of missing teeth and structures in the mouth.

Space Maintainers

Appliances to prevent adjacent teeth from moving into space left by a lost tooth.

6. Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential service designed to help you and your family solve personal problems that may affect your health, family life, or job performance.

Highlights

The EAP …

Offers Services at No Cost to You and Your Eligible Dependents

Consultations with program counselors are provided free of charge, and you may have up to five sessions per personal problem or concern per year. For more information on your or your eligible dependent's eligibility, see the "About Your Benefits" chapter.

Is Available 24 Hours a Day, 7 Days a Week

In an emergency, you can call any time, day or night, on any day of the week. Otherwise, counselors are available for appointments during normal business hours. Appointments are also available during evening hours and Saturdays.

Ensures Complete Confidentiality

Your discussions with counselors are strictly confidential. No information about you or your eligible dependents will be released unless you give written permission, or unless required by law.

What Happens to Your Benefits When ...

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

How the EAP Works

The EAP is administered by an outside firm. The provider offers confidential, professional assessment, referral, and counseling services on a one-on-one basis. The EAP can help you and your eligible dependents with:

- family or marital problems
- job-related issues
- drug or alcohol abuse
- stress, anxiety, depression, or other emotional problems

Program counselors are available for appointments during business hours and are on call for emergencies 24 hours a day, 7 days a week.

When you call the EAP, you will be encouraged to make an appointment to meet with a trained counselor in person. If you decide to meet face-to-face, you will be offered an appointment with a program counselor within 5 days. In an emergency, a counselor will be available to meet with you as soon as possible.

Together, you and the counselor will discuss your concerns and decide the appropriate course of action. You may decide that no additional services are needed, or you may choose to meet with a program counselor for up to four additional sessions (for a maximum of five sessions per personal problem per year). If necessary, the EAP can also help you identify specialized services.

Cost of Treatment

Any consultation between a program counselor and you or your eligible dependents is free of charge.

If you are referred outside the program for treatment, you will be responsible for paying for the treatment. Treatment outside the program may be covered by your medical coverage.

Continuing Treatment ...

If you require extended treatment after your EAP sessions end, you can use the behavioral health benefits available through your UnitedHealthcare Medical Plan. Be sure to ask your EAP provider if he or she also is a UnitedHealthcare provider so you can continue treatment with the same provider on an in-network basis. If your EAP provider is not a UnitedHealthcare provider, you may select an in-network UnitedHealthcare provider or continue to see your EAP counselor on an out-of-network basis.

Confidentiality

Using the EAP is strictly confidential. The provider will never release any information about you or an eligible dependent unless you give your written permission or unless required by law.

Administrative Information

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

How to Contact the EAP

If you or someone in your family needs help, contact the EAP directly at 1-800-888-2273.

7. Flexible Spending Account For Dependent Care

A Dependent Care Flexible Spending Account (FSA) offers a convenient way to pay for dependent care expenses on a pre-tax basis.

Highlights

The FSAs...

Give You Choices

You can contribute to the Dependent Care FSA per Internal Revenue Service (IRS) guidelines. Each year, you can contribute up to the limits set by the IRS for each account. You can use the Dependent Care FSA to pay for day care and elder care expenses for eligible dependents.

Offer Convenience

Your FSA contributions are automatically deducted from each paycheck and credited to your FSA.

Save You Money in Taxes

The money in your accounts is not subject to federal income taxes, Social Security taxes, or Medicare taxes, and, in most places, state and local taxes also do not apply. This means that many of your routine dependent care services will cost you less.

Require Careful Planning

You need to estimate your expenses for the upcoming year carefully, during the annual benefits Open Enrollment, when deciding how much to contribute to the Dependent Care FSAs. According to IRS rules, any money left in your account will be forfeited.

What happens to your benefits when ...

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

How the FSAs Work

Use these guidelines to put the FSAs to work for you:

Estimate your expenses. Each year, calculate your dependent care expenses. You should estimate carefully because you will forfeit any unused funds. The Dependent Care FSA based on the Plan limits. Once you begin contributing, you may not change or stop your contributions during the year unless you have a Qualifying Life Event as described in the “About Your Benefits” chapter.

When the Dependent Care account is effective. For new hires and newly eligible participants, you may use your accounts for expenses incurred beginning the day you first become eligible. For elections made during the annual Open Enrollment, the accounts are effective beginning the following January 1.

Using your account. The FSA administrator maintains a web-based participant portal that makes account information readily available. On the portal, you can do the following:

- Set up direct deposit for your reimbursements
- Get your account balance
- View payment card charges
- Enter claims and view claim status
- Submit required receipts
- View reimbursement schedule
- Find eligible and ineligible expenses, consumer tools, and frequently asked questions.

Incurring expenses. Expenses must be incurred in the plan year for which the election was made and while you were an active participant in the plan. The deadline for filing claims is March 31 following the plan year for which the election was made.

Receive reimbursement. Reimbursements from your accounts are made with pre-tax dollars.

Should You Participate?

Before you decide to contribute to an FSA ask yourself:

What do you expect your dependent care expenses will be?

Consider any times of the year when you do not have these child care expenses, such as vacation periods. Also, if your child will turn 13 during the year, estimate your expenses only for the portion of the year before your child’s thirteenth birthday.

You may also want to use an FSA calculator to help determine how much you should contribute.

Grace Period

IRS regulations provide for a 2½ month grace period for the Dependent Care FSA~~s~~. Under this provision, you are allowed to file claims for expenses incurred through March 15 of the following plan year.

Changing your Contribution

You may not change or stop your contributions to the FSAs during the year unless you have a Qualifying Life Event, such as a birth, a marriage, or a job loss by your spouse. The change in contributions must be consistent with the Qualifying Life Event. For example, with the birth of a child, you can increase your contributions but not decrease them, and the change must be made within 30 days of the Qualifying Life Event.

Changes in Cost for Dependent Care

If you contribute to the Dependent Care FSA, and there is a significant increase or decrease in the cost of services by a day care provider who is not your relative, you may be able to make corresponding changes to your contribution election for your Dependent Care FSA by submitting a new election within 30 days of the change. For example, if mid-year, your mother will begin taking care of your child at no cost and you no longer need your current dependent care center, you can revoke your election to contribute to the Dependent Care FSA due to a significant change in coverage. However, if your mother wants to start receiving an income, you cannot increase your contributions to this account due to a change in cost because she is your relative.

See the “About Your Benefits” chapter for more information on Qualifying Life Events. If you stop contributing to the FSA, you can be reimbursed only for eligible dependent care expenses incurred before you stopped contributing.

Tax Savings

The dependent care FSA is designed for one purpose: to help you save on taxes. Your taxable income is reduced by the amount you contribute to the accounts.

How Much Can You Save on Your Taxes?

Your participation in the FSA may reduce your Social Security retirement benefits, but the current tax advantages generally offset any reduction in Social Security benefits.

To determine the amount of federal tax you will save, multiply the amount of your contribution by your federal tax bracket (percentage). You may also save on Social Security and Medicare taxes—and depending on where you live, state and local taxes.

Health Care FSA

The Health Care FSA was terminated effective December 31, 2023. If you were a participant in the Health Care FSA on December 31, 2023, you have until March 31, 2024 to submit requests for reimbursement for qualifying health care expenses incurred on or after January 1, 2023 and on or before December 31, 2023.

Dependent Care FSA

Contributions

You may contribute to the Dependent Care FSA if you have eligible dependent care expenses (that is, you incur expenses to enable you to work). If you are married, you may contribute to this account only if your spouse is:

- gainfully employed outside the home
- actively searching for a job
- enrolled as a full-time student at least 5 months of the year

or

- mentally or physically disabled and unable to provide care for himself or herself.

If your spouse's employment ends during the year, or your child turns age 13, you should contact the ORNL Benefit Service Center immediately because you may no longer be eligible to participate in this account.

You can contribute from $100 up to the IRS annual limit in pre-tax dollars to your Dependent Care FSA. In some cases, however, the IRS limits the amount you can contribute, as shown in the following chart. Dependent care contributions are reported on your W-2, according to IRS rules.

Limit for Highly Compensated Employees

Certain highly compensated employees may be limited by the IRS as to how much they can contribute to the Dependent Care FSA each year. You will be notified if this limit applies to you.

Special Dependent Care FSA Limits if You Are Married

If this is your situation …	You will be taxed on reimbursements that exceed …
You or your spouse earn less than $5,000	The amount the lower-paid spouse earns*
Your spouse also participates in a similar dependent care spending account	$5,000 combined
You file separate federal income tax returns	$2,500
* If your spouse is a full-time student for at least 5 months of the year or is disabled, he or she will be treated as earning $250 a month if you have one eligible dependent ($500 a month if you have two or more eligible dependents), adjusted for future years as required by the IRS.	

Eligible Dependents

You may use the Dependent Care FSA to pay for the care of your eligible dependents so that you or, if you are married, you and your spouse, can work. Eligible dependents include:

- your children under age 13
- your spouse, if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year

or

- a disabled dependent of any age (including parents) if he or she is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than one-half of the year and regularly spends at least 8 hours a day in your home.

An eligible dependent is someone you can claim as a dependent on your federal income tax return. If you are divorced or legally separated and have custody of your eligible child, you may use the

Dependent Care FSA even though you have agreed to let your spouse claim the child as a dependent for tax purposes. If you have joint custody, you may also use the Dependent Care FSA provided you have custody of your child for a longer period during the year than your spouse does.

Eligible Expenses

Expenses eligible for reimbursement are those incurred to enable you to work and include:

- services provided in your home or someone else's home by a babysitter or companion, including wages and related taxes
- services provided by a dependent care center that meets local regulations, and receives a fee for such services, whether or not for profit
- services provided outside your home, such as day camp, preschool tuition, or other outside dependent/child care services, such as before- and after-school programs, but only if the care is for a dependent under age 13 or other eligible dependent.

Generally, eligible dependent care costs include only those for the wellbeing and protection of your dependent, not costs for education, supplies, or meals—unless those costs cannot be separated.

Expenses Not Eligible

Expenses that are not eligible for reimbursement through the Dependent Care FSA include:

- dependent care provided by your child (or stepchild) who is under age 19 at the end of the taxable year or by another dependent whom you can claim as an exemption
- dependent care obtained for non-work-related reasons such as babysitting after your working hours
- dependent care provided while you are away from work because of illness or leave of absence
- dependent care that could be provided by your employed spouse whose work hours differ from yours
- expenses for overnight camp
- dependent care expenses incurred if your spouse does not work, unless your spouse is actively seeking employment, a full-time student, or disabled
- any expenses you claim for the dependent care tax credit on your federal income tax return
- expenses paid by another organization or provided without cost
- transportation to or from the dependent care location
- care provided in a group care center that does not meet state and local laws
- agency finder fees
- charges for referral to dependent care providers
- costs for after-school educational programs
- costs for clothing, entertainment, or food
- educational expenses (such as those for private school) for kindergarten or higher
- expenses incurred before you began contributing to the account or after you stop contributing.

Dependent Care FSA vs. the Federal Tax Credit

Under the current tax law, you can save taxes on dependent care expenses either by claiming a tax credit on your federal income tax return or by participating in the Dependent Care FSA. Both are intended to offer you tax savings. The best method for you depends on your income, the number of eligible dependents you have,

Dependent Care Provider Identification

When you file a claim for reimbursement through the Dependent Care FSA, you must include an original receipt from your dependent care provider. You will have to provide the caregiver's name, address, and taxpayer identification number (or Social Security number) on IRS Form 2441 when you file your federal income tax return and when you submit a claim for reimbursement. If you cannot supply this information, you should not use the dependent care spending account.

To obtain IRS Form 2441, call the IRS at 1-800-829-3676 or visit the IRS website at www.irs.gov.

and other factors. However, for most people, using the Dependent Care FSA provides a greater tax advantage.

You may use both approaches, but you may not “double deduct” the same expense. In addition, the expenses you apply toward the tax credit will be reduced dollar-for-dollar by the amount of expenses reimbursed from your account.

You should consult a personal financial or tax advisor to help you decide whether the tax credit or the Dependent Care FSA is more favorable for you.

Refer to IRS Publication 503 for a discussion of the tax credit. To order a copy, call the IRS toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.

Filing Claims

When you have an eligible dependent care expense, you must pay the provider and then submit a claim, along with a bill or receipt, to the FSA administrator. Be sure to include the dependent care provider’s Social Security or tax identification number. **Note: You may be reimbursed only up to the amount available in your account at the time you file a claim.** The annual deadline for filing prior year claims is March 31.

You will be reimbursed only for dependent care services you have already received. For example, if you pay in advance for 3 months of care, you cannot be reimbursed for the entire amount until after the end of the 3 month period. However, you can be reimbursed for a portion of the bill at a time.

You will be reimbursed for the lesser of your current account balance or the amount of the claim. If you submit a claim for an amount that exceeds your account balance, you will be reimbursed for the remainder of the claim after you have made sufficient additional contributions for that year to cover the expenses.

Payment of eligible expenses incurred, received, and processed will be made weekly.

FSA reimbursement request forms are available on the Benefits Enrollment website or from the account administrator.

Remaining Funds

Estimate your FSA contributions carefully. You may continue to file claims for expenses incurred during the plan year until March 31 of the following year. According to IRS rules, you must “use up” amounts deducted from your pay by incurring and filing claims for eligible expenses up to the amount you have had deducted. Otherwise, you lose the money you have left in your account.

Any forfeited amounts will be used to offset the plan’s administrative expenses.

Account Statements

You may obtain account information any time by phone or by accessing the FSA vendor website.

In addition, each time you receive a reimbursement, the attached explanation provides a summary of year-to-date activity.

Administrative Information

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

8. Disability Coverage

Your Disability benefits are designed to provide continuing income if you become ill, injured, or pregnant and are unable to work.

All capitalized terms are defined in the Glossary subsection at the end of this section.

Highlights

Your Disability Benefits …

Provide Coverage at No Cost

Coverage under the Short-Term Disability Plan and Long-Term Disability Plan is provided automatically, at no cost to you.

Continue Part of Your Pay for Up to 180 Calendar Days

The Short-Term Disability Plan continues part of your Pay for up to 180 calendar days of disability, based on your length of service and the duration of your disability. *NOTE: 6 months or 26 weeks of disability are administered as 180 days.*

Replace Part of Your Pay for Disabilities that Continue Past 180 Calendar Days

The Long-Term Disability Plan continues part of your Pay after you have been disabled for 180 calendar days with benefits payable until you reach age 65 or until your disability ends, if earlier. If you become disabled on or after reaching age 60 but before age 69, benefits may continue for 5 years (starting with the date you begin long-term disability), or until you reach age 70, whichever comes first. If you become disabled on or after reaching age 69, benefits may continue for up to 12 months (starting with the date you begin long-term disability).

Are Coordinated with Other Disability Income

Your short-term disability and long-term disability benefits may be reduced by other income benefits, such as Workers' Compensation and Social Security, you receive while disabled.

What happens to your benefits when ...

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

Short-Term Disability Plan

The Short-Term Disability Plan is designed to protect your income if you are unable to work due to pregnancy or non-occupational illness or injury. Employees who are on a leave of absence without pay, including educational leave, personal leave, military leave, or family medical leave for bonding or to care for a family member with a serious health condition, are not eligible for short-term disability benefits.

Short-Term Disability

IGUA SPO employees participate in the Short-Term Disability Plan described in the collective bargaining agreement. The collective bargaining agreement may be obtained from UT-Battelle Labor Relations.

If you are absent for a pregnancy or non-occupational illness or injury, you may receive short-term disability benefits after an unpaid waiting period of 24 hours subject to approval by a third-party claims administrator for the Company. The waiting period does not include scheduled days off. The waiting period is calculated as an absence of 24 consecutive work hours, including a partial day absence, regardless of which shift you work.

There are two cases in which you may receive benefit payments for the waiting period:

- You may receive benefit payments for the first 24 hours of a short-term disability absence if the disability extends beyond two (2) calendar weeks in which event payment will be made on the basis of absences for hours, which would normally have been worked had the employee performed his regular schedule of work during the first 24 hours of absence.
- If an employee is admitted to the hospital as an inpatient or treated on an outpatient basis and provided services that would otherwise require admission to the hospital as an inpatient during the first 24 hours of a certified non- occupational disability, any remaining hours of the 24-hour waiting period will be waived. In no case shall the period of payment exceed the schedule established herein.

Certification by a Physician is required in both cases for the day(s) you are absent, and benefit payments are subject to approval by the claims administrator.

Successive Disabilities

Periods of disability are treated as separate absences if they are:

- due to unrelated causes and are separated by your return to active work for at least one full regularly scheduled work day (normally 8 consecutive hours for a full-time employee),

  or
- due to related causes and are separated by a return to active work of at least 520 Hours of Work or 3 calendar months, whichever is longer.

Active work as referenced above does not include light duty assignments.

Each separate disability absence begins with a waiting period of 24 hours and is tracked separately against the applicable short-term disability maximum duration.

Benefit Duration and Amount

Following an unpaid 24 hour waiting period, if you are unable to work due to a pregnancy or non-occupational illness or injury, an employee employed 6-months or more, who is disabled and unable to work due to illness, pregnancy, or non- occupational injury, will be paid his or her Pay in accordance with the following schedule:

- Tier 1: 100% of Pay for the first 42 calendar days (6 weeks) of disability
- Tier 2: 80% of Pay for the next 42 calendar days (6 weeks) of disability
- Tier 3: 60% of Pay for the remaining 96 calendar days (14 weeks) of disability.

*Eligible employees are allowed to supplement approved disability pay, up to 100% of base pay, with the employee's accrued and unused Vacation benefits. The employee is required to submit timely requests to

the designated Company representative, for applying any supplemental payment. For the purposes of determining your length of Company Service, the normal Company Service rules apply. While on short-term disability, you will not accrue Company Service for the purposes of determining the duration of your short-term disability benefit. However, you will accrue Company Service for certain other benefits.

Supplementing Tier 2 and Tier 3 Benefit Payments with Vacation Pay

You may supplement the Tier 2 (80%) and Tier 3 (60%) benefit payments with vacation pay, up to the maximum amount of vacation available to you, to reach 100% of Pay by completing an authorization form after a short-term disability claim is initiated.

- The amount of vacation required to reach 100% of Pay is 6 days for the 42 days of benefit payments at Tier 2 (i.e., 1 day of vacation per week of disability) and 28 days for the 96 days of benefit payments at Tier 3 (i.e., 2 days of vacation per week of disability).
- Current year, banked, and deferred vacation may be used to supplement the benefit payments. If you accrue vacation, you may supplement the benefit payments with vacation pay up to the amount you have accrued at the time of the payments. Additional supplementation may continue as additional vacation is accrued.
- To have benefit payments supplemented with vacation pay, you must complete a Vacation Supplement Authorization form and return the completed form to the ORNL Disability Administration Office at the address on the form. You will receive the form from the third-party claims administrator for the Company after you file a short-term disability claim. The form is also available on the ORNL Benefits Forms web page.
- Vacation may be used to supplement the benefit payments in 1 hour increments.
- If you do not complete and return the Vacation Supplement Authorization form or do not have vacation available to supplement the benefit payments, you will receive only the amount of the tiered benefit.

Claiming Short-Term Disability Benefits

If you are unable to come to work because of a short-term disability absence, you must contact the claims administrator for the Company in order to receive benefits.

- You must call on the fourth work day of your absence or earlier if you are admitted to a hospital as an inpatient or receive treatment as a day surgery patient during the waiting period.
- You also must contact the claims administrator for anticipated absences related to pregnancy or a scheduled surgery or other procedure or treatment.

The claims administrator will give you further instructions, send you an information packet via US mail for your claim for benefits, and answer any questions you may have.

Also, you must furnish periodic medical evidence of your pregnancy, illness, or injury if requested by the Company or claims administrator; you must provide the requested information within the timeframe stated in the request, or your benefits may be suspended or denied. The Company and claims administrator reserve the right to confirm your Disability with a Physician and/or require a written statement from your attending Physician at any time during your absence. Upon return to work, a Physician's statement may be required indicating your fitness to resume work duties..

In addition, during your Disability, you may be required to undergo periodic evaluations in order for the Company to determine if you are able to return to light duty. If your Physician determines that you are able to return to light duty, you must then be evaluated by Your Company’s designated Physician for final clearance to return to work. If you are cleared to return to light duty, your short-term disability benefits will end.

The claims administrator has the authority to interpret and administer the plan for the Company. The claims administrator will notify you of the decision regarding approval of your claim or if additional information is needed to make a decision on your claim.

If you take an unpaid leave of absence, you must return to active work for at least 1 full regularly scheduled work day (normally 8 consecutive hours) to resume eligibility for short-term disability benefits.

Benefit Payments

Plan benefits will be reduced by income benefits you are eligible to receive from other sources because of your Disability, such as Workers' Compensation or any state or federal disability or occupational disease laws or benefits.

If your absence extends beyond 180 calendar days, benefits may become payable according to the Company's Long-Term Disability Plan. Any short-term disability benefit overpayments you receive may be recovered by the Company from amounts owed to you when you go on long-term disability or from benefit payments you receive under the Long-Term Disability plan. Your plan benefits will not be reduced by any private disability coverage that you have purchased.

Exclusions

Short-term disability benefits are not payable for Disabilities:

- if you are not under the Appropriate Care and Treatment of a licensed practicing Physician
- that result from working for yourself (in an income-producing capacity except for Company-approved arrangements) or an employer other than UT-Battelle
- due to willful misconduct, violation of Company rules, or refusal to use safety appliances
- due to any intentionally self-inflicted injury
- resulting from your attempt to commit or the commission of a crime under state or federal law.
- occurring during the first 12 months that your plan coverage is in effect if caused by any condition for which you received treatment during the 3 month period immediately before your plan coverage became effective

  or
- directly or indirectly due to war, declared or undeclared.

When Short-Term Disability Benefits End

Benefits for any absence will end on the first of the following days when:

- you refuse to contact your supervisor and the claims administrator to report your disability or to provide updates about your continuing disability
- you do not provide requested satisfactory evidence of or provide incorrect information about your disability
- you refuse to be examined by a Physician, ignore a Physician’s appointment, or stop following a Physician’s prescribed course of treatment
- you refuse to follow any step related to the administration of the Short-Term Disability Plan
- you become self-employed or perform services for a third party without the prior written permission of the Company or claims administrator
- you are no longer considered eligible because of a change in your employment status
- you recover from your disability
- you return to work

- you do not return to work for light duty if you are able
- you have received the maximum number of benefit payments
- your employment with the Company is terminated for any reason
- you are confined in a jail, prison, or other penal facility or correctional facility
- you are no longer an active employee
- you voluntarily decline the benefits
- the collective bargaining agreement expires or
- the plan terminates.

Appeal Procedures

You may file claims for plan benefits and appeal adverse claim decisions. For appeal procedures, see "Claims Review & Appeals" in the "Administrative Information" chapter.

Long-Term Disability Plan

Your long-term disability benefits are designed to provide continuing income if you become ill or injured and are unable to work. You are eligible to participate in this plan as described in the "About Your Benefits" chapter. You are not eligible to participate in this plan if you are on leave without pay, including educational leave, personal leave, family medical leave, or military leave.

You become entitled to benefits after you have been totally disabled, as defined in the **Glossary**, for 180 calendar days. Long-term disability benefits pick up where short-term disability benefits leave off, after you have been disabled for 180 calendar days.

NOTE: 6 months or 26 weeks of disability are administered as 180 days.

Benefit Amount

Your monthly Long-Term Disability Plan benefit equals 60% of your monthly basic straight time rate as of your last day of short-term disability, up to a maximum monthly benefit of $5,000, reduced by income you are eligible to receive from other sources, as described under "Reduction of Benefits".

Duration of Benefits

Benefits under the Long-Term Disability Plan are payable to you once you have been totally disabled, as defined in the **Glossary**, for 180 calendar days, subject to approval by the claims administrator for the Company.

Phase One

Under the Long-Term Disability Plan, you are considered totally disabled during your first 24 months of long-term disability if you are unable to perform the duties of your regular job with the Company due to illness or injury, and are under the Appropriate Care and Treatment of a licensed practicing Physician.

Should you recover from your illness/injury during the first 24 months of long-term disability leave, you must contact the Company Disability Administration Office to request a return-to-work medical evaluation.

The decision on whether you return to work will be based on the results of this medical evaluation and the availability of a position for which you qualify. The Disability Administration Office will verify that a position is available for you. If a position is available, a return-to-work medical evaluation will be completed.

Phase Two

After you have received long-term disability benefits for 24 months, you are considered totally disabled if you remain under the Appropriate Care and Treatment of a licensed practicing Physician and you are

unable to work at any job for which you might be qualified, based on your education, training, and experience.

You may be eligible for layoff allowance pay after receiving long-term disability benefits for 24 months. See the collective bargaining agreement for details.

While you are receiving long-term disability benefits under either Phase One or Two, you must furnish periodic medical evidence of your illness or injury if requested by the Company, and you may be required to undergo periodic evaluations in order for the Company to determine whether you are able to return to work. Failure to do so can result in your benefits being discontinued.

Normally, if you qualify for benefits under the provisions of the plan as stated above, long-term disability benefits are payable until you recover or until you reach age 65, if earlier (unless one of the events under "When Long-Term Disability Benefits End" occurs).

However, special provisions apply if you are age 60 or older when you become totally disabled. If you become totally disabled:

- at age 60 but before age 69, benefits are payable for up to 5 years (starting with the date you begin long-term disability) or until age 70, whichever comes first
- at or after age 69, benefits are payable for up to 12 months (starting with the date you begin long-term disability).

Determining Your Long-Term Disability Benefit

To calculate the amount you are eligible to receive under the Long-Term Disability Plan, follow these steps:

Step 1: Multiply your monthly Pay by 60% to determine your maximum monthly benefit from the plan, up to $15,000.

Step 2: Subtract other income you are eligible to receive, except for family Social Security, to find your adjusted monthly benefit from the plan. Continue on to Step 3 only if you are eligible to receive family Social Security.

Step 3: Add your adjusted monthly benefit (from Step 2) to all other income you are eligible to receive, including family Social Security. If the resulting total of all income benefits you are eligible to receive is more than 75% of your monthly Pay, your monthly long-term disability benefit will be reduced by the excess of your total income benefits over 75% of your monthly Pay.

