

Y-12 BOOK OF BENEFITS

**ABOUT YOUR
BENEFITS**



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF 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.

Your Benefits

- Provide eligibility for you and your family

As a **Full-Time Employee, or Full-Time Temporary Employee hired to work at least 12 months**, you are eligible for coverage under most benefit plans, including health care, life and accident insurance, the Savings Plan and the Pension Plan, on your first day of work. **Part-Time Employees and Full-Time Temporary Employees hired to work less than 12 months** are immediately eligible for life and accident insurance, the Savings Plan and the Pension Plan, and become eligible for medical and dental coverage after four months of service. Part-Time Employees are not eligible for short-term or long-term disability benefits or flexible spending accounts. Ad Hoc Employees, as defined in the Glossary, are not eligible to participate in any benefit plans.

ARRA employees, as defined in the Glossary, are classified as Full-Time Temporary Employees hired to work at least 12 months for purposes of eligibility for any benefits described in this book, except long-term disability benefits. Notwithstanding, this classification, ARRA Employees are not eligible for long-term disability benefits.

- Offer coverage automatically

If you are in the class of employees eligible for benefits, you are automatically covered under the plans below. See the “Eligibility At a Glance” chart in this section for a summary listing of employees that may be eligible for benefits.

Employee Assistance Program

- Short-Term Disability and Long-Term Disability (eligible as defined in the “Disability Coverage” and “Glossary” sections)
 - Business Travel Accident Insurance
 - Pension Plan
- 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
- Flexible Spending Accounts (excludes part-time employees)
- Basic and Supplemental Life Insurance
- Spouse and Dependent Life Insurance
- Special Accident Insurance

- Savings Plan
 - Long Term Care (plan closed to new enrollees as of April 30, 2011)
 - Long-Term Disability buy-up (B&W Y-12 salaried employees).
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- Offer tax-effective coverage

Contributions for flexible spending accounts are automatically deducted from your Pay on a before-tax basis and according to IRS rules. You can also make before-tax contributions to the Savings Plan. At the annual Open Enrollment, or when you first sign up for medical and dental coverage, you may elect to have contributions taken from your Pay on a before- or after-tax basis.

The term "Company" refers to B&W Y-12, LLC or UT-Battelle, LLC. Other terms are defined in the Glossary section.

Eligibility

Employee

You are eligible to participate in the benefit plans described in this book if you are employed and paid as a Full-Time Employee of the Company working on a regular basis, or a Full-Time Temporary Employee who is hired to work at least 12 months. Part-Time Employees and Full-Time Temporary Employees who are hired to work less than 12 months are also eligible for many of the benefits described in this book. Ad Hoc Employees are not eligible to participate in any benefit plans.

If you are an hourly employee, you are eligible for business travel accident insurance and those benefit plans in which your collective bargaining unit has agreed to participate. Part-time hourly employees are eligible for the Savings Plan and Pension Plan, but are not eligible for any other benefit plans.

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.

ARRA Employees, as defined in the Glossary, are classified as Full-Time Temporary Employees hired to work at least 12 months for purposes of eligibility for the benefits described in this book, except long-term disability benefits.

The terms "Full-Time Employee," "Part-Time Employee," "Full-Time Temporary Employee," "ARRA Employee", and "Ad Hoc Employee" are defined in the Glossary.

Dependents

You may choose to cover your Eligible Dependents for medical (including prescription drug and vision care), dental, life, special accident, and long term care insurance coverage. Your Eligible Dependents may also use the employee assistance program.

You are obligated to submit proof of dependent status for children and spouse, which includes birth certificate, social security card, marriage certificate, and other documents needed to prove eligibility.

Medical (including prescription drugs and vision care) and dental coverage may be continued for an unmarried Child who is permanently and totally disabled and incapable of self-support due to a physical or mental handicap that began before he or she reached the age at which coverage would otherwise be terminated, provided you submit proof of the Child's disability to the claims administrator within 30 days after attaining the maximum age and you remain a participant in the plan. Additional proof of the Child's continuing disability will be required periodically.

When your dependents are no longer eligible for health care coverage, they may be eligible to continue coverage for up to 36 months under COBRA. See the "Administrative Information" section for information on COBRA.

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

The terms "Eligible Dependents" and "Child" are defined in the Glossary.

Special Eligibility Rules for Families

If you and your spouse work for the Company and are eligible to participate in the Company's benefit plans, you may enroll in the plan as an employee, or you may be enrolled as a spouse. However, you may not enroll for coverage as an employee and as a spouse. In addition, only one of you may enroll your Eligible Dependent Children.

Eligibility ... At a Glance		
Benefit Plan	When You Are Eligible	
	Full-Time Employees and Full-Time Temporary Employees Hired to Work at Least 12 Months	Part-Time Salaried employees and Full-Time Temporary employees Hired to Work Less Than 12 Months
Medical (including Prescription Drugs and Vision Care)	on your first day of work	after 4 months of service
Dental	on your first day of work	after 4 months of service
Employee Assistance Program	on your first day of work	on your first day of work
Flexible Spending Accounts	on your first day of work	Full-Time Temporary Employees after 4 months of service (Part-Time Employees not eligible)
Short-Term Disability	after 1 month of service (salaried) after 3 months of service (hourly)	Full-Time Temporary Employees after 4 months of service (Part-Time Employees not eligible)
Long-Term Disability	on your first day of work ARRA Employees are not eligible	Full-Time Temporary Employees after 4 months of service (Part-Time Employees not eligible)
Long Term Care (for employees enrolled prior to April 30, 2011)	on your first day of work	Part-Time Employees if working more than 50% of a full-time schedule on your first day of work. Temporary employees hired to work less than 12 months are not eligible.
Basic, Supplemental, Spouse and Dependent Life Insurance	on your first day of work	on your first day of work
Business Travel Accident 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
Savings Plan	on your first day of work	on your first day of work—including part-time hourly employees
Pension Plan	on your first day of work	on your first day of work
Severance Plan	Full-Time Employees on your first day of work (temporary employees not eligible)	Part-Time Employees on your first day of work (temporary employees not eligible)

Enrollment

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

Benefits with no enrollment required:

- Employee Assistance Program
- Short-Term Disability
- Long-Term Disability
- Business Travel Accident Insurance
- Pension Plan

You may elect the following benefits when you are first eligible:

- Medical (including Prescription Drugs and Vision Care)
- Dental
- Flexible Spending Accounts
- Basic and Supplemental Life Insurance
- Spouse and Dependent Life Insurance
- Special Accident Insurance
- Savings Plan
- Long-Term Disability buy-up for B&W Y-12 salaried employees

To enroll for all of these benefits, except the Savings Plan and the Long Term Care plan, you must complete an enrollment form or card on which you:

- enroll yourself and Eligible Dependents
- authorize the Company to deduct from your Pay your share of the coverage you elect.

Enrollment forms are available from the Benefit Plans Office and some forms are available on the Benefit Plans Home Page on the Internet. When you begin work for the Company, the Savings Plan record keeper, Schwab Retirement Plan Services, will be notified of your employment and will send a welcome letter and a personal identification number to you.

To enroll in the Savings Plan

Call the information line after you receive your personal identification number:

In the United States
1-888-I-SAVE-IT (1-888-472-8348)

International
1-617-847-1006

Telecommunications Device for the Deaf
1-800-579-5708

Refer to the “Savings Plan” section for more information on the information line and the Savings Plan enrollment process.

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

When You May Elect Coverage

You may elect benefits coverage when you first become eligible. In addition, you may enroll for some benefit plans during the annual Open Enrollment period as described in the chart below.

Open Enrollment		
You may enroll for...	During Open Enrollment in...	For coverage effective on the following...
Medical (including Prescription Drugs and Vision) and Dental	October or November	January 1
Flexible Spending Accounts	October or November	January 1

When You May Change Your Elections

You may add or change coverage for basic life, supplemental life, and spouse and dependent life with an approved statement of health. You may add special accident insurance at any time. You may cancel these coverages at any time. You may change most Savings Plan elections at any time by calling the information line. There are limited circumstances under which you may change other benefit elections.