Reduction of Benefits

Your long-term disability benefits are reduced by other sources of income that are payable to you because of your disability. Income that will reduce your long-term disability benefits includes but is not limited to:

- Workers' Compensation benefits or benefits provided under a similar law; state disability benefits; and other statutory benefits for disability, retirement, or unemployment
- benefits provided through Company benefit plans, including the pension and business travel accident insurance plans
- income you receive for working on a reduced-hour basis or for rehabilitative employment

or

- any Social Security disability benefits for which you are eligible (refer to the Social Security and long-term disability benefits chart that follows).

If you are receiving benefits for Social Security Retirement Income and/or pension, prior to the date of disability, benefits are not reduced.

If any of this income is paid as a lump sum and results in an overpayment of disability benefits to you, you must reimburse the Company for the amount of the overpayment. If you do not repay the Company, your

long-term disability benefit will be calculated as if this income were paid monthly. The Company has the right to recover any overpayments you receive, and your monthly benefit payment will be reduced by the maximum amount possible, as determined by the claims administrator, to recover any overpayment you receive.

The claims administrator that pays the long-term disability benefits will instruct you on how to apply for Social Security benefits. If you do not exhaust the steps to obtain Social Security benefits, your long-term disability benefits will be reduced by your estimated Social Security benefits, as calculated by the claims administrator. See the following "Social Security and Long-Term Disability Benefits" chart for more information.

Your long-term disability benefits will not be reduced by any private disability coverage that you have purchased.

Disability Example	
Assume you earn $3,000 a month.	
Monthly Pay……	$3,000
× long-term disability benefit percentage……	× 60%
Maximum monthly long-term disability benefit……	***$1,800***
Assume you are eligible for primary Social Security disability benefits of $800 a month.	
Maximum monthly long-term disability benefit……	$1,800
– Primary Social Security……	– $800
Adjusted monthly long-term disability benefit……	***$1,000***
Assume you are eligible for family Social Security disability benefits of $500 a month.	
Adjusted monthly long-term disability benefit……	$1,000
+ Primary Social Security……	+ $800
+ Family Social Security……	+ $500
= Total disability income……	$2,300
– 75% of monthly Pay……	– $2,250
= Benefit reduction……	$50
Final monthly long-term disability benefit……	***$950***

Social Security and Long-Term Disability Benefits

You should apply for Social Security disability benefits within 90 days of the date your long-term disability leave becomes effective.

If you have not received a benefit determination from Social Security after you have been receiving long-term disability benefits for 12 months, or if your original claim is denied and you do not file an appeal within 30 days of your receipt of the denial, then your long-term disability benefits will be reduced by your estimated Social Security benefits, as calculated by the claims administrator.

If...	Then...
You later complete the Social Security appeals process and are denied benefits	Your long-term disability benefits will be retroactively reinstated, and you will receive a "catch-up" payment
You receive a cost of living increase to your Social Security disability income after your long-term disability benefit has been calculated	Your long-term disability benefits will not change
Your disability makes you eligible to receive family Social Security benefits	Your total disability income from all sources may not exceed 75% of your monthly Pay

Claiming Long-Term Disability Benefits

Long-term disability benefits cannot begin until the claim forms sent to you by the claims administrator have been satisfactorily completed by you and your Physician and received by the claims administrator. The claims administrator and the Disability Administration Office will assist you in filing your claim.

You are required to apply for Social Security and any other income you may be eligible to receive as a result of your disability. If your initial application for Social Security is denied, you are required to pursue the entire Social Security benefits appeals process through the Social Security Office.

Exclusions

Long-term disability benefits are not payable for disabilities:

- occurring during the first 12 months that your plan coverage is in effect if caused by any condition for which you received treatment during the 3-month period immediately before your plan coverage became effective
- if you are not under the Appropriate Care and Treatment of a licensed practicing Physician

Example of Offset for Rehabilitative Income

Assume you begin receiving rehabilitative income of $1,500 per month.	
Monthly rehabilitative income...	$1,500
× 70%	
Maximum rehabilitative income offset ...	***$1,050***
Assume your long-term disability benefit is $2,500 per month.	
Monthly long-term disability benefit …	$2,500
– Monthly rehabilitative income offset…	*– $1,050*
= Adjusted disability benefit...	$1,450
+ Rehabilitative income...	+ $1,500
Final monthly income...	***$2,950***

- that result from working for yourself (in an income-producing capacity except for Company-approved arrangements) or an employer other than UT-Battelle
- due to willful misconduct, violation of Company rules, or refusal to use safety appliances
- due to any intentionally self-inflicted injury
- resulting from your attempt to commit or commission of a crime under state or federal law

or

- directly or indirectly due to war, declared or undeclared

Taking a Job While Disabled

If you return to work at the Company in a full-time position your long-term disability benefits will end.

The claims administrator provides a rehabilitative employment program to assist you in pursuing other employment opportunities if it is determined that you will not be able to return to your job at the Company. If you participate in the rehabilitative employment program, you will be eligible to continue to receive part of your long-term disability income during your participation. Your monthly long-term disability benefits will be reduced by 70% of any income you receive from your rehabilitative employment. Your combined long-term disability benefit and rehabilitative employment income cannot exceed 100% of your regular monthly Pay as of your last day of short-term disability. Your participation in the rehabilitative employment program and the length of time you participate are subject to the discretion and approval by both the Company and the claims administrator.

When Long-Term Disability Benefits End

- Long-term disability benefits will end on the first of the following days when:
- you refuse to provide updates about your continuing disability
- you do not provide requested satisfactory evidence of or provide incorrect information about your disability
- you refuse to be examined by a Physician, ignore a Physician's appointment, or stop following a Physician's prescribed course of treatment
- you refuse to follow any step related to the administration of the long-term disability plan
- you become self-employed or perform services for a third party without the prior written permission of the claims administrator
- you recover from your disability
- you return to work
- you have received the maximum number of benefit payments
- you are confined in a jail, prison, or other penal facility or correctional facility
- you retire
- you die
- you voluntarily decline the benefits
- the collective bargaining agreement expires

or

- If your disability has not been approved for Phase 2 disability by the end of the Phase 1 period, your benefit will be terminated at the end of Phase 1, or at such earlier time if any of the above bullets apply. If your Phase 2 disability claim is later approved, your benefit will be retroactively reinstated to the beginning of Phase 2.
- the plan terminates.

Successive Disabilities

If you receive long-term disability benefits, return to work for less than 520 Hours of Work or 90 calendar days (whichever is longer) and again become disabled due to the same illness or injury, long-term disability income will resume without a 6 month waiting period. However, if you have been working for at least

Administrative Information

Information about the administration of your Disability Coverage can be found in the chapter titled "Administrative Information."

520 Hours of Work, or more than 90 calendar days (whichever is longer), you will need to satisfy the waiting period before long-term disability benefits begin.

Disabilities due to unrelated causes will be treated as separate disabilities requiring satisfaction of separate waiting periods if the disabilities are separated by your return to work for 8 consecutive hours.

Appeal Procedures

You may file claims for plan benefits and appeal adverse claim decisions. For appeal procedures, see “Claims Review & Appeals” in the “Administrative Information” chapter. In addition, the collective bargaining agreement contains information related to the resolution of disputes for Bargaining Unit employees.

Glossary

Appropriate Care and Treatment

During disability, medical care and treatment that is:

- received from a Physician whose medical training and clinical experience are suitable for treating your disability;
- necessary to meet your basic health need and is of demonstrable medical value;
- consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and health care coverage organizations and government agencies;
- consistent with the diagnosis of your condition; and
- maximizing your medical improvement.

Disability

Under UT-Battelle's Disability plans, you are determined to have a disability if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the appropriate care and treatment of a licensed practicing Physician. The Company's Claims Administrator makes that determination.

Hour of Work

Each hour of work for the Company for which you are paid, including straight time, overtime, holidays, and jury duty. However, vacations, personal leave, and time off for union business are not included in calculating your hours of work.

Light Duty Assignments

Temporary modified duties assigned as the result of temporary physical limitations due to non-occupational injury or illness or pregnancy that prevent an employee from performing the full scope of duties of his or her regular assigned job.

Pay

Your straight time earnings pay in effect just before your total disability begins and before any pre-tax salary reductions. Pay does not include overtime, bonuses, or any other form of extra compensation.

Physician

A person who is licensed to prescribe and administer drugs or to perform surgery and who operates within the scope of his or her license.

Total Disability or Totally Disabled

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

9. Life and Accident Insurance

Your Life and Accident Insurance benefits are designed to provide financial security for your survivors in the event of your death, and for you, in case of accidental dismemberment, disability or, in the case of Accidental Death & Dismemberment ("AD&D") coverage, paralysis.

All capitalized terms are defined in the Glossary subsection at the end of this section.

Highlights

Your Benefits …

Provide Security for Your Family Through Basic Life Coverage

Your Basic Life Insurance coverage pays a benefit of at least two times your Pay to your beneficiary in case of your death from any cause. You and the Company share the cost of this coverage.

Offer the Opportunity for Added Protection through Supplemental, Spouse, and Dependent Life Coverage

You may purchase Supplemental Life Insurance coverage from one to eight times your Pay to a maximum of $1,000,000 to provide greater security for your beneficiary in case of your death from any cause. You may also purchase spouse life insurance in amounts from $10,000 to $50,000 and Dependent Life Insurance in the amount of $10,000.

Automatically Provide Business Travel Accident Coverage

Business Travel Accident Insurance coverage pays a benefit of four times your Pay, up to $500,000, to you or your beneficiary in case of accidental death, dismemberment, or Total and Permanent Disability while you are traveling on a Business Trip. This coverage is provided automatically, at no cost to you.

Give You Extra Security Through Special Accident Coverage

Special Accident Insurance coverage from $20,000 to $500,000 can provide extra financial security for you or your beneficiary in the event of accidental death, dismemberment, or paralysis. Family coverage is also available.

What happens to your benefits when ...

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

Basic Life Insurance

Basic Life Insurance is available on an optional contributory basis. This coverage pays benefits to your beneficiary in the event of your death from any cause while you are insured.

Evidence of Insurability will be required if Basic Life Insurance is elected more than 30 days after date of hire.

Benefit Amounts

During Active Service

If you are actively working at the Company, your Basic Life Insurance amount is equal to two times your annual Pay, rounded to the next higher $1,000 if your annual Pay is not an even multiple of $1,000.

When your Pay increases enough to put you in a new insurance bracket, your insurance amount will automatically increase. If your Pay decreases, your insurance amount will be reduced if your new Pay rate puts you in a lower insurance bracket.

Any change will be effective immediately. If you are on leave of absence, long-term disability, or strike at that time, the increase or reduction in insurance will take place upon your return to work.

During Disability

After you have been on Short-Term Disability continuously for 13 weeks, your Basic Life Insurance coverage will continue at the level in effect at the time your disability began, providing you pay any required cost. After 13 weeks of continuous disability, your coverage continues at no cost while you are on Short-Term Disability.

If you transition to Long-Term Disability, you may continue your coverage, and you may apply for a waiver of premium. If approved, your coverage will continue at no cost.

If you become Totally Disabled during active service and before age 63, your Basic Life Insurance coverage will continue at the level in effect at the time your disability began for as long as you remain Totally Disabled or until the last day of the month preceding your 65th birthday, whichever comes sooner. If your Total Disability begins after your 63rd birthday, however, your insurance will continue for 2 years, but not beyond age 70.

On the first day of the month in which you reach age 65, or at the expiration of the 2 year period if later, you may be eligible to continue a portion of your insurance amount, as described previously.

About Your Basic Life Insurance Amount

If your annual Pay is not an even multiple of $1,000, it is rounded up for purposes of determining your Basic Life Insurance amount. This rounding of your Pay means that insurance amounts are actually provided in $2,000 steps as shown by the examples in the following chart.

If your annual Pay is:	Your Basic Life Insurance amount is:
$34,000.01 to $35,000	$70,000
$35,000.01 to $36,000	$72,000
$49,000.01 to $50,000	$100,000
$50,000.01 to $51,000	$102,000
$74,000.01 to $75,000	$150,000
$75,000.01 to $76,000	$152,000
$90,000.01 to $91,000	$182,000
$91,000.01 to $92,000	$184,000
in steps of $1,000	in steps of $2,000

IGUA Employees Hired Prior to 8/15/2016

During Retirement—At Age 65 and After

If you retire at age 65 or later, a reduced amount of Basic Life Insurance coverage (described below) will continue for the rest of your life, provided you had Basic Life Insurance coverage for at least 1 year immediately preceding retirement. This reduced coverage is currently provided at no cost to you.

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

If you had Basic Life Insurance coverage for at least 5 continuous years immediately preceding your retirement, the amount of your reduced insurance will be the greater of:

- 20% of your Basic Life Insurance just before retirement.

  or
- 1% of your Basic Life Insurance amount just before retirement multiplied by your years of service (including any fraction of a year), plus $500, with a minimum of $2,500 or 25% of your Basic Life Insurance just before retirement, up to a maximum of $10,000

During Retirement—Before Age 65

If you retire before age 65, are eligible for an immediate pension benefit, and had Basic Life Insurance coverage for at least 1 year immediately preceding retirement, you can:

- continue your full Basic Life Insurance amount until the last date of the month preceding your 65th birthday by continuing to make your regular premium payments

  or
- take the reduced Basic Life Insurance amount (as described under “During Retirement—At Age 65 and After”) immediately at no cost to you.

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

On the first of the month in which you reach age 65, your life insurance will be automatically reduced.

The balance between your reduced amount and the original amount can be converted to an individual policy within 31 days of termination of coverage.

IGUA Employees Hired on or After 8/15/2016

Coverage ends the last day of the month upon termination from the company**.** Your coverage can be converted to an individual policy. Refer to “Conversion Privileges” at the end of this section for more information.

Supplemental Life Insurance

Supplemental Life Insurance is available on an optional contributory basis. This coverage provides added protection to your beneficiary in the event of your death from any cause while you are insured. You must elect Basic Life Insurance in order to elect this coverage.

Benefit Amounts

During Active Service

If you are actively working, you can elect Supplemental Life Insurance equal to one to eight times your annual Pay (rounded to the next higher $1,000 if not an even multiple of $1,000), up to a maximum of $1,000,000.

Evidence of Insurability (EOI) is required for any insurance amount elected greater than five times salary. The amount of coverage in effect prior to the approval or after the denial of the requested insurance coverage will be five times salary.

If Supplemental Life Insurance is elected more than 30 days after date of hire, EOI will be required for the full elected amount.

When your Pay increases enough to put you in a new insurance bracket, your insurance amount will automatically increase. If your Pay decreases, your insurance will be reduced if your new Pay rate puts you in a lower insurance bracket

Any change will be effective immediately. If you are on leave of absence, long-term disability, or strike at that time, the increase or reduction in insurance will take place upon your return to work.

During Disability

After you have been on Short-Term Disability continuously for 13 weeks, your Supplemental Life Insurance coverage will continue at the level in effect at the time your disability began, providing you pay any required cost. After 13 weeks of continuous disability, your coverage continues at no cost while you are on Short-Term Disability.

If you transition to Long-Term Disability, you may continue your coverage and apply for a waiver of premium. If approved, your coverage will continue at no cost.

If you become Totally Disabled during active service and before age 63, your Supplemental Life Insurance coverage will continue at the level in effect at the time your disability began for as long as you remain Totally Disabled or until the last day of the month preceding your 65th birthday, whichever comes first.

If your Total Disability begins after your 63rd birthday, however, your insurance will continue for 2 years, but not beyond age 70. On the first day of the month in which you reach age 65, or at the expiration of the 2 year period, if later, you may be eligible to continue a portion of your insurance amount, as described in "Portability" at the end of this section.

IGUA Employees Hired Prior to 8/15/2016

During Retirement—At Age 65 and After

If you retire at age 65 or later, a reduced amount of Supplemental Life Insurance coverage (described below) will continue for the rest of your life, provided you had Supplemental Life Insurance coverage for at least 1 year immediately preceding retirement. This reduced coverage is currently provided at no cost to you.

If you had Supplemental Life Insurance coverage for at least 1 year but less than 5 years immediately preceding your retirement, your reduced life insurance amount will be $312.

If you had Supplemental Life Insurance coverage for at least 5 continuous years immediately preceding your retirement, the amount of your reduced insurance will be the greater of:

- 10% of your Supplemental Life Insurance capped at one times your salary just before retirement.

  or
- 1% of one times your salary Supplemental Life Insurance amount just before retirement multiplied by your years of service (including any fraction of a year), plus $250, with a minimum of $2,500 or 25% of your Supplemental Life Insurance just before retirement, up to a maximum of $5,000

During Retirement—Before Age 65

If you retire before age 65, are eligible for an immediate pension benefit, and had Supplemental Life Insurance coverage for at least 1 year immediately preceding retirement, you can:

- continue your full Supplemental Life Insurance capped at one times your salary amount until the last date of the month preceding your 65th birthday by continuing to make your regular premium payments

or

- take the reduced Supplemental Life Insurance amount (as described under “During Retirement—At Age 65 and After”) immediately at no cost to you.

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

On the first of the month in which you reach age 65, your life insurance will be automatically reduced.

The balance between your reduced amount and the original amount can be converted to an individual policy within 31 days of termination of coverage.

Your Supplemental Life Insurance coverage terminates unless you convert it to an individual policy or elect the portability option. Refer to “Conversion Privileges” at the end of this section if you would like to convert to an individual policy, or see “Portability” if you would like to elect the portability option.

IGUA Employees Hired on or After 8/15/2016

Coverage ends the last day of the month upon termination from the company**.** Your coverage can be converted to an individual policy. Refer to “Conversion Privileges” at the end of this section for more information.

Payment of Benefits

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

Accelerated Benefit Option

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

You may receive up to 50% of the amount of your basic and Supplemental Life Insurance coverage, with a maximum living benefit of $500,000 of your Basic Life Insurance coverage and $500,000 of your Supplemental Life Insurance coverage. Benefits will be paid in a lump sum.

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

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

Dependent Life Insurance

You may purchase Dependent Life Insurance coverage for your spouse and your eligible dependent children from the date of birth or adoption up to the last day of the month in which they turn age 26. Spouse and child life insurance is not available to those individuals on active duty in the military of any

country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard, or if they are insured under the Group Policy as an employee. You must elect Basic Life Insurance in order to elect this coverage.

Reminder: You cannot be enrolled in Basic Life Insurance as an employee and also be covered as a spouse or dependent under Dependent Life Insurance.

You may purchase $10,000 to $50,000 in increments of $10,000 for your spouse and $10,000 for each dependent child.

Evidence of Insurability is required for a spouse if you are enrolling for coverage after the first 30 days of becoming eligible.

Eligible Child Life Insurance coverage ends on the last day of the month in which they turn age 26 or the date of marriage, whichever is earlier.

UT-Battelle does not maintain a record of covered dependents for child life. It is the employee's responsibility to cancel coverage when appropriate. Otherwise premiums will continue to be taken.

All Dependent Life coverage ends on the last day of the month in which an active employee terminates employment or retires. It also ends on the last day of the month when an individual goes on long-term disability, upon divorce, or when a dependent is no longer eligible. Refer to "Conversion Privileges" at the end of this section if you would like to convert to an individual policy.

Business Travel Accident Insurance

Business Travel Accident Insurance pays benefits to you for a covered loss, if you should lose sight, speech, hearing, or limb, or become paralyzed or Totally and Permanently Disabled (See Accidental Dismemberment and Plegia Benefit). Benefits are also payable to your beneficiary in case of your death as a result of an accident that occurs while you are traveling on a Business Trip. This does not include commuting to or from work. If your spouse and/or eligible dependent children are authorized to travel with you, they will also be covered for accidental death or dismemberment.

Coverage is provided 24 hours a day during a Business Trip, starting when you leave your home or place of business (whichever is later) and continuing until you return to your home or place of business (whichever is earlier). Coverage is also provided while you are on a side trip or vacation that is taken in conjunction with a Business Trip not lasting longer than 336 hours, or on the Company premises to which you are permanently assigned in the event of a bomb scare, bomb search, bomb explosion, or felonious assault (committed by someone other than a fellow employee or family member).

Business Travel Accident Insurance benefits are paid in addition to any other life and accident insurance benefits you are eligible to receive.

Benefit Amounts

While you are actively employed, and until age 70, your Business Travel Accident benefit amount equals four times your annual Pay, with a minimum benefit of $100,000 and a maximum benefit of $500,000. Aggregate Limit of Liability per Covered Accident: $10,000,000.

Your spouse's benefit amount is $100,000, and the benefit amount for each eligible dependent child is $25,000.

As an active employee age 70 and older, your benefit amount will be reduced as follows:

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

Accidental Death Benefit

If an Insured suffers a loss of life as a result of a Covered Injury, The Zurich American Insurance Company will pay the applicable Principal Sum. The death must occur within 365 days of the Covered Injury. Principal Sum is four times the employee's base annual earnings up to a maximum of $500,000.

This benefit is subject to the limitations in General Limitations.

Accidental Dismemberment and Plegia Benefit

If an Injury to an Insured results in any of the following Covered Losses, The Zurich American Insurance Company will pay the benefit amount shown. The Covered Loss must occur within 365 days of the Accident.

The benefit amounts are based on the Insured's Principal Sum.

Dismemberment Benefits	
For covered loss of	**The plan pays**
Both hands and both feet	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot plus the loss of Sight of One Eye	Principal Sum
Sight of both eyes	Principal Sum
Speech and hearing	Principal Sum
Speech or hearing	50% of Principal Sum
One hand; one foot; or sight of one eye	50% of Principal Sum
Thumb and index finger of the same hand	25% of Principal Sum
Hearing in one ear	25% of Principal Sum
Plegia	
Quadriplegia (total paralysis of all for limbs)	Principal Sum
Triplegia (total paralysis of three limbs)	75% of Principal Sum
Paraplegia (total paralysis of both lower limbs)	75% of Principal Sum
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50% of Principal Sum
Uniplegia (total paralysis of one limb)	25% of Principal Sum

For purposes of this benefit:

1. Covered Loss means:
    a. For a foot or hand, actual severance through or above an ankle or wrist joint;
    b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
    c. Total and permanent loss of sight;
    d. Total and permanent loss of speech;
    e. Total and permanent loss of hearing.
2. Plegia must continue for twelve (12) consecutive months and be determined by Our competent medical authority to be permanent, complete and irreversible paralysis of one or more Limbs. A Limb means an arm or a leg. Proof of total paralysis may be required by Zurich American Insurance Company on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

This benefit is subject to the limitations in General Limitations.

Coma Benefit

If an Insured suffers an Injury resulting in a Covered Loss within 180 days of a Covered Accident, and such Injury causes the Insured to be in a Coma for at least thirty-one (31) consecutive days, the Zurich American Insurance Company will pay a Coma Benefit.

The Coma Benefit will be payable at 1%of the Insured's Principal Sum per month for the first 11 months the Insured remains in a Coma, following the initial thirty-one (31) day period. At the end of the 11 months of payment, if the Insured remains in a Coma, the Zurich American Insurance Company will pay a lump sum benefit equal to the Principal Sum payable under the Accidental Death Benefit less the amount of the 11 months of benefit already received.

Coma will be determined by the Zurich American Insurance Company ’s duly licensed physician. This benefit is subject to the limitations in General Limitations.

Permanent and Total Disability Benefit

If an Insured becomes Permanently and Totally Disabled as a result of a Covered Injury, The Zurich American Insurance Company will pay a Permanent and Total Disability Benefit provided that he or she becomes Permanently and Totally Disabled within 365 days of the Injury; and the Permanent and Total Disability continues for twelve (12) months.

For purposes of this benefit, Permanently and Totally Disabled means that the Insured is totally and continually disabled and cannot work at any job that he or she is reasonably suited by education, training or experience to do as a gainful or meaningful occupation. Permanent and Total Disability must be verified by a competent medical authority, and must be expected to continue for the remainder of the Insured's life.

This benefit is subject to the limitations in General Limitations.

Additional Benefits

Carjacking Benefit

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Death or Accidental Dismemberment and Plegia Benefit, as a direct result of an Accident that occurs during a Carjacking of a private passenger automobile that the Insured was operating, getting into or out of, or riding in as a passenger, Zurich will pay an additional benefit equal to 10% of the Insured's Principal Sum to a maximum of $25,000.

Verification of the Carjacking must be made part of an official police report within twenty-four (24) hours of the Carjacking or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24) hours or as soon as reasonably possible, and such verification must be provided to the Zurich American Insurance Company .

For purposes of this benefit, Carjacking means a person other than the Insured taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

Day Care Center Benefit

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, Zurich American Insurance Company will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each Dependent Child if:

1. on the date of the Accident, the Dependent Child was enrolled in an Accredited Child Care Facility, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the Dependent Child is under age 13.

The Day Care Benefit will be equal to the lesser of:

1. the actual cost of the child care;
2. 10% of the Insured's Principal Sum; or $10,000.

The Day Care Benefit will be paid annually for four (4) consecutive years if:

1. the Dependent Child is under age 13 at the time of each annual payment; and
2. proof, acceptable to Zurich American Insurance Company, is received by Zurich American Insurance Company that verifies that the Dependent Child remains enrolled in an Accredited Child Care Facility.

An Accredited Child Care Facility means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An Accredited Child Care Facility does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

Hearing Aid or Prosthetic Appliance Benefit

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Dismemberment and Plegia Benefit, the Zurich American Insurance Company will pay an additional benefit provided:

1. the Insured is required to use a hearing aid or prosthetic appliance;
2. the Injury that caused the payment of the Accidental Dismemberment and Plegia Benefit is the same Injury that requires the Insured to use the Hearing Aid or Prosthetic Appliance; and
3. the Hearing Aid or Prosthetic Appliance was required within one (1) year of the Injury.

The amount the will pay will be equal to the one-time cost of the Hearing Aid or Prosthetic Appliance actually paid by the Insured.

This benefit will not be paid unless:

1. the Hearing Aid or Prosthetic Appliance was prescribed by a legally qualified physician or surgeon who is not the Insured's spouse, child, or relative; and
2. presentation of proof of payment is provided to the Zurich American Insurance Company. For purposes of this benefit, Prosthetic Appliance will include an artificial limb or eye.

No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the Insured's Principal Sum or $25,000.

Higher Education Benefit

If the Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, the Zurich American Insurance Company will pay an additional benefit for higher education expenses to the individual who incurs the expense for each Dependent Child.

A Dependent Child is eligible for the Higher Education Benefit if on the date of the Accident:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the Accident.

The Higher Education Benefit will be equal to 10% of the Insured's Principal Sum, to a maximum of $10,000. This amount will be paid annually for up to four (4) consecutive years if the Dependent Child continues his or her education. Before this benefit is paid each year, the Dependent Child must present

written proof, acceptable to Zurich American Insurance Company, that he or she is attending an institution of higher learning on a full-time basis.

Home Alterations and Vehicle Modification Benefit

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Dismemberment and Plegia Benefit, Zurich American Insurance Company will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the Insured is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the Injury that caused the payment of the Accidental Dismemberment and Plegia Benefit is the same Injury that requires the Insured to need the wheelchair.

The amount will pay will be equal to:

1. the one-time cost of alterations to the Insured's primary residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to Zurich American Insurance Company.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 20% of the Insured's Principal Sum or $50,000.

Rehabilitation Benefit

If the Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Dismemberment and Plegia Benefit, Zurich American Insurance Company will pay an additional benefit for the Reasonable and Customary expenses actually incurred for Rehabilitation Training, in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the Accident for the Rehabilitation Training;
2. $25,000; or
3. 10% of the Insured’s Principal Sum.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by Zurich American Insurance Company prior to the provision of services;
2. is required due to the Insured’s Injury; and
3. prepares the Insured for an occupation which he or she would not have engaged in except for the Injury.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, Zurich American Insurance Company will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is Reasonable and Customary.

Seat Belt/Air Bag Benefit

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, and the Injury which caused the accidental death directly resulted from an automobile Accident, Zurich American Insurance Company will pay an additional benefit, which equals 10% of the Insured's Principal Sum up to a maximum of $25,000, provided that the Insured was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the Injury.

Verification of the Insured's actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the Accident, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to Zurich American Insurance Company.

An additional benefit equal to 10% of the Insured's Principal Sum to a maximum of $25,000, will be paid if the Insured was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the Insured's seat belt or lap and shoulder restraint was properly fastened at the time of the Accident. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the Accident, through certification by the investigating officers or by other reasonable proof, acceptable to Zurich American Insurance Company.

Zurich American Insurance Company will not pay a Seat Belt or Air Bag Benefit if the driver of the automobile in which the Insured was riding was either:

1. under the influence of alcohol;
    a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver’s intoxication. Or,
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

Therapeutic Counseling Benefit

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Dismemberment and Plegia Benefit, and the Insured requires Therapeutic Counseling, Zurich American Insurance Company will reimburse the charges for such counseling, provided:

1. all terms and conditions of the Policy are met;
2. Therapeutic Counseling begins within ninety (90) days of the Covered Accident;
3. Therapeutic Counseling must be received within one (1) year from the date of the Covered Loss.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $25,000 for any one Covered Accident.

General Exclusions

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony, an assault, insurrection or riot;
6. being intoxicated while operating a motor vehicle.
    a. An **Insured** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured's** intoxication.
7. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
8. travel or flight in any aircraft except to the extent stated in the **Coverage** Section;

General Limitations

Limitation on Multiple Covered Losses. If an Insured suffers more than one loss as a result of the same Accident, Zurich American Insurance Company will pay only one benefit, the largest benefit.

Limitation on Multiple Benefits. If an Insured can recover benefits under more than one of the following benefits: Accidental Death Benefit, Accidental Dismemberment and Plegia Benefit, Coma Benefit, Permanent and Total Disability Benefit, as a result of the same Accident, the most Zurich American Insurance Company will pay for these benefits in total is the Insured's Principal Sum.

Limitation on Multiple Hazards. If an Insured suffers a Covered Loss that is covered under more than one Hazard, Zurich American Insurance Company will pay only one benefit, the largest benefit unless there is a specific written exception in the Policy.

Aggregate Limit. Zurich American Insurance Company will not pay more than the Aggregate Limit of Liability stated in the Schedule or a specific Hazard(s).

Enhanced Travel Assistance Plan Benefits

Hospital Admission

If a Covered Person is Injured or Ill on a Covered Trip and incurs a Hospital Admission Guarantee Charge and/or a Medical Expense Guarantee Charge, Zurich Travel Assist will pay the actual expenses incurred for guarantee of payment to the hospital or the medical provider. The maximum amount Zurich Travel Assist will pay for the Hospital Admission/Medical Expenses Guarantee is $10,000.

Medical Evacuation Benefit

If a Covered Person is Injured or Ill on a Covered Trip and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon Our or Our Assistance Provider's evaluation, cannot provide medical care in accordance with Western Medical Standards, Zurich Travel Assist will arrange for, and cover the cost for, the transport of the Covered Person to the nearest hospital or medical facility which can provide such care. Zurich Travel Assist must be contacted prior to the transport and Zurich Travel Assist must authorize the transport for this Medical Evacuation Benefit to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

Based on all the circumstances, Zurich Travel Assist will determine the standard of care of a hospital or medical facility, clinic or medical provider for the limited purpose of determining Our liability

Medical Repatriation Benefit

If a Covered Person is Injured or Ill on a Covered Trip and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, Zurich Travel Assist will arrange for, and cover the cost for, the transport of the Covered Person to his or her Principal Residence, in such transportation. Zurich Travel Assist must be contacted prior to the transport and Zurich Travel Assist must authorize the transport for this Medical Repatriation Benefit to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

Based on all the circumstances, for the limited purpose of determining Our liability, Zurich Travel Assist will determine the appropriateness of the scheduling and the mode of transportation as well as what special equipment and/or personnel are covered.

Non-Medical Evacuation Benefit

If a Covered Person is Injured or Ill on a Covered Trip and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, Zurich Travel Assist will arrange for, and cover the cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her Principal Residence. Zurich Travel Assist must be contacted prior to the transport and Zurich Travel Assist must agree to the change in the travel date and/or upgrade for this Non-Medical Repatriation Benefit to be payable. No change or upgrade will be made without the prior recommendation of the attending physician.

Return of Remains Benefit

If a Covered Person dies while on a Covered Trip, Zurich Travel Assist will make arrangements and pay for the local preparation of the body for transport including cremation, travel clearances and authorizations, standard shipping container (including urn or coffin) and transportation of the body or remains to its country of destination. Zurich Travel Assist must be contacted prior to the preparation and transportation of the body and Zurich Travel Assist must authorize the services and transportation for this Return of Remains Benefit to be payable.

Return of Child Benefit

If a Covered Person is traveling with a Dependent Child(ren), who is under nineteen (19) years of age or a Dependent Child(ren) who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental or physical handicap and remains chiefly dependent upon the Covered Person for support and maintenance, while on a Covered Trip, and due to the Illness of or Injury to the Covered Person, such Dependent Child(ren) is left unattended, Zurich Travel Assist will arrange for, and cover the cost of, the transport of the Dependent Child(ren) by a regularly scheduled economy class air flight to the location chosen by the Covered Person, and for an attendant, if applicable. Zurich Travel Assist must authorize the transportation of the Dependent Child(ren) and attendant, if applicable, for this Return of Child Benefit to be payable.

Return of Companion Benefit

If a Covered Person is traveling with a companion while on a Covered Trip, and due to the Illness of or Injury to the Covered Person the Covered Person cannot complete the Covered Trip as scheduled, Zurich Travel Assist will arrange for, and pay for, the lesser of the change fee for the companion's return air flight or a one way economy class flight. Zurich Travel Assist must authorize such costs for this Return of Companion Benefit to be payable.

Escort Services Benefit

If a **Covered Person** is traveling with a companion while on a **Covered Trip**, and due to **Illness** or **Injury** the **Covered Person** qualifies for medical evacuation, medical repatriation, non-medical repatriation or return of remains transportation and/or services, **Zurich Travel Assist** will arrange for, and cover the cost for, the companion to join the **Covered Person** during the **Covered Person's** transport. **Zurich Travel Assist** must authorize such costs for this Escort Services Benefit to be payable.

Based on all the circumstances, for the limited purpose of determining Our liability, Zurich Travel Assist will determine the appropriateness of the companion joining the Covered Person during the Covered Person's transport.

Dispatch of a Physician or Specialist Benefit

If a Covered Person is Injured or Ill on a Covered Trip and, based on the information available, Zurich Travel Assist cannot adequately assess whether or not medical care can be provided in accordance with Western Medical Standards and/or medical evacuation, medical repatriation or non-medical repatriation transportation and/or services are necessary, Zurich Travel Assist will arrange for, and cover the cost of, a physician's or specialist's travel to the Covered Person's location, as well as the medical services provided on location by such physician or specialist, to make the assessment. Zurich Travel Assist must authorize such costs for this Dispatch of a Physician or Specialist Benefit to be payable.

Travel Assistance Plan Exclusions

Zurich Travel Assist will not provide this Enhanced Travel Assistance Plan if:

1. the Covered Trip was undertaken for the specific purpose of securing medical treatment;
2. Zurich Travel Assist did not authorize the transportation and/or services;
3. the Covered Trip was undertaken against the advice of a physician or medical practitioner;
4. the costs incurred are not necessary and/or are excessive. Zurich Travel Assist will make that determination based on all the circumstances;
5. with respect to the Medical Evacuation Benefit, the medical care which is being provided is consistent with Western Medical Standards. Zurich Travel Assist will make that determination based on all the circumstances;
6. with respect to the Medical Evacuation Benefit, it is not medically necessary to transport the Covered Person to another hospital or medical facility. Zurich Travel Assist will make that determination based on all the circumstances;
7. based upon the medical condition of the Covered Person and/or the local conditions and circumstances, Zurich Travel Assist determines that the medical evacuation or repatriation or non-medical repatriation is not appropriate. Zurich Travel Assist will make that determination based on all the circumstances.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D Insurance is available on an optional contributory basis. This coverage provides extra financial security for you and your family in the event of accidental death, dismemberment, or paralysis.

Coverage is provided 24 hours a day anywhere in the world, on or off the job, on business or vacation, and at home.

AD&D Insurance benefits are paid in addition to any other life and accident insurance benefits you are eligible to receive.

Benefit Amounts		
If you want to cover your spouse and eligible dependent children, you can elect family coverage. The benefit amount for family members is a percentage of your benefit amount and is based on the composition of your family at the time of loss, as follows:		
If you have these dependents at the time of loss,	**Your spouse's benefit will be**	**Each child's benefit will be**
Spouse and children	90%	20%
Spouse only	100%	n/a
Children only	n/a	30%
You can elect AD&D Insurance coverage for yourself from $20,000 to $500,000 in $10,000 increments. However, the amount you choose cannot exceed 10 times your Pay. In any case, your total coverage may not exceed $500,000.		

Payment of Benefits

Accidental Death Benefits

If a Covered Person suffers a loss of life as a result of a Covered Injury, The Plan will pay the applicable Principal Sum. The death must occur within 365 days of the Covered Injury.

This benefit is subject to the limitations in General Limitations.

Accidental Dismemberment and Plegia Benefits

If an Injury to a Covered Person results in any of the following Covered Losses, The Plan will pay the benefit amount shown. The Covered Loss must occur within 365 days of the Accident.

The benefit amounts are based on the Principal Sum of the person suffering the Covered Loss.

Dismemberment Benefits	
For covered loss of	**The plan pays**
Both hands or both feet	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot plus the loss of Sight of One Eye	Principal Sum
Sight of both eyes	Principal Sum
Speech and hearing	Principal Sum
Speech or hearing	50% of Principal Sum
One hand; one foot; or sight of one eye	50% of Principal Sum
Thumb and index finger of the same hand	25% of Principal Sum
Hearing in one ear	25% of Principal Sum
Plegia	
Quadriplegia (total paralysis of all for limbs)	Principal Sum
Triplegia (total paralysis of three limbs)	Principal Sum
Paraplegia (total paralysis of both lower limbs)	Principal Sum
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	Principal Sum
Uniplegia (total paralysis of one limb)	25% of Principal Sum

For purposes of this benefit:

1. Covered Loss means:
    a. For a foot or hand, actual severance through or above an ankle or wrist joint;
    b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
    c. Total and permanent loss of sight;
    d. Total and permanent loss of speech;
    e. Total and permanent loss of hearing.
2. Plegia must continue for 12 consecutive months and be determined by Our competent medical authority to be permanent, complete and irreversible paralysis of one or more limbs. A Limb means an arm or a leg. Proof of total paralysis may be required by Zurich American Insurance Company on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

This benefit is subject to the limitations in General Limitations.

Coma Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss within 365 days of a Covered Accident, and such Injury causes the Covered Person to be in a Coma for at least thirty-one (31) consecutive days, the Plan will pay a Coma Benefit.

The Coma Benefit will be equal to 5% of the Covered Person's Principal Sum and will be paid each month the Covered Person remains in a Coma following the initial thirty-one (31) day period. The Coma Benefit will end on the earliest of the following:

1. when the Covered Person is no longer in a Coma which directly resulted from the Injury;
2. when the Covered Person has received a Coma Benefit for 20 months. Coma will be determined by Our duly licensed physician.

This benefit is subject to the limitations in General Limitations.

Additional Benefits

Additional Dismemberment Benefit for Children

If You selected a Plan covering Your eligible Dependent Child(ren), and a Covered Dependent Child suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Dismemberment Benefit, the Plan will pay You an additional benefit which will be equal to the benefit amount provided by the Accidental Dismemberment Benefit.

Carjacking Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss which is payable under the Accidental Death or Accidental Dismemberment and Plegia Benefit as a direct result of an Accident that occurs during a Carjacking of a private passenger automobile that the Covered Person was operating, getting into or out of, or riding in as a passenger, The Plan will pay an additional benefit equal to 10% of the applicable Principal Sum to a maximum of $50,000.

Verification of the Carjacking must be made part of an official police report within twenty-four (24) hours of the Carjacking or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24)hours or as soon as reasonably possible and such verification must be provided to Zurich American Insurance Company.

For purposes of this benefit, Carjacking means a person other than the Covered Person taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

Common Carrier Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss which is payable under the Accidental Death or Accidental Dismemberment and Plegia Benefit, The Plan will pay an additional benefit equal to the lesser of $500,000 or 100% of the Covered Person's Principal Sum, provided the Covered Person receives the Injury while a passenger riding in or on, boarding, or getting off a Common Carrier.

For purposes of this benefit, Common Carrier means:

1. any land or water conveyance licensed to carry persons for hire;
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

Common Disaster Benefit

If You selected a Plan covering Your Dependents and You and Your Covered Spouse are both eligible for Accidental Death Benefits as a result of Covered Injuries suffered in the same Accident and within ninety (90) days of such Accident, the Principal Sum that would have been payable because of Your Covered Spouse's Accidental Death will be increased to equal that payable for Your loss, provided:

1. the combined benefits of You and Your Covered Spouse are not more than $1,000,000.

Critical Burn Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss as a result of a Covered Accident which is payable under the Accidental Dismemberment and Plegia Benefit, an additional benefit will be payable equal to the lesser of 10% of the applicable Principal Sum or $10,000, provided all terms and conditions of the Policy are met and

1. The Covered Person has received second degree or higher burns over 25% of his or her body; and
2. The Covered Person has undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within 365 days of the occurrence of the Injury.

Conversion Privilege

If the insurance of an Insured ceases for reasons other than termination of the Policy or nonpayment of premium, the Insured is entitled to convert his or her Coverage to an Individual Accidental Death or Dismemberment (IAD) policy or to a Family AD&D (FAD) policy if the Insured selected a Plan covering his or her Dependents. The new IAD or FAD policy will be on approved forms and will not include all the Benefits and Additional Benefits of the Group Accident Policy. The Insured must make a written application for the IAD or FAD policy within sixty (60) days of the cessation of insurance under the Group Accident Policy. To request a Conversion Application Form, the Insured must call 1-888-634-6780, Option 2. The Insured does not have to show proof of good health.

The issuance of the IAD or FAD policy is subject to the following conditions:

1. the Principal Sum for the IAD or FAD policy will be the lesser of the Insured's Principal Sum under the Group Accident Policy or $250,000;
2. the premium for the IAD or FAD policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. any IAD or FAD policy issued will take effect on the termination date of the Insured's insurance under the Group Accident Policy; and
4. when an IAD or FAD policy becomes effective, the relationship between the Insured and Us will be governed by that policy, including all terms and conditions, and benefits and termination dates.

The Conversion Privilege will cease when the Insured attains age 70.

Day Care Center Benefit

If You selected a Plan covering Your Dependents and You or Your Covered Spouse suffer an Injury resulting in a Covered Loss which is payable under the Accidental Death Benefit, The Plan will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each Covered Dependent Child if:

1. on the date of the Accident, the Covered Dependent Child was enrolled in an Accredited Child Care Facility, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the Covered Dependent Child is under age 13.

The Day Care Benefit will be equal to the lesser of:

1. the actual cost of the child care;
2. 10% of the Covered Person's Principal Sum who suffered the Covered Loss; or $10,000.

If both You and Your Covered Spouse suffer a simultaneous Covered Loss, the Day Care Benefit will be based on Your Principal Sum.

The Day Care Benefit will be paid annually for four (4) consecutive years if:

1. the Covered Dependent Child is under age 13 at the time of each annual payment; and
2. proof, acceptable to Zurich American Insurance Company, is received by Zurich American Insurance Company that verifies that the Covered Dependent Child remains enrolled in an Accredited Child Care Facility.

An Accredited Child Care Facility means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An Accredited Child Care Facility does not include a hospital; the child’s home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

The maximum amount payable under this benefit is $50,000.

Exposure and Disappearance Coverage

If a Covered Person is exposed to weather because of an Accident and this results in a Covered Loss, We will pay the applicable Principal Sum, subject to all Policy terms.

If the conveyance in which a Covered Person is riding disappears, is wrecked, or sinks, and the Covered Person is not found within 180 days of the event, We will presume that the person lost his or her life as a result of Injury. If travel in such conveyance was covered under the terms of this Policy, We will pay the applicable Principal Sum, subject to all Policy terms. We have the right to recover the benefit if We find that the Covered Person survived the event.

Limitations and Exclusions that apply to this Hazard are in Section VII General Exclusions and Section VIII General Limitations.

Hearing Aid or Prosthetic Appliance Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss which is payable under the Accidental Dismemberment and Plegia Benefit, the Plan will pay an additional benefit provided:

1. the Covered Person is required to use a hearing aid or prosthetic appliance;
2. the Injury that caused the payment of the Accidental Dismemberment and Plegia Benefit is the same Injury that requires the Covered Person to use the Hearing Aid or Prosthetic Appliance; and

3. the Hearing Aid or Prosthetic Appliance was required within one (1) year of the Injury.

The amount the Plan will pay will be equal to the one time cost of the Hearing Aid or Prosthetic Appliance actually paid by the Covered Person.

This benefit will not be paid unless:

1. the Hearing Aid or Prosthetic Appliance was prescribed by a legally qualified physician or surgeon who is not the Covered Person's spouse, child, or relative; and
2. presentation of proof of payment is provided to the Zurich American Insurance Company.

For purposes of this benefit, Prosthetic Appliance will include an artificial limb or eye. No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the Covered Person's Principal Sum or $10,000.

Higher Education Benefit

If You selected a Plan covering Your Dependent Child(ren) and You suffer an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, the Plan will pay an additional benefit for higher education expenses to the individual who incurs the expense for each Covered Dependent Child.

A Covered Dependent Child is eligible for the Higher Education benefit if on the date of the Accident:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she was at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the Accident.

The Higher Education will be equal to 10% of Your Principal Sum, to a maximum of $10,000. This amount will be paid annually for four (4) consecutive years if Your Covered Dependent Child continues his or her education. Before this benefit is paid each year, Your Covered Dependent Child must present written proof, acceptable to Zurich American Insurance Company, that he or she is attending an institution of higher learning on a full-time basis.

The maximum amount payable for this benefit is $50,000.

If, at the time of the Accident, a Plan covering Your Dependents was selected, but there are no Covered Dependent Child(ren) who qualify for this benefit, the Plan will pay an additional benefit of $1,000 to the designated beneficiary.

Home Alterations and Vehicle Modification Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Dismemberment and Plegia Benefit, the Plan will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the Covered Person is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the Injury that caused the payment of the Accidental Dismemberment and Plegia Benefit is the same Injury that requires the Covered Person to need the wheelchair.

The amount the Plan will pay will be equal to:

1. the one time cost of alterations to the Covered Person's primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to the Zurich American Insurance Company.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 20% of the Covered Person's Principal Sum or $50,000.

Parent Care

If You or Your Spouse suffer an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, We will pay an additional benefit for Parent Care, in equal shares, to each of Your Dependent Parent(s) (or his or her legal guardian). The amount payable for the Parent Care Benefit will be 10% of Your Principal Sum to a maximum of $40,000 for all Dependent Parents.

For purposes of this benefit, Dependent Parent means Your parent(s) or grandparent(s) or those of Your Covered Spouse/Covered who, at the time of a Covered Accident, is receiving support and care provided by You or Your Covered Spouse/Covered as evidenced by the most current tax return filed with the government of the United States of America.

Rehabilitation Benefit

If You suffer an Injury resulting in a Covered Loss which is payable under the Accidental Dismemberment and Plegia Benefit, the Plan will pay an additional benefit for the Reasonable and Customary expenses actually incurred for Rehabilitation Training in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the Accident for the Rehabilitation Training;
2. $50,000; or
3. 10% of Your Principal Sum.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by the Plan prior to the provision of services;
2. is required due to Your Injury; and
3. prepares You for an occupation which You would not have engaged in except for the Injury.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, the Plan will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

The Plan reserves the right to make the final determination of what is Reasonable and Customary.

Seat Belt Benefit

If a Covered Person suffers an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, and the Injury which caused the accidental death directly resulted from an automobile Accident, the Plan will pay to the beneficiary an additional benefit, which equals 10% of the applicable Principal Sum up to a maximum of $25,000, provided that the Covered Person was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and

2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the Injury.

Verification of the Covered Person's actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the Accident, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to the Plan.

An additional benefit equal to 5% of the Covered Person's Principal Sum to a maximum of $10,000, will be paid if the Covered Person was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the Covered Person's seat belt or lap and shoulder restraint was properly fastened at the time of the Accident. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the Accident, through certification by the investigating officers or by other reasonable proof, acceptable to the Plan.

The Plan will not pay a Seat Belt or Air Bag Benefit if the driver of the private passenger automobile in which the Covered Person was riding was either:

1. under the influence of alcohol;
    a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver’s intoxication. Or,
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

Spouse Retraining Benefit

If You selected a Plan covering Your Spouse and You suffer an Injury resulting in a Covered Loss which is payable under the Accidental Death Benefit, the Plan will pay to, or on behalf of, Your Covered Spouse the actual cost of any professional or trade-training program in which the Covered Spouse enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from Your death; and
3. the professional or trade training program is licensed by the state.

The maximum amount payment under this benefit will be the lesser of 10% of Your Principal Sum up to $50,000.

Surviving Spouse Benefit

If You, selected a Plan covering Your Spouse, and You suffer an Injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, We will pay an additional benefit to Your Covered Spouse. The monthly benefit will be equal to 1% of Your Principal Sum and will be paid for a period of six (6) months

Therapeutic Counseling Benefit

If You selected a Plan covering Your Dependents and You or Your Covered Dependents suffer an Injury resulting in a Covered Loss which is payable under the Accidental Death or Accidental Dismemberment

and Plegia Benefit, and You or Your Covered Dependents require Therapeutic Counseling, the Plan will reimburse the actual expense for such counseling to the individual who incurs the expense, provided:

1. all terms and conditions of the Policy are met;
2. Therapeutic Counseling begins within ninety (90) days of the Covered Accident;
3. Therapeutic Counseling must be incurred within one year from the date of the Covered Loss.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $25,000 for any one Covered Accident.

General Exclusions

A loss will not be a Covered Loss if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for Accidental ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony;
6. being intoxicated while operating a motor vehicle.
    a. A Covered Person will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be intoxicated if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the Covered Person’s intoxication.
7. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
8. travel or flight in any aircraft except to the extent sated in the Coverage Section;

Hazard Exclusions

Coverage is not provided:

A. If the Covered Person is the pilot, operator, member of the crew or cabin attendant of any aircraft.

B. Unless Zurich American Insurance Company has previously consented in writing to the use, Coverage is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
    1. any aircraft other than those expressly stated in this Coverage;
    2. any aircraft Owned or Controlled by, or Under lease to the Policyholder except the following aircraft including Substitute Aircraft:

        As on File with the Policyholder provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the Policyholder's consent; c) is not

carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft.

3. any aircraft Owned or Controlled by, or Under lease to an Insured;
4. any aircraft operated by the Policyholder except those indicated in 2. above, or one of the Policyholder's employees;
5. any aircraft engaged in a Specialized Aviation Activity;
6. any conveyance used for tests or experimental purposes, or in a race or speed test.

Hazard Definitions:

Substitute Aircraft means an aircraft, which is not owned by the Policyholder, and:

1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
2. is the same class of aircraft as the specified aircraft; and
3. is being used by the Policyholder because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.

Note: A complete updated list of all Corporate Aircraft must be provided to Us on each anniversary of the Policy.

Other Limitations and Exclusions that apply to this Hazard are in General Exclusions and General Limitations.

General Limitations

Limitation on Multiple Covered Losses. If a Covered Person suffers more than one loss as a result of the same Accident, The Plan will pay only one benefit, the largest benefit.

Limitation on Multiple Benefits. If a Covered Person can recover benefits under more than one of the following benefits: Accidental Death Benefit, Accidental Dismemberment and Plegia Benefit, Coma Benefit, Permanent and Total Disability Benefit, as a result of the same Accident, the most the Plan will pay for these benefits in total is the Covered Person's Principal Sum.

Limitation on Multiple Hazards. If a Covered Person suffers a Covered Loss that is covered under more than one Hazard, the Plan will pay only one benefit, the largest benefit unless there is a specific written exception in the Policy.