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

You are obligated to submit proof of dependent status for children and spouse, which includes birth certificate, social security card, marriage certificate, and other documents needed to prove eligibility.

If you would like to request a mid-year election change because of a qualifying event, you must complete a change form and return it to the Benefit Plans Office **within 30 days** of the event. You may enroll a newborn or newly adopted child for dental coverage at any time until the child is one year of age. Otherwise, the child can only be enrolled at Open Enrollment.

❗ B&W Y-12 salaried employees must elect the 30% Long-Term Disability buy-up within 30 days of becoming eligible.

Reference to a 30-day time limit in this book means calendar days. The 30-day period begins on the day of the event and ends 29 days thereafter. Holidays and weekends are included in the 30-day period. Forms must be received in the Benefit Plans Office by close of business on day 30 in order to be accepted.

Changes at Other Times

Qualifying Life Events

If you elected after-tax contributions for medical and/or dental coverage, you may drop that coverage any time during the year, for any reason. However, you may change your before-tax medical and dental contributions, as well as your flexible spending account contributions, during the year only on account of and consistent with a Qualifying Life Event or when certain significant changes in cost or in coverage happen. With the exception of the birth of a child in Tennessee, as described below, a change during the year must be made within 30 days of the qualifying event.

A Qualifying Life Event includes:

- marriage, legal separation, annulment, or divorce
- the death of your spouse or child
- the birth or adoption (or placement for adoption) of a child
- the loss or gain of benefit eligibility of your child
- the termination or commencement of employment of you, your spouse or child
- reduction or increase in hours of employment of you, your spouse or child, including a switch between part-time and full-time, a strike or lockout, or commencement of or return from unpaid leave of absence
- a change in health coverage due to your spouse's employment
- a "special enrollment period" under the group health plan as required by law
- 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
- involuntary loss of other group health plan coverage.

❗ REMINDER: Enrollment forms must be completed AND submitted to the Benefit Plans Office within 30 days of any Qualifying Life Event. THIS INCLUDES THE BIRTH OF A NEWBORN. Otherwise, you will have to wait

until Open Enrollment to enroll and the coverage will not be effective until the next January 1.

Birth of a child under Tennessee law:

A newborn of a participant is automatically covered under the medical plan for 31 days. Enrollment forms must be completed and submitted to the Benefit Plans Office within 30 days of the end of the state mandated coverage to continue to cover the newborn. Coverage is effective the first day of the first calendar month after the completed enrollment forms are submitted to the Benefit Plans Office. Otherwise, you will have to wait until Open Enrollment to enroll the newborn, and the coverage will not be effective until the next January 1. Enrollment forms must be submitted to the Benefit Plans Office within 30 days of the date of birth, to cover the newborn beginning at the end of the state mandated coverage.

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

Example of Election Changes consistent with a Qualifying Life Event	
With this Qualifying Event	You can make these changes, if consistent*
Marriage, birth, adoption, or placement for adoption of a child	Add yourself, your spouse and/or children; drop coverage if you are to be covered by your spouse's plan
Divorce, legal separation, or annulment (NOTE: You must cancel coverage for an ex-spouse within 30 days of divorce. He/she is no longer an Eligible Dependent under the Company's plans.)	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 a dependent (such as due to age, marriage or employment)	Drop dependent coverage
* For your election to be effective, the Plan Administrator must determine that your requested mid-year change is consistent with the event.	
You are obligated to submit proof of dependent status for children and your spouse, which includes birth certificate, social security card, marriage certificate, and other documents needed to prove eligibility.	

Changes in Cost or Coverage

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

If you contribute to the dependent care flexible spending account, and there is a significant increase or decrease in the cost of services by a day care provider who is not your relative, you may be able to make corresponding changes to your contribution election for your dependent care spending account by submitting a new election within 30 days of the change. If your dependent care provider changes or services are significantly curtailed, you may be able to change your election within 30

days. For example, if 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 significant change in coverage. However, if your mother wants a raise mid-year, you cannot increase your contributions to this account due to a change in cost because she is your relative.

In addition, if annual enrollment for your spouse is for a period of coverage other than the calendar year, you may be permitted to make a corresponding election change under this plan during your spouse's enrollment period. For example, if you elect family medical coverage and, in May, 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 31.