Other Important Information

The following information applies to your life and accident insurance benefits.

Naming Your Beneficiary

You may name anyone as your beneficiary, and you also may change your beneficiary designation at any time on the ORNL Benefits Enrollment web site at https://my.adp.com or by phone at

1-800-211-3622. The beneficiary you name for Basic Life Insurance benefits automatically will be your beneficiary for Supplemental Life and Business Travel Accident Insurance unless you elect otherwise in writing. You may also name anyone as your beneficiary for AD&D Insurance.

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

- your spouse
- your child or children

- your mother and/or father
- your sisters and/or brothers

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

If you elect Dependent Life coverage or family coverage under the AD&D Insurance plan, you will automatically be the beneficiary in case of the death of a family member unless you elect otherwise in writing.

Costs for Coverage

As described in the “About Your Benefits” chapter, you and the Company share the cost of Basic Life Insurance coverage. You pay the full cost of all supplemental and Dependent Life Insurance and AD&D Insurance coverage. The Company pays the cost of Business Travel Accident coverage.

Tax Consequences

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

Claiming Benefits

You or your beneficiary must file a claim with the ORNL Benefits Office to receive any life and accident insurance benefits. By contacting the ORNL Benefits Office, you or your beneficiary will receive the necessary forms as well as instructions and assistance in filing forms. . For claims under the Business Travel Accident Insurance and Accidental Death & Dismemberment Insurance policies, you, your beneficiary, or someone on your behalf, must give the claims administrator written notice of the Covered Loss within ninety days of such Covered Loss.

When Coverage Ends

Business Travel Accident Insurance coverage ends on the date your employment terminates for any reason. AD&D Insurance ends on the last day of the month your employment terminates.

If you are on temporary suspension of work or an approved leave of absence, you may continue your Basic Life Insurance and Supplemental Life Insurance coverage until the end of the third month following the month in which your absence began. In addition, you may elect to continue your AD&D Insurance coverage if you are on an approved benefits eligible leave of absence or sabbatical, provided the required premiums are paid.

Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance, Business Travel Accident Insurance, and AD&D Insurance coverages may end before termination of employment.

However, these coverages will end on the earliest of the following dates:

- the date you are no longer considered eligible because of a change in your employment status
- the last day of the period for which your last contribution was made
- the date the plan is terminated.

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

Conversion Privileges

Within 31 days after your Basic Life Insurance, Supplemental Life Insurance, spouse and Dependent Life Insurance, and AD&D Insurance coverages terminate, you may convert all or part of these coverages to an individual whole life insurance policy without taking a medical examination. The cost for individual coverage will be based on the insurance company’s regular premium rates for the type and amount of insurance available to you through the conversion privilege. The conversion privilege under the AD&D Insurance plan ends at age 70.

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

If your AD&D insurance ends, you must make a written application for the policy within sixty (60) days of the cessation of insurance under the Group Accident Policy. To request a Conversion Application Form, you must call 1-800-834-1959. You do not have to show proof of good health.

Business Travel Accident Insurance may not be converted to an individual policy.

Portability

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

Within 31 days after your Supplemental Life Insurance coverage terminates due to voluntary termination, retirement, or dismissal, you may port all of the coverage to a term life policy without taking a medical examination. The cost for the ported coverage will be based on your age and will increase incrementally as you get older.

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

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

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

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

Administrative Information

Information about the administration of your Disability Coverage can be found in the chapter titled "Administrative Information."

Glossary

Accident or Accidental

An unexpected and unintended event that occurs by chance during the Policy term.

Active and Actively at Work

Describes You if You are able and available for active performance of all of Your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Actively at Work provided You are able and available for active performance of all of Your regular duties and were working the day immediately prior to the date of Your absence.

Aggregate Limit of Liability

The total benefits Zurich American Insurance Company will pay for a Covered Accident or Covered Accidents set forth in the Payment of Benefits Section. For purposes of the Aggregate Limit of Liability provision, Covered Accident or Covered Accidents will include a Covered Loss or Covered Losses arising out of a single event or related events or originating cause and includes a resulting Covered Loss or Covered Losses. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each Insured, Zurich American Insurance Company will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.

Business Trip

A Covered Trip anywhere in the world while on an assignment by or at the direction of the Company to further the business of the Company. It does not include an accident occurring during usual travel to and from work; bona fide leaves of absence or vacation. It does not include a Personal Deviation and Side Trips of a personal nature.

Carjacking

A person other than the Insured taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

Covered Trip

Travel more than 100 miles from outside the Covered Person's Principal Residence.

Covered Accident

An Accident that results in a Covered Loss.

Covered Injury

An Injury directly caused by accidental means, which is independent of all other causes, results from a Covered Accident, occurs while You are insured under the Policy, and results in a Covered Loss.

Covered Loss

A loss which meets the requisites of one or more benefits or additional benefits, results from a Covered Injury, and for which benefits are payable under the Policy.

Covered Person

Any person who has insurance under the terms of the Policy. It includes You.

Dependent

Your Spouse and Dependent Child(ren).

Dependent Child(ren)

For purposes of Child Life Insurance, means Your unmarried Child(ren) and, those unmarried Child(ren) of Your legally married Spouse from birth until age 26.

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

Hospital Admission Guarantee Charge

Any charge or expense made by a hospital prior to and as a condition of a Covered Person's admission to that hospital.

Ill or Illness

A sickness or disease, which impairs the normal functions of the body and which first manifests itself during a Covered Trip.

Injured, Injury or Injuries

A bodily injury or injuries and is not limited to accidental bodily injuries.

Insured

An individual who is eligible for Coverage under the Policy as provided in the Certificate holder part of the Eligibility and Classification of Insureds Section, and who completes the enrollment material, if required.

Medical Expense Guarantee Charge

Any charge or expense made by a medical provider other than a hospital prior to and as a condition of a Covered Person being provided with the medical service or treatment by that provider.

Pay

Your annual basic rate of pay before any pre-tax salary reductions. Pay does not include overtime, bonuses, or any other form of extra compensation.

Permanently and Total Disability

The Insured is totally and continually disabled and cannot work at any job that he or she is reasonably suited by education, training or experience to do as a gainful or meaningful occupation. Permanent and Total Disability must be verified by a competent medical authority, and must be expected to continue for the remainder of the Insured's life.

Personal Deviation

Non-business activities undertaken while on the Business of the Company, but unrelated to furthering the Business of the Company.

Plan

The Plan design as described in this AD&D Insurance Section.

Policy

The Business Travel Accident Insurance Policy or the AD&D Insurance Policy.

Policyholder

The Company.

Principal Residence

The legal domicile of the Covered Person. If the Covered Person has dual citizenship, his or her country of citizenship is the country of the passport he or she used to enter the location in which he or she is traveling.

Side Trip

Non-business travel of a personal nature that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; 3) is taken during the course of the business trip; and 4) is limited to 336 hours (14 days).

Spouse

For purposes of Life Insurance, means Your lawful spouse.

For purposes of the Business Travel Accident Insurance and AD&D Insurance, means Your legally married Spouse.

Total Disability or Totally Disabled

For purposes of Life Insurance, You are considered Totally Disabled if, because of an illness or injury,

- you cannot do your job and
- you cannot do any other job for which you are qualified by your education, your training, or your experience.

Western Medical Standards

Generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

You, Your

Refers to the Insured.

10. Legal Insurance with ID Theft Protection

The Legal Insurance with Identity (ID) Theft Protection provides you and your family affordable, reliable legal coverage to help with everyday life matters and to protect one of your most valuable assets—your identity.

Highlights

The Legal Insurance Plan with Identity Theft Protection …

Helps You Pay the Costs of Planned and Unplanned Legal Needs

The plan provides you with affordable, reliable legal coverage to help with everyday life matters—like identity (ID) theft, a dispute with a contractor, creating a will, buying a home, or an auto repair that doesn't go as planned.

Offers Access to an Attorney for a Consultation

You have access to an attorney who can consult, advise, and represent you if something unexpected happens like identity theft, credit problems, or contractor issues.

What Happens to Your Benefits When ...

For more information about what happens to your Legal Insurance with Identity Theft Protection coverage when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" chapter.

How the Legal Insurance Plan with Identity Theft Protection Works

The UltimateAdvisor® legal plan from ARAG® offers affordable and knowledgeable legal counsel through professional legal guidance and valuable resources to protect you and your loved ones and to help you address everyday life matters or situations that may turn into legal matters, such as:

- Creating or updating a will
- Protecting your personal information against identity theft
- Making a financial plan for retirement
- Adopting a child
- Selling your house and buying a new one
- Settling a legal dispute with a neighbor
- Acting as a caregiver and advocate on behalf of your aging parents

This coverage helps you to avoid paying high-cost attorney fees— most covered legal matters are 100% paid in full when you work with a Network Attorney. The benefits described in this section are an optional benefit provided by the Company. The "About Your Benefits" Chapter further describes eligibility and the enrollment process. If you enroll, you pay the full cost of premiums on an after-tax basis.

What the Plan Pays

You may receive covered services from any attorney; however, benefits are paid differently depending on whether you choose to work with a Network Attorney (an attorney who is part of the ARAG attorney network) or you choose to work with an attorney who is not in the network:

- If you work with a Network Attorney, the plan pays the attorney fees in full for most covered legal matters. The Network Attorney will bill ARAG directly for legal services rendered to you that are covered under the legal plan.
- A list of Network Attorneys for each state, which includes the areas of law they practice, their phone numbers, and if they speak a foreign language, is available by calling 800-247-4184. You can also visit the ARAGLegalCenter.com, access code 18095 to access the online Attorney Finder feature.
- If you choose to receive services from an attorney not in the ARAG Network, you pay the cost of legal services and then file a claim form, along with your attorney's billing statement, to ARAG. You will be reimbursed for covered legal fees up to the lesser amount of actual fees incurred or the benefit amount indicated in your plan Certificate for that specific coverage.
- You must notify ARAG within the time period described in the Certificate.
- Unless otherwise specified, your coverage will include coverage for your eligible dependents, including your spouse and/or dependent children until the end of the month that they reach age 26 regardless of student or marital status. Disabled dependents may continue beyond age 26.

How to Contact ARAG

If you or someone in your family needs legal or identity theft assistance, contact ARAG at 800-247-4184 or service@ARAGlegal.com.

Administrative Information

Information about the administration of the Legal Insurance with Identity Theft Protection coverage can be found in the chapter titled "Administrative Information."

Covered Services

This document, along with the Certificate provided by ARAG, and any endorsements or amendments to it, together form the Summary Plan Description of the Legal Insurance Plan. A description of the benefits and covered services provided under the Legal Insurance Plan can be found in the Certificate.

Other Important Information

Conversion

You may continue this insurance when you no longer qualify as an employee of UT-Battelle. You must notify ARAG within 90 days of this disqualifying event to make arrangements for premium payment.

For questions regarding the ARAG conversion plan, please contact ARAG at 800-247-4184.

Questions/Concerns

If you have any questions or concerns, please contact the insurer by telephone at 800-247-4184 or by mail at:

ARAG®
500 Grand, Suite 100
Des Moines, IA, 50309

Disclaimer Language

This information is for illustrative purposes only. This information is intended to provide a general review of the plan described. Please remember that only the insurance policy can give actual terms, coverages, amounts, conditions, and exclusions.

Underwriter Information

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa; GuideOne® Mutual Insurance Company of West Des Moines, Iowa; or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC.

This material is for illustrative purposes only and is not a contract. For terms, benefits, or exclusions, call 800-247-4184.

Subrogation

ARAG may require you to assign all rights of recovery of legal fees to the extent that payment is made by ARAG. If an assignment is sought, you must cooperate with ARAG.

11. Pension Plan

The Pension Plan described in this chapter is intended for grandfathered employees who transitioned to ORNL from the National Strategic Protection Services Plan (NSPS) effective December 30, 2018.

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

All capitalized terms are defined in the Glossary subsection at the end of this section.

Highlights

The Pension Plan …

Provides You With Flexibility in Planning Your Retirement

You can retire with a full pension benefit at age 65 or over. You can also receive a full pension benefit when you retire at age 62 or older if you have at least 10 years of Company Service, or when your age and years of Company Service equal 81 or more. You can receive a reduced benefit as early as age 50 if you have at least 10 years of Company Service.

Lets You Choose from a Variety of Payment Forms

There are several payment forms to choose from, including life annuity and survivor benefit options. If you are married, you will be paid in a joint and 50% survivor benefit unless you have your spouse's written consent to elect another payment form.

Offers Financial Security to Your Family in Case of Your Death

If you should die while you are still working, the Pension Plan will pay a survivor benefit to your surviving spouse, Dependent Child, or Dependent Parent if you are vested (you have at least 5 years of Credited Service).

What Happens to Your Benefits When ...

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

Plan Eligibility

Company employees, shown on the regular payroll and personnel records with Compensation reported by the Company on an Internal Revenue Service (IRS) Form W-2, automatically become Pension Plan participants unless they are in one of the following excluded categories:

- leased employees,
- independent contractors,
- non-resident aliens who do not have earnings from the Company from sources within the United States,
- employees who have entered into a written agreement with the Company waiving the right to participate in the plan,
- IGUA represented employees (Security Police Officers or Central Alarm System Operators) hired on or after August 15, 2016, and
- Non-represented employees hired on or after June 4, 2007.

Employee Contributions

Mandatory participant contributions are required to be made to the Pension Plan effective December 30, 2018 by Salaried Employees equal to the sum of:

- 2% of employee's Compensation up to the maximum Social Security wage base for the year, and
- 4% of the employee's Compensation above the Social Security wage base for the year, and

However, no mandatory participant contributions may be made for Compensation above the 401(a)(17) limit.

If you terminate your employment prior to being vested (have 5 years of Credited Service), you will receive a refund for the amount of your contributions plus applicable interest, and you will forfeit any other benefit under the Pension Plan.

If you terminate your employment after being vested (have 5 years of Credited Service), your contributions will be reflected as a nontaxable portion of your monthly benefit when it commences. Also, the Pension Plan includes a refund feature to make sure that the cumulative benefit distributions are at least equal to the amount of your contributions plus applicable interest.

After December 30, 2018, salaried employees will only be credited with Company Service under the pension benefit formulas for periods during which you make a mandatory participant contribution.

When You Can Retire

To offer you flexibility in planning for retirement, the Pension Plan provides a choice of retirement dates.

You can retire with a full pension:

- at age 65 or later, regardless of Company Service, or
- at age 62 or later, with at least 10 years of Company Service, or
- when your age and years of Company Service total 81 or more.

Company Service for Prior Contractors

Service with contractors prior to participation in this Pension Plan does not count for any purpose unless specifically credited under the terms of the Pension Plan document.

You can retire with a reduced pension:

- at age 50, with at least 10 years of Company Service.

If you choose to retire after age 65 and continue to work for the Company, you will continue to earn Company Service and pay for plan benefit purposes until you actually retire. In any event, your plan

benefits will begin no later than the first of the month after you reach age 70½, unless you decide to defer commencement of your benefit until you actually retire.

There is one important exception to these retirement dates. If your employment is involuntarily terminated by action of the Company (other than for cause), you will be considered to have met the age and service requirements for:

- a full pension benefit if you are age 60 or over and have at least 8 years of Company Service or if your years of Company Service and age total 79 or more, or
- a reduced pension benefit if you are at least age 48 with at least 8 years of Company Service.

Any service added under the involuntary termination provisions will count for your eligibility for the benefit but does not count to determine the amount of benefit.

Determining Your Pension Benefit

Your pension benefit is calculated under three different formulas: Regular, Alternate, and Minimum. The formula that gives you the largest benefit will be used.

All of the formulas are based in part on:

- your Average Straight-Time Monthly Earnings—the average of your highest earnings for 3 years during the last 10 years just before you retire (for a discussion of how these earnings are calculated, continue reading), and
- your Company Service—including all your years and completed months of service—with each completed month counting as 1/12 of a year.

Regular Formula

The Regular formula provides a monthly benefit of:

- 1.2% of your Average Straight-Time Monthly Earnings times your years and months of Company Service plus $18.

Alternate Formula

The Alternate formula provides a monthly benefit of:

- 1.5% of your Average Straight-Time Monthly Earnings times your years and months of Company Service minus 1.5% of your monthly primary Social Security benefit times your years and months of Company Service up to 33 1/3 years.

Under this formula, 50% of your primary Social Security benefit will be used to offset your earnings. If you provide the Company with the Social Security Administration's estimated benefit within 6 months of your retirement date, the Company will use the official estimate rather than a benefit based on your estimated earnings history if it provides a higher benefit. Otherwise, the Company will use your estimated earnings history.

When you retire, your primary Social Security benefit for purposes of this formula is the benefit you would be eligible to receive at your retirement age or age 62, if later. This benefit is based on the Social Security laws in effect on the date you retire.

Minimum Formula

The Minimum formula provides a monthly benefit of:

- $5 for each of your first 10 years of Company Service, plus $7 for each of the 11th through 20th years of service, plus $9 for each year in excess of 20 years of service, plus 10% of your Average Straight-Time Monthly Earnings (if you have less than 8 years of Company Service, this will be reduced 1% a year for each year less than 8), plus $18.

Pension Benefit Formulas	
Formula	**Provides Monthly Benefit of …**
Regular	1.2% of your Average Straight-Time Monthly Earnings times your years and months of Company Service plus $18.
Alternate	1.5% of your Average Straight-Time Monthly Earnings times your years and months of Company Service minus 1.5% of your monthly primary Social Security benefit times your years and months of Company Service up to 33 1/3 years.
Minimum	$5 for each of your first 10 years of Company Service, plus $7 for each of the 11th through 20th years of service, plus $9 for each year in excess of 20 years of service, plus 10% of your Average Straight-Time Monthly Earnings (if you have less than 8 years of Company Service, this will be reduced 1% a year for each year less than 8), plus $18.

Reduced Benefits

If you retire before you are entitled to a full pension, your monthly benefit is reduced. The amount of reduction is based on your age and service. For example, if you are age 55 and have 23 years of service, you will receive 85% of your full benefit. (For the reduction factors, see Table 1 at the end of this chapter.)

The three formulas used to calculate full pensions are also used to calculate reduced pensions. The one which produces the largest benefit will be the one used. In the Regular and Minimum formulas, the reduction factor is applied after calculating the total benefit. In the Alternate formula, the reduction factor is applied before subtracting the primary Social Security benefit.

Examples of Estimated Monthly Pension Income at Age 65					
Average Straight-Time Monthly Earnings	**Years of Service at Retirement**				
	20	**25**	**30**	**35**	**40**
$2,000	$498	$618	$738	$858	$978
$3,000	738	918	1,098	1,278	1,458
$4,000	978	1,218	1,458	1,698	1,938
$5,000	1,218	1,518	1,818	2,118	2,418
$6,000	1,458	1,818	2,178	2,538	2,898

The above amounts were calculated under the Regular formula. However, the relationship of average earnings and Social Security benefits at the time you retire might result in the Alternate formula producing a higher benefit than shown in some of the above examples. In such a case, the actual benefit will be greater than that shown in the above table, because the highest benefit produced by any of the three formulas is the one used.

If you retire before you are eligible for a full pension, you may postpone starting your pension and thus lessen or eliminate the reduction. In the example above, if you retire at age 55 with 23 years of service but postpone starting your pension until age 58, you will receive a full pension because your 23 years of service and your age will then total 81. You can add years to your age after you terminate employment only if you were eligible for early retirement when you terminated employment.

Any reduction for early retirement is in addition to the reduction that may be made to your plan benefit if you elect to provide continuing plan benefits to your spouse, Dependent Children, or Dependent Parents after your death, as discussed on the following pages. (See Tables 3, 4, 5, and 6 at the end of this chapter for survivor reduction factors.)

Guard Supplement

If your job requires compliance with certain medical and physical standards as described in 10 CFR Part 1046 of the *Code of Federal Regulations* for at least 10 years in the last 12 years of your employment

with the Company, you may be eligible for this supplemental pension benefit, beginning upon your retirement commencement and ending when you reach age 65. You will only be eligible for this supplemental benefit if it is larger than your benefit calculated under the Plan, without taking the supplement into account. In general, this supplemental benefit applies if you have not accrued a full pension and retire prior to age 65. When you reach age 65, your benefit will be reduced to the pension calculated prior to the additional supplement.

Calculating Your Earnings

Average Straight-Time Monthly Earnings are computed using your straight-time rate of pay (including certain variable pay, shift differential, and hourly cost of living adjustment [COLA]) and your regularly scheduled hours during:

- the 3 calendar years in which these earnings were highest, during the 10 calendar years just before you retire

  or, if greater

- the final 3 years (36 months) just before you retire.

The Average Straight-Time Monthly Earnings during the final 3 years are calculated by using:

- scheduled straight-time monthly earnings in the completed months of the calendar year in which you retire, and
- scheduled straight-time earnings in the 2 preceding calendar years, and
- for any months in the third preceding calendar year, the average of the scheduled straight-time monthly earnings for that year times the number of months used in that year.

You should note that this calculation does not use the actual scheduled earnings for the specific months of the third year. The earnings rate used will be the monthly average for the entire year.

Differential pay during certain periods of military service is included in earnings unless you return to employment following a qualified military service leave within the required time period. In that case, your earnings during the military service leave will be credited based on your rate of pay when your leave started, adjusted as required by a law called the Uniformed Services Employment and Reemployment Rights Act (USERRA). For more information about the impact of a military service leave on your plan benefits, see the discussion titled “Service and Earnings During Military Service Leave” in the “Credited Service and Severance from Service” section.

NOTE: The IRS places restrictions on the amount of compensation to be used in calculating the pension benefit. Certain highly compensated employees may have a limit imposed.

Pension Benefit Example		
A full pension will be the largest amount produced by any of the three formulas. For example, suppose you retire at age 65 with 30 years of Company Service and Average Straight-Time Monthly Earnings of $4,500 a month. Here is how your full pension would be calculated:		
Regular Formula		
.012 × 30 × $4,500 + $18	=	$1,638
Per Month	**=**	**$1,638**
Alternate Formula		
.015 × 30 × $4,500	=	$2,025
minus .015 × $1,400* x 30	=	$630
Per Month	**=**	**$1,395**
Minimum Formula		
$5 × 10 years	=	$50
$7 × 10 years	=	$70
$9 × 10 years	=	$90
10% × $4,500	=	$450
Flat amount	=	$18
Per Month	**=**	**$678**
In this case, the Regular formula would give you a higher pension than the Alternate or Minimum formulas. You would receive the highest benefit of $1,638 a month for the rest of your life. Of course, if you elect to continue benefits to your spouse or other eligible dependents after your death, this amount will be reduced to account for the longer period over which plan benefits will be paid. (See Tables 3, 4, 5, and 6 at the end of this chapter for survivor reduction factors.)		
*This is a typical Primary Social Security Benefit.		

Normal Forms of Payment

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

For Married Employees

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

If you retire with a full or reduced pension as described in the “When You Can Retire” section, and your spouse dies before you but after your payments start, this form of payment will “pop up” to the amount that would be paid to a single employee, following receipt of proper documentation required by the Plan Administrator. (For the 50% Surviving Spouse reduction factors, see Table 3 at the end of this chapter.)

Married participants also may elect a 75% survivor annuity option. Under this form of payment, your pension is reduced and, after your death, 75% of that benefit is continued to your surviving spouse for the rest of his or her life. If your spouse dies before you but after your payments start, this form of payment will “pop up” to the amount that would be paid to a single employee, following receipt of proper documentation required by the Plan Administrator. (For the 75% Surviving Spouse reduction factors, see Table 6 at the end of this chapter.)

For Single Employees

The plan’s normal form of payment for a single employee is a life annuity. Under this form of payment, you receive the full benefit earned at retirement for your lifetime. After your death, the monthly life annuity will cease.

Optional Forms of Payment

You may elect an optional form of payment at retirement. If you are married, you will need your spouse’s written consent, witnessed by a notary public or a representative of the Plan Administrator on the form provided for this purpose by the Plan Administrator, to elect one of the following optional forms of payment.

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

Single Lump-Sum Payment

If upon your termination of employment your actuarially equivalent lump-sum value is $150,000 or less, you will have a 90-day window to elect to have your benefit paid in either a single lump sum payment or in the form of an immediate annuity. If you fail to elect a distribution during the 90-day period, you will not be eligible to receive your benefit in a lump sum until your Early or Normal Retirement Age.

Life Annuity Option for Married Employees

This option for married employees is the same as the normal form of payment for single employees. Under this form of payment, you receive your full pension benefits for your lifetime only. After your death, the monthly life annuity will cease.

50% Survivor Benefit Option

You can elect a reduced pension to provide continuing income to an unmarried Dependent Child (or unmarried Dependent Children) under age 23, or a Dependent Parent (or Dependent Parents), but not to both Dependent Children and parents.

If you elect the 50% survivor benefit for your Dependent Child (or children), after your death 50% of your reduced benefit will continue to your Dependent Child until the earliest of: age 23 (or as long as the child remains totally and permanently disabled), or the Dependent Child dies. If you elect the 50% survivor benefit for your Dependent Parent(s), after your death 50% of your reduced benefit will continue to your Dependent Parent for the rest of his or her life.

The amount of reduction in your pension to provide a survivor benefit depends on your age and the age of your named survivor. (Examples of survivor factors are shown in Tables 3, 4, and 5 at the end of this chapter). If there are multiple dependents receiving a survivor benefit, and a dependent dies or is no longer eligible for the dependent survivor benefits, his or her benefit will be divided equally among the remaining eligible dependents.

Your election of a 50% survivor benefit cannot be changed after your pension begins. If your named survivor should die before you, this payment form will “pop up” to the amount paid to a single employee.

You must provide a certified copy of your elected survivor's death certificate to ORNL Benefits to initiate the "pop up."

Level Income Option

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

If you elect the level income option with the 50% survivor's benefit, the 50% survivor's benefit will be based on the pension amount before adjustment for this option.

If you elect the level income option with the 75% survivor's benefit, the 75% survivor's benefit will be based on the pension amount before adjustment for this option.

Social Security

Social Security retirement benefits are in addition to benefits paid from the Pension Plan.