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 automatically changed to reflect the change in the cost of coverage.

How Changes Affect Your Benefits

Steps to Take If You Get Married or Divorced

If You Get Married ...

Notify the Benefit Plans Office and your 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. In addition, make sure your supervisor or department office knows of any address changes and ask how to update payroll records.

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, as well as a copy of his/her social security card is required.

Change your benefit elections within 30 days of your marriage.

Consider increasing your contributions to the health care spending account, so you can pay for your spouse's unreimbursed medical, dental and vision care expenses with before-tax dollars.

Update your life and accident insurance beneficiary records. Consider enrollment in spouse life insurance.

Update your Savings Plan beneficiary records. Keep in mind that if you have been married for at least one year and you want to designate someone other than your spouse as your beneficiary, you must have your spouse's written and notarized consent. Contact Schwab Retirement Plan Services or the Benefit Plans Office for more information.

If You Get Divorced ...

Notify the Benefit Plans Office and your company's Personnel Records Department to update your personnel records if your name changes. Make sure your supervisor or department office knows of any address changes and ask how to update payroll records.

Change your benefit elections within 30 days after the date your divorce is final. You must submit a copy of the final 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 have 60 days to notify the Benefit Plans Office in order to obtain COBRA benefits. See the "Administrative Information" section.

You may also add your eligible dependents to your medical and dental coverage if a court establishes that you must provide coverage for dependent children who previously had coverage provided by your ex-spouse. You must provide sufficient documentation to establish dependent eligibility and receive approval through Benefits Plans.

Cancel spouse and/or dependent life insurance.

Update your life insurance, accident insurance and Savings Plan beneficiary records. Life and accident insurance forms are available from the Benefit Plans Office or on your company's benefit forms web page. You can request a Savings Plan beneficiary form by calling the Savings Plan information line.

Contact the Benefit Plans Office 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 Benefit Plans Office to ask about the steps that should be taken, and the deadlines that must be met in order to add a newborn to your coverage. This will help maximize available benefits.

In-Network Benefits

Schedule prenatal appointments. You will pay a physician office copayment only at the initial visit.

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.

YOU MUST COMPLETE AND RETURN ENROLLMENT FORMS WITHIN 30 DAYS OF THE BIRTH OF YOUR BABY TO ENSURE CONTINUOUS COVERAGE.

Birth of a child under Tennessee law:

A newborn of a participant is automatically covered under the medical plan for 31 days. Enrollment forms must be completed and submitted to the Benefit Plans Office within 30 days of the end of the state mandated coverage to continue to cover the newborn. Coverage is effective the first day of the first calendar month

after the completed enrollment forms are submitted to the Benefit Plans Office. Otherwise, you will have to wait until Open Enrollment to enroll the newborn, and the coverage will not be effective until the next January 1. Enrollment forms must be submitted to the Benefit Plans Office within 30 days of the date of birth, to cover the newborn beginning at the end of the state mandated coverage.

Your OB/GYN will precertify your hospital or birthing center admission.

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

Before the fourth month of pregnancy, you should call CIGNA Member Services to notify CIGNA of your pregnancy so CIGNA can provide pregnancy case management support. Refer to the back of your identification card for contact information.

If You Adopt a Child ...

Notify your supervisor and the Benefit Plans Office if you would like to arrange for a family leave of absence.

Interview and choose a pediatrician. If you are in a Point-of-Service Plan, you must choose a primary care physician for your child from the provider directory to receive in-network benefits, including coverage for well-child care.

When Your Child Arrives

Enroll your newborn or newly adopted Child for medical benefits **within 30 days** so your Child's medical expenses will be covered from the date of birth or adoption. You have up to age one to enroll the Child for dental coverage. Call the Benefit Plans Office to request a change form or print a form from your company's benefit forms web page.

Consider beginning or increasing your contributions to the flexible spending accounts, so you can pay for your Child's unreimbursed medical expenses and child care expenses with before-tax dollars.

Steps To Take If You Become Disabled

If You Become Disabled and Cannot Work ...

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

Contact your Company's benefit office to request a form for disability benefits, or your supervisor may request the form for you.

Remain in contact with your Company's benefit office about how long you anticipate being away from work.

Receive short-term disability benefits for up to six months of disability (if eligible). If your disability continues longer than six months, you can apply for long-term disability benefits. Contact your Company's benefit office to find out how to apply.

File forms for long-term disability benefits if your disability will continue longer than six months. Claim forms are available from the Benefit Plans Office.

Apply for other disability benefits that may be payable (such as 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" section.

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) and Dental

During Short-Term Disability

Coverage continues. Contributions are deducted from your disability benefits.

During Long-Term Disability

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

Employee Assistance Program

You may continue to access the services of the employee assistance program.

Health Care Spending Account

During Short-Term Disability

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

During Long-Term Disability

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

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

Dependent Care Spending Account

During Short-Term Disability

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

During Long-Term Disability

Participation ends. You may submit claims for expenses incurred before your disability began, up to the balance in your account. Submit claims for expenses incurred before your disability began and during your short-term disability if you were unable to care for your Eligible Dependents up to the balance in your account.

Short-Term and Long-Term Disability

Short-term disability provides benefits for up to six months of disability, depending on your length of service. Long-term disability benefits provide a percentage of your annual Pay, which is offset by Social Security and other benefits payable. Eligibility for benefits is defined in the "Disability Coverage" section.

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 hourly 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 two years, but not beyond age 70.)

Spouse and Dependent Life Insurance

Coverage continues for six months. After six months, you may convert to an individual policy or terminate coverage.

Business Travel Accident Insurance

During Short-Term Disability and Long-Term Disability

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

Special Accident Insurance

During Short-Term Disability and Long-Term Disability

Coverage continues during short-term disability and up to 12 months during long-term disability, provided you pay the premiums. If you are an hourly employee and you become eligible for Total and Permanent Disability within 365 days of a qualifying accident, you will receive an additional monthly benefit after you have been disabled for 12 consecutive months. These benefits will continue for up to 50 months. Refer to the "Life and Accident Coverage" section for other special accident insurance benefits.

Pension Plan

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, 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. You have a choice of payment forms, or you may choose to defer payment. If you have an outstanding loan, you must continue to make repayments directly to Schwab Retirement Plan Services.

Long Term Care

You may continue your coverage by making payments directly to the insurance company.

Steps to Take If You Leave the Company

If You Leave the Company ...

Notify your supervisor.

Apply for COBRA within 60 days of your termination if you wish to continue medical (including prescription drugs and vision care) and dental coverage or to continue participating in the health care spending account.

Convert your life, dependent life and accident insurance to a private policy within 30 days of your termination if you wish to continue this type of coverage.

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

Notify the Benefit Plans Office if your address changes.

What Happens to Your Benefits If You Leave the Company

Here is what happens to your benefits when 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 dependents 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. 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.

Flexible Spending Accounts

Coverage ends. You may submit health care spending account claims and dependent care spending account claims for expenses incurred before your termination. You may continue your health care spending account participation on an after-tax basis through the end of the year of the COBRA qualifying event, and submit claims for expenses incurred during the period you continue to make contributions.

Disability

Coverage ends.

Long Term Care

You may continue your coverage by making payments directly to the insurance company.

Life and Accident Insurance

Coverage ends. You may convert your basic life, supplemental life, spouse and dependent life, and special accident insurance to individual policies. You may not convert business travel accident insurance.

Pension Plan

You may receive pension benefits when you reach retirement age if you are vested.

Savings Plan

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

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

Steps to Take If You Retire

If You Are About to Retire ...

Call the Benefit Plans Office to receive retirement counseling and to get an estimate of your pension benefit. During retirement counseling, you will also receive forms that you must complete to apply for

your pension benefit. You will have the opportunity to decide if you want 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 Major Medical Medicare Supplement plan and post-65 dental and vision plans if you are age 65 or older. You must make your benefit elections immediately upon retiring.

Notify your supervisor.

Call the Savings Plan information line 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 your benefits and information about Medicare (if applicable).