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

Participation While You Are Disabled

Continuation of Plan Participation

If you become disabled and qualify for benefits under the Company's Long-Term Disability plan ("Totally Disabled"), you will continue to accrue Company Service just as if you had continued working. While you continue to be Totally Disabled, your earnings will be assumed to remain the same as at the time you became disabled. For purposes of determining your benefit and for calculating your mandatory participant contributions, your Average Straight-Time Monthly Earnings will be based on:

- the 3 calendar years in which your earnings were highest, during the 10 calendar years just prior to your last day worked, or
- the final 3 years just prior to your last day worked.

For information on how your Average Straight-Time Monthly Earnings during the final 3 years are calculated, refer to "Calculating Your Earnings."

Effect of Disability on Your Pension Benefit

If you continue to be Totally Disabled until age 65, you will be entitled to retire under the same conditions as any other participant. If your disability ends before age 65, you will receive credit for Company Service for the period of your disability, provided you return to work or transfer from disability status to retirement status immediately upon ceasing to be disabled. If you do not return to work or retire after your disability ends, you will be considered to have terminated employment on the date your disability began.

If You Die While Employed

If you die while you are still employed and have completed at least 5 years of Credited Service, the plan will pay a benefit to your surviving spouse or Dependent Child or Dependent Parent. The timing and amount of this benefit will depend on your years of Credited Service at the time of death.

If you die after completing 10 years of Credited Service, the survivor benefit is payable immediately. (The age 50 requirement for early retirement does not apply in determining eligibility for the survivor benefit). The benefit is a monthly income equal to 50% of the pension you would have received if you had retired on the day of your death. If your survivor is a younger spouse, the benefit will be reduced ½% for each full year more than 5 years that your spouse is younger than you. However, in no event will the survivor benefit be reduced to less than 25% of your full pension, calculated using your average earnings and service at your death.

If you die before completing 10 years of Credited Service (but after 5 years), the survivor benefit is payable the first day of the month following the day you would have reached age 65. The benefit is a monthly income equal to 50% of the benefit you would have received had you terminated employment on the day of your death and had you elected to receive your benefit at age 65 in the joint and 50% survivor form of payment.

Your survivor can elect to receive reduced benefits as early as the date you would have reached age 50. The reduction will be 6⅔% for each year before age 65, for up to 3 years (to age 62), plus 5% for each year before age 62 that benefits begin.

The benefit will be paid to your spouse for the rest of his or her life. If you are employed and not married when you die, the benefit will be paid in equal shares to your Dependent Children until age 23 (or as long as a child remains totally and permanently disabled).

If you have no Dependent Children, the benefit will be paid in equal shares to your Dependent Parents for life.

If you have no spouse, no Dependent Children, and no Dependent Parents, no survivor monthly benefit is payable. However, a refund of your contributions with applicable interest will be paid to your estate.

Any benefit being paid to a Dependent Child or Dependent Parent cannot be transferred to someone else when the child or parent no longer qualifies for it. However, if a spouse dies while receiving the survivor benefit, the spouse's benefit will continue in equal shares to any of your Dependent Children under age 23 (or as long as a child remains totally and permanently disabled).

If You Leave Before You Are Eligible for Normal or Early Retirement

If you leave the Company for any reason after completing at least 5 years of Credited Service, you are "vested." Being vested means you have a nonforfeitable right to receive plan benefits.

Credited Service generally means the time you work at the Company, from your first hour of service until you sever from service.

Further discussion follows in the "Credited Service and Severance from Service" section below.

Benefit Amount

The amount of your vested pension payable at age 65 depends on your Average Straight-Time Monthly Earnings (including certain variable pay, shift differential, and hourly COLA), your total Company Service at the time you leave the Company, and your age at the time you want your vested pension payments to begin. The three formulas described previously are used to calculate your vested pension, but with these differences:

- The flat amount of $18 per month under the Regular and Minimum formulas will be multiplied by a "service fraction." This fraction is your actual years of Company Service divided by your years of Company Service that would be credited had you continued with the Company until age 65.
- If your vested benefit is calculated using the Minimum formula and you have less than 10 years of Company Service, that part of the formula using 10% of your Average Straight-Time Monthly Earnings will be reduced by 1% for each full year less than 10.

The Alternate formula is revised to require the following steps:

1. 1.5% × Average Straight-Time Monthly Earnings × your years of service that would be credited had employment continued to age 65 Minus
2. 1.5% × years of service (up to 33 1/3) that would be credited had employment continued to age 65 × Primary Social Security Benefit at age 65, assuming continued employment at current earnings rate Times
3. The service fraction:

   Years of actual service/Years of service had employment continued to age 65

Payment of Benefits

Vested benefits normally become payable at age 65. However, you can elect to receive a reduced benefit as early as age 50, but the benefit will be calculated as described in this section, not as an early retirement benefit. The amount of the reduction will depend on how many years before age 65 you elect to begin benefits. The reduction is 6⅔% for each year before age 65 for up to 3 years (age 62). In addition, the reduction is 5% for each year before age 62 that plan payments start. For example, if you leave the Company and begin receiving your pension at age 60, your benefit will be reduced 30%; that is 20% for the years between 65 and 62 (6⅔% × 3) plus 10% for the years between 60 and 62 (5% × 2).

Your vested benefit will commence effective the first of the month following receipt of your written request. If you are married at the time of your request, your benefit will automatically be paid as a joint and 50% survivor benefit, unless you elect otherwise with your spouse's written consent witnessed by a notary public or representative of the Plan Administrator. If your benefit is paid in the joint and 50% survivor form, it will be reduced according to Table 3 at the end of this chapter. If your benefit is paid in the 75% surviving spouse form, it will be reduced according to Table 6 at the end of this chapter (based on applicable mortality and interest rates as specified by the Internal Revenue Code).

Preretirement Spouse's Benefit

If you leave the Company with vested benefits, at least 10 years of Company Service, and you die before plan payments begin, your spouse may be eligible to receive a preretirement benefit equal to 50% of the benefit you would have received if you had retired on the day of your death. If you leave the Company with vested benefits, at least 5 years but less than 10 years of Company Service, and you die before plan payments begin, your spouse may be eligible to receive a preretirement benefit equal to 50% of the benefit you would have received under the joint and 50% survivor benefit. Your spouse will be eligible if you and your spouse have been married at least 1 year at the time of your death.

If you die after age 50, payments may begin on the first of the month following your death. If you die before age 50, payments may begin on the first of the month following the date you would have reached age 50.

Forfeiture of Benefits

If your employment terminates before you have completed 5 years of Credited Service, you will forfeit your right to any monthly plan benefits. However, if you are a salaried employee and subject to mandatory pension contributions, you will receive a refund of your contributions plus any applicable interest.

Credited Service and Severance from Service

"Credited Service" is used to determine whether you are eligible for a vested pension. Note: for former NSPS Plan participants who transition to ORNL on the Employee Transfer Date, your Credited Service includes what was credited under the NSPS Plan.

"Company Service" is used to determine the amount of your pension benefit. Note: for former NSPS Plan participants who transition to ORNL on the Employee Transfer Date, your Company Service includes what was credited under the NSPS Plan.

Credited Service begins with your first hour of service and ends when you have a severance from service.

A severance from service occurs on the earlier of:

- the day you quit, retire, are discharged, or die, or
- 1 year after your first day of absence due to layoff, or, if earlier, the first day after recall if you fail to return to work, or
- 1 year after your first day of absence while on an approved leave, or, if earlier, the first day after the final day of leave if you fail to return to work, or
- 2 years after your first day of absence for a parental leave due to pregnancy, birth, or adoption, and for child care immediately following the birth or adoption, or, if earlier, the first day after the final day of leave if you fail to return to work.

Special rules apply to determine your severance from service, Credited Service, and Company Service if you are classified as a Casual Employee. Generally, you must perform at least 1 hour of service in a 12 month period to avoid a severance from service and receive Credited Service and Company Service.

If you are reemployed within 1 year of your date of severance, you will receive Credited Service for your period of severance, and your prior Credited Service will be restored. If you are reemployed more than 1 year after your date of severance and you were vested as of that date, your prior Credited Service will be restored automatically upon reemployment, regardless of your period of severance.

If you were not vested as of your date of severance, your prior Credited Service will be restored if you are reemployed more than 1 year after the period of severance, the length of your severance is less than

5 years, and you are employed for at least 1 year after reemployment.

In any event, you will not earn Credited Service during a period of severance lasting 1 year or more.

Reemployment After Retirement

If you had been receiving pension payments and return to work at the Company, your benefit will be suspended during your period of reemployment until you actually retire, or until your work schedule is such that you are not subject to a benefit suspension. Your benefits will be suspended for any month in which you receive payment from the Company for hours of service performed on each of 8 or more days (or separate work shifts). When payments begin again, they will be adjusted to reflect your additional service and earnings after returning to work.

If you are a NSPS Plan Retiree who has commenced a pension or vested benefit under the NSPS Plan before the Employee Transfer Date and as of the Employee Transfer Date you are actively employed by ORNL, you will not have your pension benefits suspended.

If you are a NSPS Plan Retiree who has not commenced your pension or vested benefit under the NSPS Plan before the Employee Transfer Date and as of the Employee Transfer Date you are actively employed by ORNL, you cannot commence any pension or vested benefit until you have terminated employment from ORNL.

If you return to work as a Casual Retiree and work for more than 7 shifts/days in any calendar month, your pension payment is suspended for that month unless you are over age 70½.

If you are considering returning to active service after you retire, you should contact the ORNL Benefits Office to make a determination concerning whether your return to work will cause your benefit to be suspended.

Service and Earnings During Military Service Leave

If you are on a qualified military service leave, you will be treated as not having had a break in service by reason of such leave if you return to employment within the time period during which your reemployment rights are protected by USERRA. Upon your timely return to employment, your leave will be included in your Company Service and Credited Service. If you do not return to employment within the required period (or you do not meet any other USERRA requirements), but you received differential pay from the Company during the leave, the period you received differential pay will be included in your Company Service and Credited Service.

Plan-eligible earnings during a period of qualified military service leave will be credited based on your rate of pay when your leave began, adjusted as required by USERRA if you return to employment within the required period and meet any other USERRA requirements. If you do not return within the required period and meet all other USERRA requirements, your earnings will include only your differential pay.

If you think you have a qualified military service leave and have questions about how it may affect your pension benefit, please contact the ORNL Benefits Office. You may also contact the US Department of Defense, Employer Support of the Guard and Reserve, at 1-800-336-4590 (website: www.esgr.org) about your military service rights and responsibilities under USERRA.

Applying for Benefits

Upon your request, the ORNL Benefits Office will provide you with the necessary information and instructions for receiving benefits and completing payment forms. In case of your death, your spouse, other beneficiary, or personal representative should notify the ORNL Benefits Office and request information about any plan benefits that might be payable as a result of your death.

If the appropriate forms are not completed and submitted, or if any information requested by the ORNL Benefits Office is not provided, benefits will be delayed.

Transfer of Assets and Benefit Liabilities for Grandfathered Employees who Transitioned from NSPS

As of the Asset Transfer Date, accrued benefit liabilities were transferred from The National Strategic Protection Services Plan (the “NSPS Plan”) to the Pension Plan for Employees at ORNL (the “ORNL Plan”). Plan assets were transferred to the ORNL Plan in connection with the benefit liability transfer in accordance with the law.

Your benefit in the plan was transferred to the ORNL Plan effective December 30, 2018, if either (i) you were employed (or on leave) and covered under the NSPS Plan on December 30, 2018, or (ii) you terminated employment or retired on or before December 30, 2018, and you were assigned to ORNL by the DOE. If you satisfy one of these conditions, your benefit will be paid by the ORNL Plan.

Other Important Information

Other Retirement Income

Any benefits due to you (or your survivor if you die before retirement) from the Pension Plan will be reduced by the amount (or the actuarial equivalent, if appropriate) of any retirement benefit payable from any of the following sources, provided the benefit is related to service recognized under this Pension Plan and is attributable to contributions made by a Department of Energy contractor:

- any other private plan, or
- any retirement or separation benefit payable under the law of any foreign government, or
- any public pension other than military or Social Security for which you received credit for Company Service.

The reduction will be made under rules which will apply uniformly to all affected employees. If your pension is to be reduced because of this provision, you will be given a full explanation at the time your pension benefit is calculated.

Withholding Taxes

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

Direct Deposit of Payments

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

Change of Address

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

Administrative Information

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

Pension Reduction Tables

Table 1—Early Retirement Reduction Factors

These factors use your age and years of service to determine the percentage of your full pension that is payable.

Age	Years of Service													
YEARS	10–18	19	20	21	22	23	24	25	26	27	28	29	30	31 & over
50	40	45	50	50	55	60	65	70	75	80	85	90	95	100
51	45	45	50	55	60	65	70	75	80	85	90	95	100	100
52	50	50	55	60	65	70	75	80	85	90	95	100	100	100
53	55	55	60	65	70	75	80	85	90	95	100	100	100	100
54	60	60	65	70	75	80	85	90	95	100	100	100	100	100
55	65	65	70	75	80	85	90	95	100	100	100	100	100	100
56	70	70	75	80	85	90	95	100	100	100	100	100	100	100
57	75	75	80	85	90	95	100	100	100	100	100	100	100	100
58	80	80	85	90	95	100	100	100	100	100	100	100	100	100
59	85	85	90	95	100	100	100	100	100	100	100	100	100	100
60	90	90	95	100	100	100	100	100	100	100	100	100	100	100
61	95	95	100	100	100	100	100	100	100	100	100	100	100	100
62–64	100	100	100	100	100	100	100	100	100	100	100	100	100	100
65	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Factors for intermediate ages and service are available from the ORNL Benefits Office.

Table 2—Early Retirement Reduction Factors if Terminated by Company Action

If you are terminated by Company action other than for cause, use this table instead of Table 1 to determine the percentage of your full pension that is payable.

	Years of Service														
Age	**8–9**	**10–18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31 & over**
48	40	40	45	50	50	55	60	65	70	75	80	85	90	95	100
49	40	40	45	50	50	55	60	65	70	75	80	85	90	100	100
50	40	40	45	50	50	55	60	65	70	75	80	85	100	100	100
51	45	45	45	50	55	60	65	70	75	80	85	100	100	100	100
52	50	50	50	55	60	65	70	75	80	85	100	100	100	100	100
53	55	55	55	60	65	70	75	80	85	100	100	100	100	100	100
54	60	60	60	65	70	75	80	85	100	100	100	100	100	100	100
55	65	65	65	70	75	80	85	100	100	100	100	100	100	100	100
56	70	70	70	75	80	85	100	100	100	100	100	100	100	100	100
57	75	75	75	80	85	100	100	100	100	100	100	100	100	100	100
58	80	80	80	85	100	100	100	100	100	100	100	100	100	100	100
59	85	85	85	100	100	100	100	100	100	100	100	100	100	100	100
60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
61	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
62–64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Factors for intermediate ages and service are available from the ORNL Benefits Office.

Table 3—50% Surviving Spouse Reduction Factors

	Pensioner's Age																									
Spouse's Age	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
40	.955	.951	.947	.943	.939	.935	.930	.926	.921	.915	.910	.904	.893	.891	.885	.878	.870	.862	.854	.843	.836	.827	.817	.808	.798	.786
41	.956	.952	.949	.945	.941	.936	.932	.927	.922	.917	.911	.906	.900	.893	.886	.879	.872	.864	.856	.847	.838	.829	.819	.810	.800	.789
42	.957	.954	.950	.946	.942	.938	.933	.929	.924	.919	.913	.908	.901	.895	.888	.881	.874	.866	.858	.849	.840	.831	.821	.812	.802	.792
43	.958	.955	.951	.948	.944	.939	.935	.930	.925	.920	.915	.909	.903	.897	.890	.883	.876	.868	.860	.851	.842	.833	.823	.814	.804	.794
44	.960	.956	.953	.949	.945	.941	.937	.932	.927	.922	.917	.911	.905	.899	.892	.885	.878	.870	.862	.853	.844	.835	.826	.816	.806	.796
45	.961	.958	.954	.950	.947	.943	.938	.934	.929	.924	.919	.913	.907	.901	.894	.887	.880	.872	.864	.856	.847	.838	.828	.818	.808	.798
46	.962	.959	.956	.952	.948	.944	.940	.935	.931	.926	.921	.915	.909	.903	.897	.890	.882	.875	.867	.858	.849	.840	.830	.821	.811	.801
47	.963	.960	.957	.953	.950	.946	.942	.937	.933	.928	.923	.917	.911	.905	.899	.892	.885	.877	.869	.861	.852	.842	.833	.823	.813	.803
48	.965	.962	.958	.955	.951	.948	.943	.939	.935	.930	.925	.919	.914	.908	.901	.894	.887	.879	.872	.863	.854	.845	.836	.826	.816	.806
49	.966	.963	.960	.957	.953	.949	.945	.941	.937	.932	.927	.921	.916	.910	.903	.897	.890	.882	.874	.866	.857	.848	.838	.829	.819	.809
50	.967	.964	.961	.958	.955	.951	.947	.943	.938	.934	.929	.924	.918	.912	.906	.899	.892	.885	.877	.868	.860	.851	.841	.832	.822	.812
51	.969	.966	.963	.960	.956	.953	.949	.945	.940	.936	.931	.926	.920	.915	.908	.902	.895	.887	.880	.871	.863	.854	.844	.835	.825	.815
52	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.928	.923	.917	.911	.904	.897	.890	.882	.874	.866	.857	.847	.838	.828	.818
53	.971	.969	.966	.963	.960	.956	.953	.949	.945	.940	.935	.931	.925	.920	.913	.907	.900	.893	.885	.877	.869	.860	.851	.841	.831	.821
54	.973	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.928	.922	.916	.910	.903	.896	.888	.880	.872	.863	.854	.844	.835	.825
55	.974	.971	.969	.966	.963	.960	.956	.952	.949	.944	.940	.935	.930	.925	.919	.913	.906	.899	.891	.883	.875	.866	.857	.848	.838	.828
56	.975	.973	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.927	.921	.915	.909	.902	.894	.887	.878	.870	.861	.851	.842	.832
57	.976	.974	.972	.969	.966	.963	.960	.956	.953	.949	.944	.940	.935	.930	.924	.918	.912	.905	.898	.890	.882	.873	.864	.855	.845	.836
58	.978	.975	.973	.970	.968	.965	.962	.958	.955	.951	.947	.942	.938	.932	.927	.921	.915	.908	.901	.893	.885	.877	.868	.859	.849	.840
59	.979	.977	.974	.972	.969	.966	.963	.960	.957	.953	.949	.945	.940	.935	.930	.924	.918	.911	.904	.897	.889	.880	.871	.862	.853	.844
60	.980	.978	.976	.973	.971	.968	.965	.962	.959	.955	.951	.947	.943	.938	.933	.927	.921	.914	.907	.900	.892	.884	.875	.866	.857	.848
61	.981	.979	.977	.975	.972	.970	.967	.964	.961	.957	.954	.950	.945	.940	.935	.930	.924	.918	.911	.904	.896	.888	.879	.870	.861	.852
62	.982	.980	.978	.976	.974	.971	.969	.966	.963	.959	.956	.952	.948	.943	.938	.933	.927	.921	.914	.907	.900	.892	.883	.874	.865	.856
63	.983	.981	.979	.977	.975	.973	.970	.968	.965	.961	.958	.954	.950	.946	.941	.936	.930	.924	.918	.911	.903	.895	.887	.879	.870	.861
64	.984	.982	.981	.979	.977	.974	.972	.969	.967	.963	.960	.957	.953	.948	.944	.939	.933	.927	.921	.914	.907	.899	.891	.883	.874	.865
65	.985	.984	.982	.980	.978	.976	.974	.971	.968	.965	.962	.959	.955	.951	.947	.942	.936	.931	.925	.918	.911	.903	.896	.887	.879	.870
66	.986	.985	.983	.981	.979	.977	.975	.973	.970	.967	.964	.961	.958	.954	.949	.945	.940	.934	.928	.922	.915	.908	.900	.892	.883	.875
67	.987	.986	.984	.982	.981	.979	.977	.974	.972	.969	.967	.963	.960	.956	.952	.948	.943	.937	.932	.925	.919	.912	.904	.896	.888	.879
68	.988	.987	.985	.984	.982	.980	.978	.976	.974	.971	.969	.966	.962	.959	.955	.951	.946	.941	.935	.929	.923	.916	.908	.901	.893	.884
69	.989	.987	.986	.985	.983	.981	.980	.978	.975	.973	.971	.968	.965	.961	.957	.953	.949	.944	.939	.933	.927	.920	.913	.905	.897	.889
70	.990	.988	.987	.986	.984	.983	.981	.979	.977	.975	.972	.970	.967	.964	.960	.956	.952	.947	.942	.937	.930	.924	.917	.910	.902	.894

Table 4—Surviving Child Reduction Factors

If you elect to provide your dependent child with a survivor pension, use this table instead of Table 3.

Child's Age	Your Age															
	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
1	.961	.957	.952	.948	.943	.938	.932	.926	.918	.910	.902	.892	.882	.871	.859	.847
2	.964	.960	.956	.952	.947	.943	.937	.931	.924	.917	.908	.899	.890	.879	.868	.855
3	.967	.963	.960	.956	.951	.946	.942	.936	.930	.923	.915	.906	.897	.887	.876	.864
4	.970	.967	.963	.959	.955	.951	.946	.942	.936	.928	.921	.913	.905	.895	.884	.873
5	.973	.970	.967	.963	.960	.955	.951	.946	.941	.935	.928	.920	.912	.903	.893	.882
6	.976	.973	.971	.967	.964	.960	.956	.951	.946	.941	.935	.927	.920	.911	.902	.891
7	.979	.976	.974	.971	.968	.965	.961	.957	.952	.947	.942	.935	.928	.919	.910	.901
8	.981	.979	.977	.976	.972	.969	.966	.962	.958	.953	.948	.943	.936	.928	.920	.911
9	.984	.982	.980	.978	.976	.973	.970	.967	.963	.959	.954	.949	.944	.937	.930	.921
10	.986	.985	.983	.981	.979	.977	.974	.971	.968	.965	.961	.956	.951	.945	.939	.931
11	.988	.987	.985	.984	.982	.980	.978	.976	.973	.970	.966	.962	.958	.952	.947	.941
12	.990	.989	.988	.986	.985	.983	.982	.980	.977	.975	.972	.968	.964	.960	.955	.949
13	.992	.991	.990	.989	.988	.986	.985	.983	.981	.979	.977	.974	.970	.967	.962	.958
14	.993	.993	.992	.991	.990	.989	.988	.986	.985	.983	.981	.979	.976	.973	.969	.965
15	.995	.994	.994	.993	.992	.991	.990	.989	.988	.987	.985	.983	.981	.979	.976	.973
16	.996	.996	.995	.995	.994	.993	.993	.992	.991	.990	.989	.987	.986	.984	.981	.979
17	.997	.997	.996	.996	.996	.995	.995	.994	.993	.993	.992	.991	.989	.988	.986	.984
18	.998	.998	.998	.997	.997	.997	.996	.996	.995	.995	.994	.994	.993	.992	.991	.989
19	.999	.999	.998	.998	.998	.998	.998	.997	.997	.997	.996	.996	.995	.995	.994	.993
20	.999	.999	.999	.999	.999	.999	.999	.999	.998	.998	.998	.998	.997	.997	.997	.996
21	—	—	—	—	—	—	.999	.999	.999	.999	.999	.999	.999	.999	.999	.998
22	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

Factors for intermediate ages are available from the ORNL Benefits Office.

Table 5—Surviving Dependent Parent Reduction Factors

If you elect to provide you dependent parent with a survivor pension, use this table instead of Table 3.

	Your Age		
Parent's Age	55	60	65
70	.950	—	—
75	.985	.949	—
80	.991	.985	.972
85	.995	.992	.985

Factors for intermediate ages are available from the ORNL Benefits Office.