What Happens to Your Benefits If You Retire

Here is what happens to your benefits when you retire:

Medical (Including Prescription Drugs and Vision Care) and Dental

At early retirement prior to age 65, you may continue coverage until the end of the month in which you reach age 65. At age 65, coverage ends and you become eligible for the Major Medical Medicare Supplement plan and the post-65 dental and vision plans. However, you may elect to continue coverage under the plan for an enrolled younger spouse until he or she reaches age 65 as long as you remain enrolled on the post-65 plans. In any case, when your coverage ends, Eligible Dependents may be able to continue coverage for up to 36 months (longer under certain circumstances) under COBRA.

If you had at least 10 years of full-time service under the Pension Plan and were at least age 50 at the time of your retirement, you may elect to continue coverage for yourself and your Eligible Dependents. You must pay any cost required by the Company for the continued coverage.

If you had less than 10 years of full-time service under the Pension Plan and were at least age 50 at the time of your retirement, you may elect to continue coverage for yourself and your Eligible Dependents. However, you must pay the full cost for the continued coverage.

The Company intends to continue the medical plan for employees who retire early. However, the Company reserves the right to amend or terminate the medical plan and the Medical Medicare Supplement plan, in whole or in part, at any time. The Company may also increase or decrease participants' contributions to these plans. The establishment of the plans does not impose on the Company any contractual obligation to continue them in the future.

The Company may incorporate managed care programs, utilization management programs, and network management programs (such as pre-authorization of services or products, formulary or preferred prescriptions, or exclusion of certain benefits).

Employee Assistance Program

Coverage ends.

Flexible Spending Accounts

You may continue to contribute to the health care spending account on an after-tax basis until the end of the year of the COBRA Qualifying Life Event which is your retirement effective date. Participation in the dependent care spending account ends.

You may submit claims for eligible health care and dependent care expenses incurred before you retire. You may submit health care spending account claims for eligible expenses incurred after you retire only if you continue to participate as described above.

Disability

Coverage ends.

Long Term Care

You may continue your coverage by making payments directly to the insurance company.

Basic Life Insurance

At early retirement, 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 one year immediately preceding retirement. You may convert the discontinued basic life insurance coverage to an individual policy.

Supplemental Life Insurance

Group coverage ends. However, the plan has a conversion feature that allows you to continue coverage on an individual basis if you apply within 31 days after the group coverage ends. Group rates and individual rates under that feature will be different.

Spouse and Dependent Life Insurance

Group coverage ends. However, the plan has a conversion feature that allows you to continue coverage on an individual basis if you apply within 31 days after the group coverage ends. Group rates and individual rates under that feature will be different.

Business Travel Accident Insurance

Coverage ends.

Special Accident Insurance

You may convert your special accident insurance coverage to an individual policy.

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 age 70-1/2. Mandatory minimum distribution rules apply after age 70-1/2 if you have retired from the Company. Any outstanding loans must be paid within six months of your retirement. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

Steps To Take If You or a Family Member Dies

In the Case of Death, You or Your family member (whichever applies) Should ...

Notify the Benefit Plans Office of the death.

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

Complete a life insurance claim form and special accident insurance claim form, if applicable. Send the completed forms, along with a certified death certificate and other supporting information, to the Benefit Plans Office.

Convert any family special accident insurance coverage to a private policy within 30 days of your death if they wish to continue this coverage.

Convert spouse and dependent life insurance coverage to an individual policy within 31 days of your death.

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 at the time of your death.

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

Notify the Benefit Plans Office and complete a life insurance claim form, if applicable.

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

Change your medical (including prescription drugs and vision care), dental, flexible spending account, life, and special accident insurance elections within 30 days of the death, if coverage changes are appropriate.

Review your beneficiary elections for life and accident insurance and the Savings Plan.

Remember, the employee assistance program is available if you or your family members need counseling.

What Happens to Your Benefits If You Die

Here is what happens to your benefits if you die:

Medical (Including Prescription Drugs and Vision Care) and Dental

Your Eligible Dependents may elect to continue medical (including prescription drugs and vision care) and dental coverage for three months at the appropriate active employee contribution rate. If you had less than 10 years of full-time service when you died and you were not eligible for a pension, or had more than 10 years of Company Service but you were not at least age 50 when you died, your eligible dependents may continue coverage after the initial three-month period for an additional 33 months through COBRA. See the "Administrative Information" section for more information.