Table 6—75% Surviving Spouse Reduction Factors

Spouse Age	Pensioner's Age																						
	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
41	.920	.914	.907	.901	.894	.887	.880	.872	.865	.857	.848	.838	.829	.820	.809	.799	.787	.775	.764	.751	.740	.727	.714
42	.921	.915	.910	.903	.897	.890	.883	.875	.868	.859	.850	.841	.832	.822	.812	.801	.789	.778	.766	.754	.742	.730	.717
43	.924	.918	.911	.906	.899	.892	.885	.878	.869	.861	.853	.844	.834	.825	.814	.804	.792	.780	.769	.756	.745	.732	.720
44	.925	.920	.914	.908	.901	.894	.887	.880	.872	.864	.856	.846	.837	.828	.817	.806	.795	.783	.771	.760	.747	.735	.722
45	.927	.923	.917	.910	.904	.897	.890	.883	.875	.867	.859	.849	.840	.830	.820	.809	.799	.787	.775	.762	.750	.737	.725
46	.930	.924	.918	.913	.906	.900	.893	.886	.878	.869	.861	.853	.844	.833	.824	.813	.801	.789	.778	.765	.754	.741	.729
47	.931	.927	.921	.915	.908	.903	.896	.889	.880	.872	.864	.856	.848	.837	.826	.816	.805	.793	.780	.769	.756	.743	.731
48	.934	.928	.924	.917	.911	.906	.899	.892	.883	.878	.868	.859	.849	.840	.829	.820	.808	.797	.784	.773	.760	.747	.735
49	.937	.931	.925	.920	.914	.908	.901	.894	.886	.879	.871	.861	.853	.844	.833	.822	.812	.800	.788	.775	.764	.751	.738
50	.938	.934	.928	.923	.917	.910	.904	.897	.890	.882	.874	.865	.856	.846	.837	.826	.814	.804	.792	.779	.768	.755	.742
51	.941	.935	.931	.925	.920	.913	.907	.900	.893	.885	.878	.868	.860	.850	.840	.830	.818	.808	.796	.783	.771	.756	.748
52	.943	.938	.933	.928	.923	.915	.910	.903	.896	.889	.880	.872	.863	.853	.844	.833	.822	.812	.800	.787	.775	.762	.750
53	.946	.941	.935	.931	.925	.920	.913	.906	.900	.892	.885	.875	.867	.857	.848	.837	.826	.816	.804	.792	.779	.766	.754
54	.947	.943	.938	.933	.928	.923	.915	.910	.903	.896	.887	.879	.871	.861	.852	.841	.830	.820	.808	.796	.783	.771	.759
55	.950	.946	.941	.935	.930	.925	.918	.913	.906	.899	.892	.883	.875	.865	.858	.845	.834	.824	.812	.800	.788	.775	.760
56	.951	.947	.943	.938	.933	.928	.923	.915	.910	.903	.894	.886	.878	.869	.860	.850	.840	.828	.817	.805	.792	.780	.768
57	.954	.950	.946	.941	.935	.931	.925	.918	.913	.906	.899	.890	.882	.874	.864	.854	.844	.833	.821	.809	.797	.784	.773
58	.956	.953	.948	.944	.938	.934	.928	.923	.915	.910	.901	.894	.886	.878	.868	.859	.848	.837	.826	.814	.802	.789	.778
59	.959	.954	.950	.946	.941	.937	.931	.925	.920	.913	.908	.899	.890	.882	.872	.863	.853	.842	.830	.818	.806	.795	.783
60	.960	.957	.953	.948	.944	.940	.934	.928	.923	.917	.910	.903	.894	.886	.876	.867	.857	.846	.836	.824	.812	.800	.788
61	.963	.959	.956	.951	.947	.943	.937	.933	.927	.920	.913	.906	.899	.890	.882	.872	.863	.852	.841	.829	.817	.805	.793
62	.964	.962	.957	.954	.950	.946	.940	.935	.930	.924	.917	.910	.903	.894	.886	.876	.867	.857	.846	.834	.822	.810	.799
63	.966	.963	.960	.956	.953	.948	.943	.938	.933	.927	.921	.914	.907	.899	.890	.882	.872	.861	.850	.840	.829	.817	.805
64	.969	.968	.962	.959	.954	.951	.946	.941	.937	.931	.924	.918	.911	.903	.894	.886	.876	.867	.856	.845	.834	.822	.810
65	.970	.967	.964	.962	.957	.953	.948	.944	.940	.934	.928	.923	.915	.907	.900	.892	.882	.872	.861	.852	.840	.829	.817
66	.972	.969	.966	.963	.960	.956	.951	.947	.943	.938	.933	.925	.920	.913	.904	.896	.887	.878	.868	.857	.846	.834	.824
67	.973	.972	.969	.966	.962	.959	.954	.951	.948	.941	.935	.930	.924	.917	.908	.901	.892	.883	.874	.863	.852	.841	.829
68	.976	.973	.970	.967	.964	.962	.957	.954	.950	.944	.940	.934	.928	.921	.914	.908	.897	.889	.879	.868	.859	.848	.836
69	.978	.975	.972	.970	.967	.963	.960	.957	.953	.948	.943	.937	.931	.925	.918	.911	.903	.894	.885	.875	.864	.853	.842
70	.979	.978	.975	.972	.969	.966	.963	.959	.956	.951	.947	.941	.935	.930	.923	.915	.908	.899	.890	.880	.871	.860	.849

Glossary

Average Straight-Time Monthly Earnings

The average of your highest earnings for 3 years during the last 10 years just before you retire (for a discussion of how these earnings are calculated, see the “Calculating Your Earnings” section).

Casual Retiree

An employee hired by the Company to work on a protect type or intermittent basis whose work hours are determined by the Company and who is classified by the Company on its payroll system as a Casual Employee.

Company Service

The total elapsed time between the date you begin employment with the Company and your last day of work. The Pension Plan uses Company Service to calculate pension benefits—except to determine your eligibility for a vested pension benefit, which uses Credited Service.

Compensation

Straight-time rate of pay (including certain variable pay, shift differential, and hourly cost of living adjustment) based on regularly scheduled hours.

Credited Service

All the time you work for the Company, from your first hour of service until you sever from service. Credited Service is used for vesting purposes.

Dependent Child

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

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

12. Savings Plan for IGUA Employees at ORNL

Summary Plan Description

This information is not intended to be a substitute for specific individualized tax, legal, or investment planning advice. Where specific advice is necessary or appropriate, you should consult with a qualified tax advisor, CPA, Financial Planner or Investment Manager.

Introduction

Type of Plan

Effective January 1, 2022, UT-Battelle, LLC amended and restated its 401(k) plan. The plan is named the Savings Plan for IGUA Employees at ORNL, but it will be referred to in this Summary as the *Plan*. The Plan contains a cash or deferred arrangement, and once you're eligible to participate, you can contribute to the Plan on a tax deferred basis by payroll deductions.

Plan Sponsor

UT-Battelle, LLC is the sponsor of the Plan and will sometimes be referred to in this Summary as the "Sponsoring Employer," the "Employer," "we," "us" or "our". Our address is 1 Bethel Valley Road, Oak Ridge, TN 37830; our telephone number is (865) 574-8943; and our employer identification number is 62-1788235.

Collective Bargaining Agreements

The Plan is subject to one or more collective bargaining agreements. You may obtain a copy of any such agreement upon written request to your union representative or to the Administrator.

Purpose of This Summary

This booklet is called a Summary Plan Description (the "SPD") and it is meant to describe highlights of the Plan in understandable language. It is not, however, meant to be a complete description of the Plan, nor is it meant to interpret, extend or change the provisions of the Plan in any way. If there is a conflict between this SPD and the Plan, the provisions of the Plan control your right to benefits. A copy of the Plan and related documents are on file with the Administrator, and you can read them at any reasonable time. Also, no provision of the Plan or this SPD is intended to give you the right to continued employment or to prohibit changes in the terms or conditions of your employment. If you have any questions that are not addressed in this SPD, you can contact the Administrator (described in the next section) during normal business hours.

Who to Contact for Account Questions[1]

Schwab Retirement Plan Services, Inc. is the plan recordkeeper. Participant Services Representatives are available at 800-724-7526 during prescribed business hours if you have questions about your Account or want to know more about saving.

Account Access

You can check balances, request investment information, choose investments, change how much you save, and more at 800-724-7526 or www.workplace.schwab.com.

Plan Administration

Plan Trustee[2]

The Plan is administered under a written plan and trust agreement, with Charles Schwab Trust Bank as the trustee. The trustee can be contacted at 2360 Corporate Circle, Suite 400, Henderson, NV 89074.

Plan Administrator

All matters that concern the operation of the Plan are the responsibility of the Plan Administrator (“Administrator”). The Administrator is UT-Battelle, LLC, whose address is 1 Bethel Valley Road, Oak Ridge, TN 37830, and whose telephone number is (865) 341-2107. The Administrator has the power and discretionary authority to interpret the terms of the Plan based on the Plan document and existing laws and regulations, as well as the power to determine all questions that arise under the Plan. Such power and authority include, for example, the administrative discretion necessary to resolve issues with respect to an Employee’s eligibility for benefits, credited service, Disability, and retirement, or to interpret any other

term contained in the Plan and related documents. The Administrator's interpretations and determinations are binding on all Participants, employees, former employees, and their beneficiaries.

1. Schwab Retirement Plan Services, Inc. provides recordkeeping and related services with respect to retirement plans and has provided this communication to you as part of the recordkeeping services it provides to the Plan.
2. Trust, custody, and deposit products and services are available through Charles Schwab Trust Bank.

Plan Number

For identification purposes, we have assigned number 003 to the Plan.

Plan Year

The Plan Year is the 12-month accounting year of the Plan, which begins each January 1st and ends the following December 31st.

Service of Legal Process

If you have to bring legal action against the Plan for any reason, legal process can be served on the General Counsel at UT-Battelle, LLC, 1 Bethel Valley Road, Oak Ridge, TN 37830. Legal process can also be served on the trustee or on the Administrator. You must exhaust the Plan's claims procedures (see the Section titled *Claims Procedures)* before you can bring legal action against the Plan.

Service Crediting

Your Service refers to the portion of your employment with us that is used to determine the Vested Interest in your Account; and to determine whether you are entitled to a contribution allocation for an Allocation Period. The way your Service is determined is described in more detail below.

Hour of Service

You are credited with an Hour of Service for each hour that you have a right to be paid by us for the performance of your duties. This includes the actual number of hours that you work and hours for which you are paid but are not at work, such as paid vacation, paid holidays, or paid sick leave.

Year of Eligibility Service

A Year of Eligibility Service is a period of time used to determine your eligibility to participate in one or more parts of the Plan. You will be credited with a Year of Eligibility Service for each 1-year Period of Service.

Break in Eligibility Service

You will incur a Break in Eligibility Service if you are not credited with at least one Hour of Service during the 1-year period beginning on the earlier of (a) the date you quit or your employment was terminated, or (b) the first anniversary of your absence for any other reason (your "severance date"). However, in certain circumstances, such as taking time off to give birth to a child or to adopt a child, or taking time off to care for a child following the birth or adoption, you will not incur a Break in Eligibility Service until the second anniversary of your severance date. However, the second 12 months will not be used to determine your Years of Eligibility Service.

Long-Term Part-Time Employees

If the Plan is subject to the Long-Term Part-Time rules, and you are a Long-Term Part-Time Employee (and not otherwise excluded under the Plan), you will be eligible to make 401(k) Contributions upon the earlier of (a) satisfaction of the Plan's service requirement applicable to you; or (b) completion of at least 500 Hours of Service during each of three consecutive 12-month Eligibility Computation Periods. You must also meet any age and Entry Date requirements imposed by the Plan. Any 12-month Eligibility Computation Period prior to January 1, 2021, is not considered when determining eligibility for Long-Term Part-Time Employees. This special rule for participation does not apply to you if you are subject to a

collective bargaining agreement. The rules for determining your service requirements under these Long-Term Part-Time rules are complex. For more information, please contact the Administrator.

Year of Vesting Service

A Year of Vesting Service is a period of time used to determine your Vested Interest in one or more of your Accounts. You will be credited with a Year of Vesting Service for each Vesting Computation Period during which you are credited with at least 1,000 Hours of Service. The Vesting Computation Period is the Plan Year.

Break in Vesting Service

You will incur a Break in Vesting Service if you are not credited with more than 500 Hours of Service during a Vesting Computation Period. However, in certain circumstances, such as taking time off to give birth to a child or to adopt a child, or taking time off to care for a child following the birth or adoption, you will be credited with 501 Hours of Service even though you did not actually work 501 hours in order to prevent you from incurring a Break in Vesting Service (but this type of special credit will not be used to determine your Years of Vesting Service or to determine your entitlement to a contribution for any Allocation Period).

Period of Service

A Period of Service, in general, is a period of time that begins on your date of hire and ends on the date you terminate employment or incur a Break in Eligibility Service or a Break in Vesting Service. The rules for determining your Period of Service are more complex than the explanation described in this section, especially the rules that apply if you terminate employment and are then rehired. For more information, you can check with the Administrator.

Prior Service Crediting

All service with us, any Adopting Employer, any Affiliated Employer, if applicable, and with (a) Wackenhut Service, Inc. (Oak Ridge, TN), to the extent that such service was counted as service under the NSPS OR-BU 401(k) Retirement Plan for Employees whose first date of employment with the Employer was December 31, 2018; and (b) National Strategic Protective Services, LLC with respect to former employees of National Strategic Protective Services, LLC who became Employees of the Employer on December 31, 2018 will be credited to determine your Vested Interest in all your Accounts. Please see the Administrator for specific details.

401(k) Contributions

How the Contribution Is Determined

Once you become a Participant, you can begin making 401(k) Contributions. 401(k) Contributions are amounts that you elect to contribute to the Plan through payroll withholding, and they can be made on a pre-tax basis (that is, they are deducted from your Compensation free of current income taxes but are fully taxable when they are subsequently distributed from the Plan) or on an after-tax basis (that is, as Roth 401(k) Contributions, which are deducted from your Compensation on an after-tax basis but may be distributed on a tax-free basis if certain requirements are met). You can designate up to 100% of your 401(k) Contributions as Roth 401(k) Contributions.

Your pre-tax 401(k) Contributions, plus any Roth 401(k) Contributions you make, can't be less than 1% of your Compensation and can't be more than 40% of your Compensation, or if less, the dollar limit on 401(k) Contributions announced annually by the IRS, which is $22,500 for the 2023 calendar year. In addition, for any calendar year in which you are age 50 or older, you can also make additional "catch-up" 401(k) Contributions in excess of the annual dollar limit on 401(k) Contributions described above. The catch-up contribution limit is also announced annually by the IRS and is $7,500 for the 2023 calendar year.

Roth 401(K) Contributions

There are two types of 401(k) Contributions permitted under the Plan – pre-tax 401(k) Contributions and Roth 401(k) Contributions. You may make either or both types of 401(k) Contributions during a year, provided the total amount of your combined pre-tax 401(k) Contributions and Roth 401(k) Contributions does not exceed any plan-imposed limitation (e.g., a specified percentage of Compensation) or the IRS maximum deferral limit for that year.

Generally, pre-tax 401(k) Contributions are deducted from your paycheck each pay period before Federal and most state income taxes have been calculated. That means pre-tax 401(k) Contributions lower your current taxable income. You do not pay income taxes on your pre-tax 401(k) Contributions until you receive them as a distribution when you retire or terminate employment.

In contrast, Roth 401(k) Contributions are deducted from your paycheck after income taxes have been calculated. However, you will not pay additional taxes on Roth 401(k) Contributions, or the investment earnings on Roth 401(k) Contributions, when they are distributed from the Plan provided that you meet certain criteria (see the section titled Tax Withholding on Distributions).

Unless specifically stated otherwise, Roth 401(k) Contributions are treated just like pre-tax 401(k) Contributions for all plan purposes. As such, any reference in this Summary Plan Description to “401(k) Contributions” or “elective deferrals” shall mean both your pre-tax 401(k) Contributions and Roth 401(k) Contributions.

How You Become a Participant

To become a Participant in this part of the Plan, you must satisfy the following criteria: (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable Entry Date.

- **Eligible Employees.** All employees are Eligible Employees for this part of the Plan except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Employees who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; and (d) Employees not covered by a collective bargaining agreement and employees covered by a collective bargaining agreement which does not allow for their participation in the Plan. Employees classified as Puerto Rico Based Employees are also ineligible to participate under the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant on the same date that you are hired.

Salary Deferral Agreements

You must file a Salary Deferral Agreement with the Administrator before you can begin making 401(k) Contributions to the Plan. Your Salary Deferral Agreement is where you indicate the amount that you want us to withhold from your Compensation and contribute to the Plan on your behalf. This is also where you indicate if you want all or any part of the amount withheld to be treated as a Roth 401(k) Contribution. You can elect to contribute a percentage of your Compensation as your 401(k) Contribution.

After your initial election, you can change your Salary Deferral Agreement by filing a new agreement with the Administrator at any time. You can also cancel your Salary Deferral agreement at any time by giving written notice to the Administrator on the date(s) established by the Administrator for such purpose. Your cancellation will be implemented as soon as administratively possible after your notice is received. If you do cancel your agreement, you will not be permitted to make a new election until the first available date that you would otherwise be entitled to change an existing agreement as described above. If your employment terminates, and you are rehired, your Salary Deferral Agreement will not be reinstated.

The Administrator from time to time may establish additional administrative procedures (or change existing procedures) concerning deferral elections, in which case you will be appropriately notified. The Administrator can also temporarily suspend your deferral agreement if you reach the maximum deferral amount that is permitted by law or by the Plan, or if the Administrator believes the Plan may fail certain required non-discrimination tests. You will be notified if your deferral agreement is temporarily suspended.

How Your Compensation Is Determined

In general, you can make 401(k) Contributions from all of the Compensation that is paid or made available to you during the Plan Year, excluding any Compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) as shift differential.

How Your Vested Interest Is Determined

Your Vested Interest in your 401(k) Contributions Account is 100% at all times.

Matching Contributions

How the Contribution Is Determined

We will make a Matching Contribution to the Plan for each eligible Participant equal to 100% of the Participant's 401(k) Contributions that do not exceed 6% of Compensation. The Allocation Period for this contribution is each payroll period.

How You Become a Participant

To become a Participant in this part of the Plan, you must satisfy the following criteria: (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable Entry Date.

- **Eligible Employees.** All employees are Eligible Employees for this part of the Plan except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Employees who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; and (e) employees covered by a collective bargaining agreement which does not allow for their participation in the Plan. Employees classified as Puerto Rico Based Employees are also ineligible to participate under the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant on the same date that you are hired.

How You Qualify for a Contribution Allocation

Once you become a Participant in this part of the Plan, you are eligible for a Matching Contribution for any Allocation Period in which we make one if you satisfy the requirements (if any) described below for that Allocation Period.

- **Active Participants.** If you are still employed by us on the last day of an Allocation Period, you will be eligible to receive an allocation regardless of the length of your service during the Allocation Period.
- **Terminated Participants.** If you terminate employment for any reason before the last day of an Allocation Period, you will be eligible to receive an allocation for that Allocation Period.

How Your Compensation Is Determined

In general, the amount of any Matching Contributions made on your behalf is based on all of the Compensation that is paid or made available to you during the Allocation Period, excluding any Compensation received (a) as a bonus;(b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and as shift differential. However, no contributions will be made with respect to Compensation in excess of the annual dollar limit on Compensation, which is announced annually by the IRS, and which is $330,000 for the 2023 calendar year.

How Your Vested Interest Is Determined

Your Vested Interest in your Matching Contribution Account is determined by the schedule following this paragraph, based on your Years of Vesting Service. Any part of this Account which is not vested will be

forfeited when you receive a distribution or after you incur 5 consecutive Breaks in Vesting Service, if earlier.

1 Year of Vesting Service.....0% Vested
2 Years of Vesting Service.....0% Vested
3 Years of Vesting Service..100% Vested

Profit Sharing Contributions

How the Contribution Is Determined

We make Profit Sharing Contributions to the Plan. The amount of the Profit Sharing Contribution for any Allocation Period will be equal to 3.5% of each benefiting Participant's Compensation. The Allocation Period for this contribution is the Plan Year.

How You Become a Participant

To become a Participant in this part of the Plan, you must satisfy the following criteria: (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable Entry Date.

- **Eligible Employees.** All employees are Eligible Employees for this part of the Plan except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Employees who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; (e) Employees covered by a collective bargaining agreement which does not allow for their participation in the Plan; and (f) Unit employees with a NSPS company service date prior to August 15, 2016 who are eligible to participate in the defined benefit Pension Plan. Employees classified as Puerto Rico Based Employees are also ineligible to participate under the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant on the same date that you are hired.

How You Qualify For a Contribution Allocation

Once you become a Participant in this part of the Plan, you are eligible for a Profit Sharing Contribution for any Allocation Period in which we make one if you satisfy the requirements (if any) described below for that Allocation Period.

- **Active Participants.** If you are still employed by us on the last day of an Allocation Period, you will be eligible to receive an allocation if you are credited with at least 1,000 Hours of Service during the Allocation Period.
- **Terminated Participants.** If you terminate employment for any reason before the last day of an Allocation Period, you will not be eligible to receive an allocation regardless of your service during the Allocation Period.

How the Contribution Is Allocated

Profit Sharing Contributions are allocated in accordance with the terms of the collective bargaining agreement, as reflected in the Section entitled “How the Contribution is Determined” above.

How Your Compensation Is Determined

In general, the amount of any Profit Sharing Contributions made on your behalf is based on all of the Compensation that is paid or made available to you during the Allocation Period, excluding any Compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) shift differential. However, no contributions will be made with respect to Compensation in excess of the annual dollar limit on Compensation, which is announced annually by the IRS, and which is $330,000 for the 2023 calendar year.

How Your Vested Interest Is Determined

Your Vested Interest in your Profit Sharing Contribution Account is determined by the schedule following this paragraph, based on your Years of Vesting Service. Any part of this Account which is not vested will be forfeited when you receive a distribution or after you incur 5 consecutive Breaks in Vesting Service, if earlier.

1 Year of Vesting Service.....0% Vested
2 Years of Vesting Service.....0% Vested
3 Years of Vesting Service..100% Vested

Top Heavy Requirements

Under certain circumstances, you may be entitled to a minimum allocation for any Plan Year in which the Plan is considered "top heavy." The Plan is considered top heavy for any Plan Year in which more than 60% of Plan assets are allocated to the Accounts of Participants who are Key Employees. However, the Plan may be exempt from this requirement in any Plan Year if certain conditions are satisfied. If the Plan is not exempt, then for each Plan Year in which the Plan is considered top heavy and in which you are a non-Key Employee who is employed by us on the last day of the Plan Year, you will receive a minimum allocation to this Plan or another plan that we sponsor equal to the lesser of 3% of your Compensation for the entire Plan Year or the highest percentage of Compensation allocated for that Plan Year to the Accounts of Participants who are Key Employees.

Maximum Allocation Limitations

The amount of contributions and forfeitures that can be allocated to your Account for any Plan Year is limited by law to the lesser of 100% of your Compensation or the annual dollar limit, which is announced annually by the IRS and is $66,000 for the 2023 calendar year. However, this dollar limit does not apply to the amount of earnings that can be allocated to your Account, to the “catch-up” contributions you can make to the Plan, to the amount of any Rollover Contributions you can make to the Plan, or to any other funds transferred to this Plan on your behalf from another qualified plan.

Rollover Contributions

If you participated in another retirement plan, you may be permitted to roll over any distribution you receive from the other plan to this Plan if all legal requirements and any requirements imposed by the Administrator on such rollovers are satisfied. If you decide to make a rollover contribution and it is accepted by the Administrator, it will be kept in a separate Rollover Account established on your behalf. If this Plan accepts a Rollover Contribution of Roth 401(k) Contributions, it will separately account for the Roth 401(k) Contributions and for any prior and subsequent earnings or losses attributable to such Roth 401(k) Contributions. Your Vested Interest in your Rollover Account will be 100% at all times.

Specifically, if you are eligible to participate in this Plan (whether or not you have met the participation requirements), then you may roll over amounts from the following retirement plans:

- qualified plans excluding After-Tax Contributions;
- a 403(a) or 403(b) annuity plan excluding After-Tax Contributions;
- governmental plans (Code Section 457(b) plans);
- Roth 401(k) Contributions made to any plan described above;
- Individual Retirement Accounts (“IRAs”) and individual retirement annuities; and
- Participant loans from such plans as permitted by the Administrator.

Distribution of Benefits

Distributions for Reasons Other Than Death

If your employment is terminated for any reason other than death, your Vested Interest will be distributed within an administratively feasible time after you request payment. Your Vested Interest will be distributed in a lump sum which can be paid to you or, at your election, can be rolled over to another qualified retirement plan or to an individual retirement account. You can also elect not to receive a lump sum and instead elect (a) installments, but only for purposes of the required minimum distribution rules; or (b) partial payments in amounts that you request from time to time.

There are rules which require that certain minimum distributions be made from the Plan. Generally, these minimum distributions must begin by the later of (a) the April 1st following the end of the calendar year in which you reach age 72 (or age 70½ if you reached age 70½ by December 31, 2019) or (b) the April 1st following the end of the calendar year in which you retire. However, if you are a 5% owner, you must begin receiving these distributions by the April 1st following the end of the calendar year in which you reach age 72 (or age 70½ if you reached age 70½ by December 31, 2019) even if you are still employed by the Employer. If the minimum distributions do not become payable until after you terminate employment, and the only form of distribution at termination is a lump sum, you will receive your entire Account balance.

Distribution of benefits because of Disability (as defined in the *Glossary*) will commence at the earliest time permitted after your Termination of Employment.

Distributions Upon Death

Your Vested Interest will be distributed to your beneficiary as soon as administratively feasible after your death. If you are not married, you can name anyone to be your beneficiary. If you are married, your Spouse by law is your beneficiary unless he or she waives the death benefit in writing. Your beneficiary can elect to receive (a) a lump sum; or (b) installments for purposes of the required minimum distribution rules.

If you fail to designate a beneficiary, or if the beneficiary is not alive at the time of your death, the death benefit will be paid in the following order of priority to: (a) your Spouse; (b) your children and any descendants of deceased children (i.e., “per stirpes”); and (c) your estate. If you designate your Spouse as beneficiary and later become divorced, the designation of your Spouse as beneficiary will no longer be valid. Under these circumstances, you should submit a new beneficiary designation.

After your death, the distribution to your beneficiary must be made within certain legal timeframes that are dependent upon several factors, including (a) whether you have a designated beneficiary, (b) your relationship to the beneficiary (spousal or non-spousal beneficiary), and (c) certain elections that your beneficiary may make after your death. Contact the Administrator or consult with a qualified tax advisor or financial planner for more information regarding payments to beneficiaries.

Cash-Outs of Small Accounts

If your employment is terminated for any reason and your Vested Interest is $5,000 or less (including your Rollover Account balance) it will be distributed in a lump sum, or, at your election, will be rolled over to another qualified retirement plan or to an individual retirement account (“IRA”) of your choosing. However, if you do not make an election, then the distribution (a) will be made in a lump sum if your Vested Interest is $1,000 or less; or (b) if your Vested Interest is more than $1,000, will be rolled over to an IRA that we establish for you at an IRA provider. The IRA provider may charge your IRA for any expenses associated with the establishment and maintenance of the IRA and with the investments of the IRA. You will be given more information at the time of distribution regarding the IRA provider and any associated fees or expenses.

In-Service Distributions

As long as you remain employed by us, you can elect at any time to take a lump sum distribution of up to 100% of your Vested Interest in the following Accounts:

- **401(k) Contributions Account.** You can request a distribution from your 401(k) Contributions Account if you have reached age 59½.
- **Qualified Matching Contribution Account.** You can request a distribution from your Qualified Matching Contribution Account if you have reached age 59½. This Account is one to which we may elect to make contributions in order to pass certain Plan testing requirements.
- **Qualified Non-Elective Contribution Account.** You can request a distribution from your Qualified Non-Elective Contribution Account if you have reached age 59½. This account is one to which we may elect to make contributions in order to pass certain Plan testing requirements.
- **Matching Contribution Account.** You can request a distribution from your Matching Contribution Account if you have reached age 59½.
- **Profit Sharing Contribution Account.** You can request a distribution from your Profit Sharing Contribution Account if you have reached age 59½.
- **Rollover Contribution Account.** You can request a distribution from your Rollover Contribution Account at any time.

Hardship Distributions

As long as you are an employee, you can take a distribution to pay for a financial hardship caused by one or more of the following circumstances:

- Unreimbursed expenses for medical care (or unreimbursed expenses necessary to obtain medical care) incurred by you, your Spouse, your dependents, or the person named as your primary Plan beneficiary, provided the expenses are the type that are considered tax deductible under the Internal Revenue Code.
- Costs related to the purchase of your principal residence (excluding mortgage payments).
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage of your principal residence.
- Tuition, related educational fees, and room and board, for up to the next 12 months of post-secondary education for you, your Spouse, your children, other eligible dependents, or the person named as your primary Plan beneficiary.
- Funeral expenses for your parent, your Spouse, your children, other eligible dependents, or the person named as your primary Plan beneficiary.
- Expenses for repair of damage to your principal residence that would qualify for a casualty deduction (without regard to whether the loss exceeds 10% of your adjusted gross income or whether the loss is attributable to a federally declared disaster).
- Expenses and losses (including loss of income) you incur on account of a disaster declared by the Federal Emergency Management Agency (FEMA) provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster.
- Any other distribution which is deemed by the Commissioner of Internal Revenue to be made on account of immediate and heavy financial need as provided in Treasury Regulations.

If you have one of the above expenses, a hardship distribution can only be made if the following rules are also satisfied:

- The hardship distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the hardship distribution.
- You must have taken any other distribution available under this or any Plan maintained by us.
- You must represent, in writing, by an electronic medium, or in such other form required by the Administrator, that you have insufficient cash or other liquid assets reasonably available to satisfy your financial need.

Hardship distributions can be taken from (a) your Pre-tax 401(k) Contributions Account(s); and (b) your Roth 401(k) Contributions Account(s).

Loans to Participants

You are permitted to borrow from the Plan with the approval of the Administrator using an electronic authorization system available by contacting a Participant Services Representative at 800-724-7526 or on the website at www.workplace.schwab.com (see page 1). Loans will be made only to actively employed Participants in accordance with the Loan Policy established by the Administrator. Your vested Account balance is used as security for the loan.

Loans will be made pursuant to the following terms:

- You may have a maximum of 2 loans outstanding at any time.
- The minimum amount of a loan is $1,000.
- The maximum amount of the loan, when added to the outstanding balance of all other loans from the Plan, is generally the lesser of 50% of your vested Account balance or $50,000 (reduced by the excess of your highest outstanding loan balance during the prior 1-year period over the outstanding loan balance as of the day the loan is made).
- The loan term may not exceed 5 years, except that any loan used to purchase your principal residence may be repaid over a 20-year period.
- Loans are available from the vested portion of all of your Accounts.
- The following loan fee will be charged to your Account: $50 to establish the loan.

You will be charged a reasonable rate of interest on any loan that you take from the Plan. Loan proceeds are generally taken pro-rata from investment funds in which your Account balance is invested. All payments of principal and interest that you make on a loan will be credited to your Account. Loan payments must be made through payroll deduction.

If you fail to make payments when they are due under the loan terms, you will be considered to be in "default." A loan in default may be treated as a distribution from the Plan, thus resulting in taxable income to you. In any event, your failure to repay a loan will reduce the benefit that you would otherwise be entitled to from the Plan.

Note that if you have an unpaid leave of absence or go on military leave while you have an outstanding loan, you may qualify for a suspension of loan payments. Upon termination of employment, all loans will immediately become due and payable. If a loan is not repaid within a reasonable time following termination, it will be offset against your vested Account balance.

The Administrator may periodically revise the Plan's loan policy. For further details on Plan loans, you may request a copy of the Loan Policy from the Administrator.

Investment of Accounts

Subject to an investment policy established by the Administrator, you can direct how your Account will be invested. You can choose from any investment options offered by the Plan. You can switch between investments as often as is permitted under the investment options you choose. All earnings and losses on your directed investments will be credited directly to your Account. Investment results will reflect any fees and investment expenses for the investments you select. You may request more information on fees associated with an investment option from the Administrator. At the appropriate time, we will provide you with more detailed information about the investment options offered by the Plan.

We intend to comply with Section 404(c) of the Employee Retirement Income Security Act of 1974. This means that if you are permitted to exercise independent control over the investment of your Account and you are offered a reasonably diverse selection of well managed investment options, then the fiduciaries of the Plan, including the Administrator and us, may be relieved of certain liabilities for any losses which occur because you exercise control.

Generally, you will receive a quarterly statement that contains information regarding your investment choice(s), any contributions received by the Plan during that quarter, your investment gains or losses, ending fund balances, and your vested percentage.

Tax Withholding on Distributions

Due to the complexity and frequency of changes in the federal laws that govern benefit distributions, penalties and taxes, the following is only a brief explanation of the law and IRS rules and regulations as of the date this Summary is issued. You will receive additional information from the Administrator at the time of any benefit distribution, and you should consult your tax advisor to determine your personal tax situation before taking the distribution.

Direct Rollovers Not Subject to Tax

Any eligible distribution that is directly rolled over to another eligible retirement account (either another qualified retirement plan or an individual retirement account) is not subject to income tax withholding. Generally, any part of a distribution from this Plan can be directly rolled over to another eligible retirement account unless the distribution (1) is part of a series of equal periodic payments made over your lifetime, or over the lifetime of you and your beneficiary, or over a period of 10 years or more; or (2) is a minimum benefit payment which must be paid to you by law. There are other distributions that are not eligible for direct rollover treatment, and you should contact the Administrator if you have questions about a particular distribution.

20% Withholding on Taxable Distributions

If you have your benefit paid to you and it's eligible to be rolled over, you only receive 80% of the benefit payment. The Administrator is required to withhold 20% of the benefit payment and remit it to the Internal Revenue Service as income tax withholding to be credited against your taxes. If you receive the distribution before you reach age 59½, you may also have to pay an additional 10% tax. You can still rollover all or a part of the 80% distribution that is paid to you by putting it into an IRA or into another qualified retirement plan within 60 days of receiving it. If you want to rollover 100% of the eligible distribution to an IRA or to another qualified retirement plan, you must find other money to replace the 20% that was withheld. You cannot elect out of the 20% withholding (1) unless you are permitted (and elect) to leave your benefit in this Plan, or (2) unless you have 100% of an eligible distribution transferred directly to an IRA or to another qualified retirement plan that accepts rollover contributions.

Tax Treatment Of Roth 401(k) Distributions

The tax treatment of a distribution of Roth 401(k) contributions (and the associated investment earnings) depends upon whether the distribution is a “qualified Roth distribution” or a “nonqualified Roth distribution”. If the distribution is a “qualified Roth distribution,” then the entire amount distributed is tax-free, even the portion attributable to investment earnings on the Roth 401(k) contributions. To be considered a “qualified Roth distribution,” the following two conditions must be met:

- You have satisfied the 5-year rule (also known as the 5-year clock); and
- The distribution is made after you have reached age 59 ½, died or become disabled.

The 5-year rule is satisfied if the Roth 401(k) distribution occurs at least five (5) years following the year the first Roth 401(k) Contribution is made to the plan. For example, if you first make Roth 401(k) contributions in 2024, you will satisfy the 5-year rule as of January 1, 2029. It is not necessary that you make a Roth 401(k) contribution in each of the five (5) years.

A “non-qualified Roth distribution” is any distribution that is not a “qualified Roth distribution.” Non-qualified Roth distributions are subject to taxation (and in some cases, a 10% early distribution penalty) on the portion of the distribution which is attributable to investment earnings, unless you roll over the distribution as described below.

You may elect to make a rollover of your Roth 401(k) contributions and earnings to a Roth IRA. The tax treatment of any subsequent distribution from the Roth IRA will be governed by the tax rules attributable

to Roth IRA distributions. Please note that the 5-year clock for a Roth IRA distribution will not include the portion of time that the Roth 401(k) contributions were in the Plan.

You may also elect to make a rollover to an eligible retirement plan that accepts rollovers and agrees to separately account for Roth 401(k) Contributions. To the extent that you make a plan-to-plan rollover (direct rollover), you will be provided a statement indicating the amount of your Roth 401(k) Contribution (basis) and the year that your 5-year clock started. This information must generally be provided to the recipient plan in conjunction with your rollover. Please note that the 5-year clock in the recipient plan will include the portion of time that you made Roth 401(k) contributions to this Plan.

When you roll a Roth 401(k) balance to a new Roth IRA, the 5-year qualification period starts over. This may impact the rollover decision. If you have an established Roth IRA, then the qualification period is calculated from the initial deposit into the IRA and the rollover will be eligible for tax-free withdrawals when that 5-year period has ended (and the age qualifier has been met).

Claims Procedures

If you feel that you are entitled to a benefit that you are not receiving from the Plan, you can make a written request to the Administrator (or its delegate) for that benefit. Plan Benefits fall into two categories – Disability related benefits and non-Disability related benefits. A Disability-related benefit means a benefit that is available under the Plan and that becomes payable upon a determination of a Participant's Disability by the Administrator. A Disability- related benefit does not include a benefit that, under the terms of this Plan, becomes payable upon a determination of a Participant's Disability by the Social Security Administration or under a long-term Disability plan sponsored by the Employer. The claims procedure for Disability-related benefits and non-Disability benefits are similar, but there are differences. While the claims procedure for each benefit is described below, this is just a Summary, and the Administrator can supply you with a more detailed claims procedure.

Exhaustion of Remedies

No civil action for benefits under the Plan will be brought unless and until you have (1) submitted a timely claim for benefits in accordance with the provisions of this Section; (2) been notified by the Administrator that the claim has been denied; (3) filed a written request for a review of the claim in accordance with the applicable provisions; and (4) been notified in writing of a final adverse benefit determination on review. Any civil action must be brought no later than the earlier of two years after the date of a final adverse determination or the shortest applicable statute of limitations provided by law.

Grounds for Judicial Review

Any civil action will be based solely on your advanced contentions in the administrative review process, and the judicial review will be limited to the Plan document and the record developed during the administrative review process as set forth in this Section.

Written Claims

Any claim for benefits must be filed in writing with the Administrator, but the Administrator may permit the filing of a claim for benefits electronically as long as the Administrator complies with certain Department of Labor requirements. Any Employee, Participant or Beneficiary who files a claim for benefits under the Plan is a "Claimant" under these claims procedures.

As a Claimant, you may authorize a representative to act on your behalf with respect to any claim under the Plan. The representative must provide satisfactory evidence to the Administrator of its authority to act on your behalf, such as a letter of authority with your notarized signature. To the extent consistent with the authority you grant to your representative, references to “you” or to "Claimant" in these claims procedures include your representative.

The Administrator may review claims under the Plan or may delegate that authority to an appropriate claims adjudicator. References in these claims procedures to the Administrator include any claims adjudicator acting on behalf of the Administrator. Benefit claim determinations shall be made based on the applicable provisions of the Plan document and any documents of general application that interpret

the Plan provisions and are maintained by the Employer or the Administrator for purposes of making benefit determinations. The Administrator shall take such steps as are necessary to ensure and verify that benefit claim determinations are made in accordance with such documents and that the Plan provisions are being applied consistently with respect to similarly situated Claimants. All notices to Claimants will be written in a manner calculated to be understood by the Claimant.

Review of Non-Disability Benefit Claims

The provisions of this paragraph will apply if your claim for a benefit does not require a determination as to whether or not you are disabled or if a claim requires a Disability determination, but that determination is made outside the Plan for reasons other than determining eligibility for a Plan Benefit. Examples of this are where the Disability determination is based solely on whether you are entitled to disability benefits under either the Social Security Act or the Employer's long-term disability plan.

- **Initial Denial.** Whenever the Administrator decides for any reason to deny a claim in whole or in part, the Administrator will give you a written or electronic notice of its decision within 90 days of the date the claim was filed, unless an extension of time is necessary or you voluntarily agree to an extension. If special circumstances require an extension, the Administrator will notify you before the end of the initial review period that additional review time is necessary. The notice for an extension (a) will specify the circumstances requiring a delay and the date that a decision is expected to be made; and (b) will describe any additional information needed to resolve any unresolved issues. Unless the Administrator requires additional information from you to process the claim, the review period cannot be extended beyond an additional 90 days unless you voluntarily agree to a longer extension or the Administrator determines that special circumstances require a further extension. If special circumstances require a further extension, the Administrator will notify you before the end of the extended review period that further additional review time is necessary and such notice will describe the special circumstances requiring a further delay and specify the date a decision is expected to be made. The Administrator cannot extend the review period beyond an additional 90 days unless you voluntarily agree to a longer extension. If the Administrator requires additional information from you to process the claim and a timely notice requesting the additional information is transmitted to you, it must be provided within 90 days of the date that the notice is provided by the Administrator.
- **Notice of Denial.** If your claim is denied, the notice will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; (e) a description of the Plan's review (i.e., appeal) procedures, the time limits applicable to such procedures, and in the event of an adverse review decision, a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (f) a statement that if you request a review of the Administrator's decision and the reviewing fiduciary's decision on review is adverse to you, there is no further administrative review following the initial review, and that you then have a right to bring a civil action under ERISA §502(a). The notice will also include a statement advising you that, within 60 days of the date on which you receive such notice, you may obtain review of the decision as explained in the next paragraph.
- **Right to Appeal.** Within the 60-day period beginning on the date you receive notice regarding disposition of your claim, you may request that the claim denial be reviewed by filing with the Administrator a written request for such review. The written request must contain the following information: (a) the date on which your request was received by the Administrator; (b) the specific portions of the denial of your claim which you request be reviewed; (c) a statement setting forth the basis upon which you believe the Administrator's denial of your claim should be reversed and your claim should be accepted; and (d) any other written information (offered as exhibits) which you want to be considered to explain your position, without regard to whether such information was submitted or considered in the initial benefit determination.

- **Review on Appeal.** In general, your appeal will be reviewed within 60 days of the date it is received by the Administrator (unless special circumstances require an extension to 120 days and you are so notified before the end of the 60-day review period). The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial determination. The decision on review will contain the following: (a) the specific reasons for the denial on review; (b) reference to specific Plan provisions on which the denial is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; (d) a statement describing any voluntary review procedures and your right to obtain copies of them; and (e) a statement that there is no further administrative review of decision and that you have a right to bring a civil action under ERISA §502(a).

Review of Disability Benefit Claims

The provisions of this paragraph will apply if your claim for a benefit requires a determination as to whether or not you are disabled. These provisions will not apply if a Disability determination is made outside the Plan for reasons other than determining eligibility for a Plan Benefit. Examples of this are where the Disability determination is based solely on whether you are entitled to disability benefits under either the Social Security Act or the Employer's long- term disability plan.

- **Initial Denial.** Whenever the Administrator decides for any reason to deny a claim for a Disability benefit in whole or in part, the Administrator will transmit to you a written or electronic notice of its decision within 45 days of the date the claim was filed, unless an extension of time is necessary or you voluntarily agree to an extension. If, prior to the expiration of the initial 45-day period, the Administrator determines that a decision cannot be made within that initial 45-day period due to matters beyond the control of the Plan, the Administrator will provide you a notice before the end of the 45-day review period that a 30-day extension of time is necessary. If, prior to the end of the first 30-day extension period, the Administrator determines that a decision cannot be made within that first 30- day extension period due to matters beyond the control of the Plan, the Administrator will provide you a notice before the end of the first 30-day extension period that an additional 30-day extension of time is necessary. Any notice of an extension of time will (a) specify the circumstances requiring the extension of time and the date a decision is expected to be rendered; (b) explain the standards on which entitlement to a Disability Benefit is based; (c) state the unresolved issues that prevent a decision on the claim; and (d) describe any additional information needed to resolve those issues. If the Administrator requires additional information from you to process the Disability Benefit claim and a timely notice requesting the additional information is transmitted to you, you must provide the additional information within 45 days of the date the notice is provided. The claims review period will be temporarily suspended until the earlier of the date you provide the required information or the end of your permitted response period.

  The notice requesting additional information may also serve as notice of a claim denial if the notice clearly states that unless you provide the requested information within the prescribed time period, the claim will be denied for failure to provide sufficient information. A combined notice must provide both the information described above and the information under *Notice of Denial* below. If you are required to provide additional information, the Administrator has discretion to decide whether to request the information and extend the initial review period as described in this section or, instead, to deny the claim on the basis that there is not sufficient information to proceed.

- **Notice of Denial.** If your claim is denied, the notice will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; (e) either (1) if the claim denial is based on an internal rule, guideline, protocol, or other similar provision, a copy of the specific rule, guideline, protocol, or other similar criterion relied upon, or (2) an affirmative statement that the claim denial is ***not*** based on an internal rule, guideline, protocol, or other similar criterion; (f) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an

explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation is available upon request, free of charge; (g) a discussion of the decision, including an explanation for disagreeing with or not following (1) the views you presented of health care professionals who treated you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied on in making the determination; and (3) any Disability determinations made by the Social Security Administration; (h) a description of the review (i.e., appeal) procedures, the time limits applicable to such procedures, and in the event of an adverse review decision, a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (i) a statement that if you request a review of the Administrator's decision and the review is adverse to you, that there is no further administrative review following such initial review, and that you have a right to bring a civil action under ERISA §502(a). The notice will also include a statement advising you that, within 180 days of the date you receive the notice, you may obtain review of the decision as explained in the next paragraph.

- **Right to Appeal.** Within the 180-day period beginning on the date you receive notice regarding disposition of your claim, you may request that the claim denial be reviewed by filing with the Administrator a written request for such review. The written request for such review must contain the following information: (a) the date on which your request was received by the Administrator; (b) the specific portions of the denial of your claim which you request be reviewed; (c) a statement setting forth the basis upon which you believe the Administrator's denial of your claim should be reversed and your claim should be accepted; and (d) any other written information (offered as exhibits) which you want to be considered to explain your position, without regard to whether such information was submitted or considered in the initial benefit determination.
- **Review by Alternate Reviewer.** Review of a Disability Benefit claim that has been denied under the procedures described in the preceding two paragraphs will be conducted by a reviewer who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The reviewer will not afford deference to the initial adverse benefit determination, but will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If the adverse benefit determination was based on a medical judgment, the reviewer will consult with an appropriate health care professional who (a) was not consulted on the original adverse benefit determination, (b) is not subordinate to someone who was consulted on the original adverse benefit determination, and (c) has appropriate training and experience in the field of medicine involved in the medical judgment. The reviewer will either (1) provide you with a list of any experts whose advice was obtained on the original adverse determination, without regard to whether the advice was relied upon in making the determination or (2) notify you that you may request, in writing, a list of such experts. You must also be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim. No fee may be charged for such access and/or copies.
- **Review on Appeal.** In general, your appeal will be reviewed within 45 days of the date it is received by the Administrator (unless special circumstances require an extension to 90 days and you are so notified before the end of the 45-day review period). The reviewer will conduct a full and fair review of the Administrator’s decision denying your claim for benefits and will render its written decision. If the reviewer anticipates denying your appeal, whether in whole or in part, based on new or additional evidence or a new or additional rationale, the reviewer must provide you with (i) the new or additional evidence considered, relied upon, or generated by or at the direction of the Plan, the insurer, the reviewer, or any other person making the benefit determination and/or (ii) the new or additional rationale for the determination. The information must be provided to you free of charge and as soon as possible so that you have a reasonable opportunity to review the information and submit a response before the reviewer is required to render its decision. If the reviewer decides for whatever reason to deny, whether in whole or in part, your appeal of an adverse benefit determination, the reviewer's decision will be provided in a culturally and linguistically appropriate manner and contain the following: (a) the specific reasons for the denial; (b) reference to specific Plan provisions on which the

denial is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; (d) either (1) if the claim denial is based on an internal rule, guideline, protocol, or other similar criterion, a copy of the specific rule, guideline, protocol, or other similar criterion relied upon, or (2) an affirmative statement that the claim denial is ***not*** based on an internal rule, guideline, protocol, or other similar criterion; (e) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation is available upon request, free of charge; (f) a discussion of the decision, including an explanation for disagreeing with or not following (1) the views you presented of health care professionals who treated you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied on in making the determination; and (3) any Disability determinations made by the Social Security Administration; (g) a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (h) a statement that you have a right to bring a civil action under ERISA §502(a).

- **Additional Levels of Appeal.** If the Plan provides additional level(s) of appeal, the Plan may not require you to file more than two appeals of an adverse benefit determination prior to bringing a civil action under ERISA Section 502(a). If the Plan offers voluntary level(s) of appeal, then (a) the Plan waives any right to assert that you failed to exhaust administrative remedies because you did not submit a benefit dispute to any voluntary level of review provided by the Plan; (b) any statute of limitations or other defense based on timeliness is temporarily suspended during the time that a voluntary appeal pursuant to the Plan's procedures is pending; (c) you may only submit a benefit dispute to a voluntary level of review if you have exhausted the appeals permitted above; and (d) the Plan provides to you, upon request, sufficient information concerning the voluntary level(s) of appeal to enable you to make an informed decision about whether to submit a benefit dispute to the voluntary level of appeal, including (1) a statement that your decisions as to whether or not to submit a dispute to the voluntary level of appeal will have no effect on your right to other benefits under the Plan, (2) information about the applicable rules, (3) your right to representation, (4) the process for selecting a decision maker, and (5) any circumstances that may affect the impartiality of the decision maker. No fees or costs may be imposed on you as part of the voluntary level of appeal.

Participants Absent Because of Military Duty

Participants Who Die During Military Absence

If you are absent from employment with us because of military service and you die on or after January 1, 2007 while you are performing "qualified" military service (as defined under the Internal Revenue Code), you will be treated as having returned to employment on the day before your death for Vesting purposes. However, you will not be entitled to any additional benefits or contributions with respect to your period of military leave.

Qualified Reservist Distributions

A Qualified Reservist Distribution may be made to a Participant who is a Qualified Reservist under any circumstance and/or for any reason. A Qualified Reservist Distribution is any distribution of 401(k) Contributions to a Qualified Reservist that is made during the period beginning on the date the Qualified Reservist is ordered or called to active duty and ending on the last day of active duty. A Qualified Reservist is an individual who is a member of a reserve component and is called to active duty after September 11, 2001 either for a period in excess of 179 days or for an indefinite period.

A Participant who is a Qualified Reservist may request a Qualified Reservist Distribution on or after the date of the order or call to active duty and before the last day of the Plan Year during which the order or call to active duty occurred. The Administrator must receive a copy of the order or call to active duty prior to any amounts being distributed. The Administrator may rely on the order to determine the period that the Qualified Reservist has been ordered or called to active duty. The Qualified Reservist is eligible for a

Qualified Reservist Distribution if the order specifies a period of 180 or more days. It does not matter if the actual period of active duty is less or otherwise changed. A Qualified Reservist will be eligible for a Qualified Reservist Distribution if the original order or call is less than 180 days and subsequent calls or orders increase the total period of active duty to 180 or more days.

Qualified Reservist Distributions are not subject to the 10% early withdrawal penalty tax. In addition, at any time during the two-year period beginning on the day after the last day of the Qualified Reservist's active duty, a Qualified Reservist who has received one or more such distributions may make one or more repayment contributions to an IRA, up to the total amount of the Qualified Reservist Distributions, and the dollar or Compensation limitations that apply to contributions to an IRA do not apply to these repayments. However, you will not receive any tax deduction for repayment of Qualified Reservist Distributions to an IRA.

Active Duty Severance Distributions

If you are absent from employment with us while you are on active military duty for a period of more than 30 days, you are considered to have terminated employment with us and you can therefore elect to take a distribution of some or all of your Accounts. Some restrictions apply (for example, you cannot make additional 401(k) Contributions or Voluntary Employee Contributions, if applicable, for a period of 6 months after the distribution), and you should consult the Administrator in the event you are interested in taking such a distribution.

Other Information

Addition of Dividend or Income Payment Allocated Among Participants

When dividends or income payments are allocated among Participant Accounts, and the pro-rata allocation of such payment would result in the allocation of less than $25 to a terminated Participant who had previously taken a final distribution, then such terminated Participant will not receive the allocation. Such amount will be deposited to the Trust and the Administrator will allocate all such amounts on a pro-rata basis to the other Participants receiving such dividend or income payment.

Attachment of Your Account

Your creditors cannot garnish or levy upon your Account except in the case of a proper IRS tax levy, and you cannot assign or pledge your Account except as collateral for a loan from the Plan or as directed through a Qualified Domestic Relations Order (“QDRO”) as part of a divorce, child support or similar proceeding in which a court orders that all or part of your Account be transferred to another person (such as your ex-Spouse or your children). The Plan has a procedure for processing QDROs, which you can obtain free of charge from the Administrator.

Amendment or Termination of the Plan

Although we intend for the Plan to be permanent, we can amend or terminate it at any time. If we do terminate the Plan, all Participants will have a 100% Vested Interest in their Accounts as of the Plan termination date, and all Accounts will be available for distribution at the same time and in the same manner as would have been permissible had the Plan not been terminated.

Accounts Are Not Insured

Your Account is not insured by the Pension Benefit Guaranty Corporation (“PBGC”) because the insurance provisions of ERISA do not apply to 401(k) plans. For more information on PBGC coverage, ask the Administrator or contact the PBGC. Written inquiries to the PBGC should be addressed to: Technical Assistance Division, PBGC, 1200 K Street NW, Suite 930, Washington, D.C. 20005-4026. You can also call them at 800-736-2444.

Payment of Plan Expenses

The Plan routinely incurs expenses for the services of lawyers, actuaries, accountants, third party administrators, and other advisors. Some of these expenses may be paid directly by us while other

expenses may be paid from the assets of the Plan. The expenses that are paid from Plan assets will be shared by all Participants either on a pro-rata basis or an equal dollar basis. If the expense is paid on a pro-rata basis, an amount will be deducted from your Account based on its value as compared to the total value of all Participants' Accounts. For example, if the Plan pays $1,000 of expenses and your Account constitutes 5% of the total value of all Accounts, $50 would be deducted from your Account ($1,000 x 5%) for its share of the expense. On the other hand, if the expense is paid on an equal dollar basis, the expense is divided by the number of Participants and then the same dollar amount is deducted from each Participant's Account.

Statement of ERISA Rights

Your Right To Receive Information

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Participants are entitled to:

(a) Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) Obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description upon written request to the Administrator (the Administrator may make a reasonable charge for the copies);

(c) Receive a summary of the Plan's annual financial report (the Administrator is required by law to furnish each Participant with a copy of this summary annual report); and

(d) Obtain a statement telling you whether you have a right to receive a pension at Normal Retirement Age (which is defined elsewhere in this Summary Plan Description) and if so, what your benefits would be at Normal Retirement Age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Duties of Plan Fiduciaries

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

Enforcement of Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you

may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Administrator. If you have questions about this statement or about your ERISA rights, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or contact them at https://www.dol.gov/agencies/ebsa/about-ebsa/about- us/organization-chart or at the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You can call the Employee Benefits Security Administration (the “EBSA”) at 866-444-3272 (TTY/TDD users can call 877-889-5627). You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. Additional pension-related information can be obtained at the following Department of Labor's website where you can review a publication called "What You Should Know About Your Retirement Plan": https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource- center/publications/what-you-should-know-about-your-retirement-plan.pdf.

Other Account Questions?

Call 800-724-7526 to talk to a Participant Services Representative during prescribed business hours.

Glossary

Many definitions are used in this Summary and most are defined in the section in which they appear, but the following terms have broader application and are used throughout the Summary:

Account. Your Account represents the aggregate value of the contributions made to the Plan on your behalf, as well as the net earnings on those contributions. Your Account may include (but is not limited to) the following sub- accounts: the 401(k) Contributions Account; the Matching Contribution Account; and the Profit Sharing Contribution Account.

Allocation Period. The Allocation Period is the period of time for which a contribution to the Plan is allocated. The Allocation Period is generally the Plan Year but can be a shorter period of time.

Disability. Disability is a physical or mental impairment you suffer after you become a Participant in the Plan (and while you are still an employee) which, in the opinion of the insurance company, qualifies you for benefits under an Employer-sponsored long-term disability plan which is administered by an independent third party (or qualifies you for disability benefits under the Social Security Act if no such long-term disability plan exists on the date you suffer the mental or physical impairment

Foreign Compensation. Foreign Compensation, in general, is Compensation paid to a Non-Resident Alien Employee who is not a Participant in the Plan.

Fringe Benefit Payments. Fringe Benefit Payments, in general, are reimbursements or other expense allowances, cash and noncash fringe benefits, moving expenses, deferred compensation, and welfare benefits.

Key Employee. A Key Employee is an Employee who satisfies certain executive, ownership, or Compensation requirements as set forth in the Internal Revenue Code.

Merger and Acquisition Employee. A Merger and Acquisition Employee is, generally, an individual who becomes, or ceases to be, an Employee as a result of a merger or acquisition.

Non-Resident Alien Employee. A Non-Resident Alien Employee is an individual who is neither a citizen of the United States of America nor a resident of the United States of America and who does not receive earned income from the Employer which constitutes income from sources within the United States.

Normal Retirement Age. Normal Retirement Age is the date you reach age 65.

Post-Severance Compensation. In general, Post-Severance Compensation are amounts paid to you within 2½ months after your termination of employment, which, absent your termination of employment, would have been paid to you while you were still an Employee. For purposes of this Plan, Post-Severance Compensation (a) includes payments for your regular working hours, for overtime or shift differential, for commissions or bonuses, or for other similar payments; (b) includes unused paid time off such as vacation time earned while employed; (c) excludes any payments made to a non-qualified deferred Compensation plan on your behalf; and (d) if you are disabled, excludes any post-termination employment payments made to you.

Profit Sharing Contribution. A Profit Sharing Contribution is an additional type of contribution we may elect to make to the Plan for any Plan Year. Profit Sharing Contributions are generally made as a percentage of pay.

Puerto Rico Based Employee. A Puerto Rico Based Employee is an Employee who resides in Puerto Rico.

Spouse. The term “Spouse” or “marriage” should be read to include either opposite or same-gender couples legally married in any state, U.S. territory or foreign jurisdiction that recognizes such marriages, regardless of where you currently live. However, a registered domestic partnership, civil union or similar relationship recognized under state law is not considered a “marriage” for purposes of this retirement plan.

Vested Interest. Your Vested Interest is the percentage of your Account to which you are entitled at any point in time. This percentage, in turn, is the aggregate of your Vested Interest in your various sub-

accounts. However, notwithstanding any vesting schedule set forth in other sections of this Summary, you will have a 100% Vested Interest in your Account upon reaching Normal Retirement Age, or upon your death or Disability while you are still a Participant but before you terminate employment.

Appendix A – Additional Profit Sharing Contributions

With respect to Employees who are employed by UT-Battelle, LLC, we may make another Profit Sharing Contribution in addition to the one previously described in this Summary for each Participant who is eligible, as described below.

How the Contribution Is Determined

These contributions are totally discretionary on our part, as is the amount should we decide to make them. The Allocation Period for this contribution is the Plan Year.

How You Become a Participant

To become a Participant with respect to this contribution, you must satisfy the following criteria: (a) you must be an Eligible Employee; and (b) you must be employed by us on the applicable Entry Date.

- **Eligible Employees.** All employees of UT-Battelle, LLC are Eligible Employees with respect to this contribution except (a) Non-Resident Alien Employees; (b) Merger and Acquisition Employees; (c) Employees who are classified as independent contractors, even if later reclassified as common law employees by a court or governmental authority; (d) Employees not covered by a collective bargaining agreement; and (e) Employees covered by a collective bargaining agreement which does not allow for their participation in the Plan. Employees classified as Puerto Rico Based Employees are also ineligible to participate under the Plan.
- **Entry Date.** You will enter this part of the Plan as a Participant on the same date that you are hired.

How You Qualify for a Contribution Allocation

Once you become a Participant with respect to this contribution, you are eligible for a contribution for any Allocation Period in which we make one if you satisfy the requirements (if any) described below for that Allocation Period.

- **Active Participants.** If you are still employed by us on the last day of an Allocation Period, you will be eligible to receive an allocation if you are credited with at least 1,000 Hours of Service during the Allocation Period.
- **Terminated Participants.** If you terminate employment for any reason before the last day of an Allocation Period, you will not be eligible to receive an allocation regardless of your service during the Allocation Period.

How the Contribution Is Allocated

This contribution is allocated in the ratio that your Compensation for the Allocation Period bears to the total Compensation of all Participants eligible to receive an allocation for the Allocation Period. This means that the amount allocated to each eligible Participant's Profit Sharing Contribution Account will, as a percentage of Compensation, be the same. For example, if the contribution is equal to 5% of all eligible Participants' Compensation, then that is the amount that will actually be allocated to each eligible Participant's Profit Sharing Contribution Account.

How Your Compensation Is Determined

In general, the amount of any contribution described in this Appendix that is made on your behalf is based on all of the Compensation that is paid or made available to you during the Allocation Period, excluding any Compensation received (a) as a bonus; (b) as Fringe Benefit Payments; (c) while you are a member of an ineligible class of Employees with respect to this part of the Plan; (d) prior to the date you become a Participant with respect to this part of the Plan; (e) as Foreign Compensation; (f) as overtime; (g) as premium pay; and (h) as shift differential. However, no contributions will be made with respect to

Compensation in excess of the annual dollar limit on Compensation, which is announced annually by the IRS, and which is $330,000 for the 2023 calendar year.

How Your Vested Interest Is Determined

Your Vested Interest in any contribution described in this Appendix that is allocated to your Profit Sharing Contribution Account is determined by the schedule following this paragraph, based on your Years of Vesting Service. Any part of this Account which is not vested will be forfeited when you receive a distribution (or after you incur 5 consecutive Breaks in Vesting Service, if earlier).

1 Year of Vesting Service.....0% Vested
2 Years of Vesting Service.....0% Vested
3 Years of Vesting Service..100% Vested

13. Administrative Information

This chapter contains information on the administration and funding of the plans described in this book as well as your rights as a plan participant. It is important for you to understand your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

Participation in any of the Company's benefit plans should not be viewed as a contract of employment.

Plan Sponsor and Administrator

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

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

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

The term “Company” means UT-Battelle, LLC. The term “ORNL Benefits Office” refers to the ORNL Benefits Department, which operates under the sponsor and designated Plan Administrator of the plans.

Employer Identification Number

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

Plan Documents

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

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

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

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

Claiming Benefits

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

Health Claims Review and Appeal Procedures

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

Disability Claims Review and Appeal Procedures

This subsection applies to disability claims filed under the Long-Term Disability Plan and Short-Term Disability Plan. For any claims or appeals relating to a disability determination under another plan under the Employee Retirement Income Security Act of 1974 (ERISA), please contact the carrier for a detailed summary of its disability claims procedures.

Disability Claims Appeal

You or an authorized representative may file claims for plan benefits and appeal adverse claim decisions. An “authorized representative” is a person you authorize, in writing, to act on your behalf. The plan also will recognize a court order giving a person authority to submit claims on your behalf. You must exhaust all administrative remedies before filing an action to recover benefits.

Notice of Adverse Benefit Determination for a Disability Claim

You will be notified of the plan’s benefit determination not later than 45 days after the plan’s receipt of the claim. The period may be extended up to an additional 30 days due to circumstances outside the plan’s control. In that case, you will be notified of the extension before the end of the initial 45 day period. If a decision cannot be made within this 30 day extension period due to circumstances outside the plan’s control, the period may be extended up to an additional 30 days, in which case you will be notified of the additional extension before the end of the initial 30 day extension. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

Notification of Disability Claim Decision

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

1. the specific reasons for the denial with reference to the specific plan provisions on which the denial was based;
2. a description of any additional information needed to complete the claim and an explanation of why such information is necessary;
3. a description of the plan’s claim review procedures and applicable time limits;
4. a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (where applicable);
5. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   - the views presented by you to the plan of health care professional treating you and vocational professionals who evaluated you;
   - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
   - a disability determination regarding you presented by you to the plan made by the Social Security Administration;
6. either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of

charge upon request;(Applies only if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit);

7. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
8. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit.

Disability Claim Appeal of an Adverse Benefit Determination

To have your claim reconsidered, you must file an appeal of an adverse benefit determination for a disability claim. The appeal must be submitted in writing to the Claims Administrator. You will have 180 days following receipt of an adverse benefit determination to appeal the decision.

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

The plan's review on appeal shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The appeal will be conducted by an "Appeals Fiduciary" appointed by the Claims Administrator to review your claim. The Appeals Fiduciary shall not be the individual or committee who made the initial Adverse Benefit Determination or a subordinate of that individual or committee.

The assigned Appeals Fiduciary will not give deference to the initial benefit determination and will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. If the Adverse Benefit Determination on the initial claim determination was based on a medical judgment, the Appeals Fiduciary will consult with a health care professional who has appropriate training and experience in the medical field. This health care professional will not be an individual who was consulted in connection with the initial benefit determination, nor will it be the subordinate of any such individuals.

Before the plan can issue an adverse benefit determination on review, the plan shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the plan can issue an adverse benefit determination on review based on a new or additional rationale, the plan shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

You ordinarily will be notified of the decision no later than 45 days *after the appeal is received.* If special circumstances require an extension of up to an additional 45 days, you will be notified of such extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

Notification of Disability Claim Decision on Appeal

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

1. the reasons for the decision, again with reference to the specific plan provisions on which that decision is based;
2. information indicating you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits;
3. your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (where applicable);
4. notification of your option to have a second -level appeal review;
5. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   - the views presented by you to the plan of health care professional treating you and vocational professionals who evaluated you;
   - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
   - a disability determination regarding you presented by you to the plan made by the Social Security Administration,
6. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request, and
7. either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist.

Second Disability Claim Appeal of an Adverse Benefit Determination in the Disability Plans

To file an appeal of an adverse first Appeal Benefit Determination, you must, within 60 days of receiving the determination, notify the Plan Administrator that you wish to appeal again. This level of appeal is optional. You have the right to submit written comments, documents, records, and other pertinent information with your second-level appeal. You also will be given, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The Plan Administrator will notify you of the benefit determination on the second appeal within 45 days, unless special circumstances require an extension of up to 45 additional days for processing the appeal. If an extension is required, the Plan Administrator will notify you before the expiration of the initial 45 day period and will indicate the special circumstances that require an extension of time and will include the date by which the Plan Administrator will make its determination on appeal.

Notification of Disability Claim Decision on Second Appeal

If your appeal seeking reconsideration of the denied claim under the plan is denied again in whole or in part, you will receive written or electronic notification that will include similar information to what was received on the first appeal.

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

Other Claims Appeal

You or an authorized representative may file claims for plan benefits and appeal adverse claim decisions. An “authorized representative” is a person you authorize, in writing, to act on your behalf. The plan also

will recognize a court order giving a person authority to submit claims on your behalf. References to you in this section are intended to include references to a participant, an authorized representative, or a beneficiary entitled to a benefit under the plan.

Notice of Adverse Benefit Determination for Other Claims

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

Notification on Other Claim Decisions

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

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

Other Claim Appeal of an Adverse Benefit Determination

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

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

Notification of Other Claims Decision on Appeal

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

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

Legal Process

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

Agent for Service of Legal Process

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

Plan Termination and Amendment

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

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

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

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

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

Special Pension and Savings Provisions

A few special provisions apply only to the Savings Plan and Pension Plan.

Maximum Benefits

Federal tax laws impose certain limitations on the benefits and contributions under qualified retirement plans. These limitations generally apply only to highly compensated employees. You will be notified if these limitations apply to you. More information is available from the ORNL Benefits Office.

Top-Heavy Provisions

Under current tax law, the Pension Plan and Savings Plan are required to contain provisions that apply in the event a significant portion of the plan's benefits are payable to highly compensated employees. These provisions—called "top-heavy" rules—provide for accelerated vesting of plan benefits and certain minimum benefit accruals in the event the plans become top-heavy. The plans are not top-heavy now.

Therefore, the top-heavy rules are not likely to affect your benefits under the plans.

A more detailed explanation of the provisions will be provided if and when these plans become top-heavy.

Loss of Retirement Benefits

Other than failing to meet the age and service requirements for a benefit, there are no plan provisions that would cause you to forfeit your Pension Plan benefits. Under the Savings Plan, you are always 100% vested in your own contributions, and you become 100% vested in Company matching contributions after you complete 3 years of credited service. After 3 years of credited service, you are fully vested in your Company matching contributions in the Savings Plan, but the investment choices you make will affect that balance.

Assets Upon Termination

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

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

Pension Benefit Guaranty Corporation

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

The PBGC guarantee generally covers:

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

The PBGC guarantee generally does not cover

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

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

For more information about PBGC and the benefits it guarantees, ask the Plan Administrator or contact

PBGC Technical Assistance Division
1200 K Street N.W.
Washington, D.C. 20005-4026
Phone: 202-926-4000 (not a toll-free number)
Telephone text device/telecommunication device for the deaf (TTY/TDD) users: Call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000.

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

Assignment or Alienation of Benefits

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

Qualified Domestic Relations Order

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

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

A domestic relations order must meet specific requirements to be recognized by the Plan Administrator as a QDRO, and specific procedures regarding the amount and timing of payments must be followed. If you are affected by such an order, you will be notified by the ORNL Benefits Office.

Participants and beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing QDROs.

Qualified Medical Child Support Order

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

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

Health Insurance Portability and Accountability Act (HIPAA)

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

Other Administrative Facts

UT-Battelle, LLC

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Pension Plan for Employees at ORNL	001	Defined Benefit	Calendar	Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Employee (as of 1/1/2013) and Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
Savings Plan for Employees at ORNL	002	Defined Contribution and 401(k) Plan	Calendar	Charles Schwab Retirement Plan Services Charles Schwab Trust Company serves as Trustee 12401 Research Blvd. 02-130 Austin, TX 78759	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust
Group Life Insurance **	511	Welfare	Calendar	Metropolitan Life Insurance Company	Employee/ Retiree and Company	Benefits are paid from an insurance contract

Plan Name	Plan Number	Plan Type	Plan Year	Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Business Travel Accident**	511	Welfare	Calendar	Zurich American Insurance Company	Company	Benefits are paid from an insurance contract
Accidental Death & Dismemberment Insurance**	511	Welfare	Calendar	Zurich American Insurance Company	Employee	Benefits are paid from an insurance contract
Health Benefits (Medical, Dental, Vision)*	510	Welfare	Calendar	UnitedHealthcare—Medical MetLife—Dental Delta Dental Plan of Ohio—Dental Vision Service Plan (VSP)—Vision Care	Employee/ Retiree and Company	Benefits are paid (through a claims administrator) from employee contributions and general assets of the Company
Prescription Drug Plan*	510	Welfare	Calendar	Express Scripts	Employee/ Retiree and Company	Benefits are paid (through the Express Scripts claims administrator) from employee contributions and general assets of the Company
Cafeteria Plan – including the Flexible Spending Plans*	510	Welfare	Calendar	Dependent Care Flexible Spending Account Health Care Flexible Spending Account Pre-tax Medical and Dental Premium Programs	Employee (Pre-tax Contributions)	Benefits are paid (through a claims administrator) from employee contributions and general assets of the Company
Long-Term Disability Plan**	511	Welfare	Calendar	Hartford	Company	Benefits are paid (through the Hartford claims administrator) from general assets of the Company
Short-Term Disability Plan**	511	Welfare	Calendar	Hartford	Company	Benefits are paid (through the Hartford claims administrator) from general assets of the Company
Employee Assistance Plan*	510	Welfare	Calendar	Magellan Behavioral Health	Company	Company
Severance Plan for Salaried Employees	511	Welfare	Calendar	Company	Company	Company
Legal Insurance	511	Welfare	Calendar	ARAG	Employee	Benefits are paid from an insurance contract

* This plan is a component of the Oak Ridge National Laboratories Welfare Benefit Wrap Plan.
** This plan is a component of the Oak Ridge National Laboratories Fringe Benefit Wrap Plan.

Your Rights Under COBRA

You and your Qualified Beneficiaries covered under a group health plan (e.g., the Medical or Dental plans) or the health care spending account have the option to purchase a temporary continuation of health care coverages at full group rates, plus a 2% administrative charge in certain instances, when your coverage would otherwise end. This is called COBRA coverage.

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Participation

If one of the events (such events are referred to as “Qualifying Events”) listed in the Cobra Continuation Period chart later in this section causes you or an eligible dependent to lose coverage under one of the group health plans, you and/or the eligible dependent, as the case may be, are a “Qualified Beneficiary” with respect to such group health plan.

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

If you adopt or have a child while covered by COBRA, that child also is a Qualified Beneficiary entitled to COBRA coverage.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the Qualifying Event outlined in the COBRA Continuation Period chart that follows. You may continue to participate in the health care spending account only through the end of the year in which the Qualifying Event occurs.

When the Qualifying Event is the death of an employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child’s loss of eligibility as an eligible dependent child, COBRA continuation coverage lasts for up to 36 months. When the Qualifying Event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which the 18 month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under a group health plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of the disability determination and before the close of the initial 18 month period of continuation coverage, each Qualified Beneficiary is entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18 month period of continuation coverage.

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and other eligible dependents in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. These exceptions are valid only if the event would have caused the spouse or dependent child to lose coverage under the group health plan had the first Qualifying Event not occurred.

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to a plan sponsor, and if that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and other eligible dependents also will become Qualified Beneficiaries if bankruptcy results in their loss of coverage under the group health plan.

COBRA Continuation Period

Qualifying Event (if accompanied by a loss of coverage)	Maximum Continuation Period		
	You	**Spouse**	**Child**
Your hours of employment are reduced*	18 months	18 months	18 months
You terminate for any reason (except gross misconduct)	18 months	18 months	18 months
You or any Eligible Dependent who is a Qualified Beneficiary is determined to be disabled at any time during the first 60 days of COBRA coverage	29 months	29 months	29 months
You die	N/A	36 months**	36 months**
You and your spouse legally separate or divorce	N/A	36 months	36 months
You become entitled to Medicare (Part A or B, or both)	N/A	36 months	36 months
Your child no longer qualifies as an Eligible Dependent	N/A	N/A	36 months

* If you lose coverage due to not being approved for long-term disability benefits or losing long-term disability benefits, your 18-month period will begin at the time you lose medical or dental coverage.

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

Choosing COBRA

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

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

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

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

- For medical and dental coverage, premiums are based on the full group rate per covered person set at the beginning of the year, plus 2% to cover administrative costs.
- Health care spending account contributions can be continued on an after-tax basis, plus the 2% administrative charge.
- If you are disabled under the Social Security definition of disability, COBRA premiums for months 19 through 29 reflect the full group cost per person, plus 2%.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from PBGC

(eligible individuals). Under this tax provision, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance including continuation coverage.

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

Notification

The ORNL Benefits Office will notify you by mail of your COBRA election rights when the Qualifying Event is a reduction in hours or termination of employment. You will receive instructions on how to continue your health care benefits under COBRA.

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

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

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

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

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment concerning an Employee's military leave. These requirements apply to medical and dental coverage for you and your dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death and Dismemberment coverage you may have.

A military leave is a leave due to performance of duty on a voluntary or involuntary basis; military leave includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

For military leaves of less than 31 days, coverage will continue, and you are not required to pay more than the active contribution rate. For military leaves of 31 days or more, you may continue coverage for yourself and your dependents by paying 102% of the total premium, until the earliest of the following:

- 24 months from the last day of employment with the Employer,
- the day after you fail to return to work, or
- the date the policy cancels.

Regardless of whether you continue your health coverage, if you return to your position of employment, your health coverage and that of your eligible dependents (if any) will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Your Rights Under ERISA

As a participant in any of the Company's benefit plans described in this book, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified worksites, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated Summary Plan Description. 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.

In addition, once every 12 months, you may request information concerning the total value of your Savings Plan accounts and a statement as to what amount (if any) of the Company contributions to your Savings Plan account is then vested (or the earliest date on which it will become vested).

Similarly, once each year, you may request information concerning your vested rights under the Pension Plan (or, if you are not vested, the earliest date on which you become vested), and what your benefit would be at normal retirement age if you stopped working under the plan now. This information is free, but you must address a written request for it to the Plan Administrator or, for Savings Plan information, call the information line.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse, and/or eligible dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights. You should be provided a free certificate of creditable coverage from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation of coverage, and when your COBRA continuation of coverage ceases, if you request it before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. To file suit in a state or federal court concerning: (1) a claim for a benefit, (2) the qualified status of a domestic relations order or medical child support order, or (3) your service credit, you must file the suit within 1 year of the date of the final determination by the Plan Administrator which is the basis of your suit. If you do not file the suit within this period, the Plan Administrator's final determination will be binding and cannot be challenged by you in court.

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

Assistance with Your Questions

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

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

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

14. Contact Information

For all your benefit questions, call ...	
ORNL Benefits Service Center my.adp.com 1-800-211-3622	ORNL Benefits PO Box 2008, MS 6465 Oak Ridge, TN 37830-6465 1-865-574-7474 Toll Free: 1-865-576-7766 Fax: 1-865-241-3213 E-mail: ornlbenefits@ornl.gov

Benefit	Plan Provider	Contact Information
Medical—UnitedHealthcare Plans	UnitedHealthcare	**Member Services** 1-844-234-7925
		To file a claim, mail your completed claim form to the address shown on your UnitedHealthcare ID card.
		Website www.myuhc.com
Prescription Drugs	Express Scripts	**Member Services** 1-866-749-0097
		To mail order forms for new prescriptions: Express Scripts PO Box 650322 Dallas, TX 75265-0322
		To order or manage your prescriptions online: www.express-scripts.com
		For the automated refill system: 1-800-473-3455
		For instructions on how to fax your prescription, have your doctor call: 1-888-327-9791
Vision	Vision Service Plan	**Member Services** 1-800-877-7195
		To file a claim, mail your claim to: Vision Service Plan Attn: Out of Network Provider Claims PO Box 385018 Birmingham, AL 35238-5018
		Website www.vsp.com

Benefit	Plan Provider	Contact Information
Dental	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	Delta Dental	**Member Services** 1-800-524-0149
		To file a claim, mail your claim to: Delta Dental PO Box 9085 Farmington Hills, MI 48333-9085
		Website www.deltadentaloh.com
Employee Assistance Program	Magellan	**Member Services** 1-800-888-2273 TTY Service 1-800-456-4006
		Website www.magellanascend.com
Disease Management Program Clinical support for specific chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure	UnitedHealthcare	**Disease Management Program** 1-844-234-7925
Flexible Spending Accounts	HealthEquity	**Member Services** 1-866-346-5800
		To file a claim for reimbursement, mail your claim to: Claims Administrator PO Box 14053 Louisville, KY 40512
		Fax Number 1-877-353-9236
		Website healthequity.com/wageworks

Benefit	Plan Provider	Contact Information
Long-Term and Short-Term Disability	Hartford	**Member Services** 1-800-882-2894
		Mailing Address Hartford PO Box 14560 Lexington, KY 40512-4560
		Fax Number 1-866-667-1987
Life Insurance	MetLife	**Statement of Health Unit** 1-800-638-6420, prompt 1
		For Life Insurance Conversion Information 1-877-275-6387
Business Travel Accident Insurance	Zurich American Insurance Company	**For Emergencies and live support** US and Canada – 1-800-263-0261 Anywhere else, call collect at 1-416-97-0277
		Website Zurichtravelassist.com
		To Request Claim Form 1-866-841-4771
		To File a Claim Notice Zurich American Insurance Company Claims Department P.O. Box 968041 Schaumberg, IL 60196-8041
Accidental Death and Dismemberment	Zurich American Insurance Company	**To Request Claim Form** 1-866-841-4771
		To File a Claim Notice Zurich American Insurance Company Claims Department P.O. Box 968041 Schaumberg, IL 60196-8041
Legal Insurance w/ Identity Theft Protection	ARAG	**Member Services** 1-800-247-4184 Website www.ARAGLegalCenter.Com Access Code 18095or
Savings Plan	ORNL Savings, Retirement, and Investment Committee Charles Schwab Savings Information Line	**Mailing Address** UT-Battelle c/o Plan Administrator's Office PO Box 2008, MS 6434 Oak Ridge, TN 37831
		Member Services United States: 1-800-724-7526 International: 1-330-908-4777 TTY Service: 1-800-345-2550
		Website www.workplace.schwab.com

Benefit	Plan Provider	Contact Information
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