If you had at least 10 years of full-time service under the Pension Plan and were at least age 50 when you died, your Eligible Dependents may elect to continue coverage until your spouse reaches age 65. In this case, the Eligible Dependent must pay any cost required of the participant for coverage.

If you had less than 10 years of full-time service under the Pension Plan when you died, and were age at least 50 and retirement eligible, your Eligible Dependents may elect to continue coverage until your spouse reaches age 65. In this case, your Eligible Dependent must pay the full cost for the continued coverage.

See the "Medical Plan" section for more information.

Employee Assistance Program

Coverage ends.

Flexible Spending Accounts

Participation ends. Dependents may submit claims for health care and dependent care expenses incurred before your death. See the "Flexible Spending Accounts" section for eligible expenses.

Long Term Care

Your spouse may continue their coverage by making payments directly to the insurance company.

Life and Accident Insurance

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

- basic life insurance benefit
- supplemental life insurance benefit
- business travel accident insurance benefit if you die while traveling on a Company business trip
- special accident insurance benefit if your death is the result of an accident.

Family special accident insurance coverage ends, but it may be converted to an individual policy.

Pension Plan

If you are vested, your surviving spouse/beneficiary will receive any survivor benefit. The Benefit Plans 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. However, if you were eligible to retire under the Pension Plan at the time of your death, your spousal beneficiary may choose either a lump-sum payment or monthly installment payments over a five-year period. Your spousal beneficiary may also elect to defer payment until the latest date permitted by the tax laws.

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.

Benefit Plan	Your Coverage Will Begin...
<p>Medical (including Prescription Drugs and Vision Care) and Dental</p>	<p>Full-Time Employees and Full-Time Temporary Employees hired to work at least 12 months: 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 Open Enrollment to enroll. Your coverage will become effective the first day of the plan year following Open Enrollment, currently January 1. Election and enrollment changes made as a result of a Qualifying Life Event must be made within 30 days of the event. In this case, coverage is effective on the qualifying event date.</p> <p>NOTE: Birth of a child under Tennessee law: A newborn of a participant is automatically covered under the medical plan for 31 days. Enrollment forms must be completed and submitted to the Benefit Plans Office within 30 days of the end of the state mandated coverage to continue to cover the newborn. Coverage is effective the first day of the first calendar month after the completed enrollment forms are submitted to the Benefit Plans Office. Otherwise, you will have to wait until Open Enrollment to enroll the newborn, and the coverage will not be effective until the next January 1. Enrollment forms must be submitted to the Benefit Plans Office within 30 days of the date of birth, to cover the newborn beginning at the end of the state mandated coverage.</p> <p>Part-Time Employees and Full-Time Temporary Employees hired to work less than 12 months: on the first day of work following 4 months of service, 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 Open Enrollment to enroll. Your coverage will become effective the first day of the plan year following Open Enrollment, currently January 1. Election and enrollment changes made as a result of a Qualifying Life Event must be made within 30 days of the event. In this case, coverage is effective on the qualifying event date. See the note related to newborns in the section above.</p>
<p>Employee Assistance Program</p>	<p>On your first day of work.</p>
<p>Flexible Spending Accounts</p>	<p>Payroll deductions begin as soon as administratively possible, and in accordance with IRS rules following your election; however, you may claim eligible expenses incurred on or after your date of hire or on the date of the Qualifying Life Event. Full-Time Temporary Employees are eligible after 4 months of service. Before and after-tax deductions are made based on IRS rules.</p> <p>Part-Time Employees are not eligible.</p>
<p>Short-Term Disability</p>	<p>Refer to the "Disability Coverage" section.</p>
<p>Long-Term Disability</p>	<p>On your first day of work if you are a Full-Time Employee hired to work at least 12 months or a Full-Time Temporary Employee who has completed 4 months of service and was hired to work less than 12 months. Part-Time Employees are not eligible.</p>
<p>Basic Life Insurance</p>	<p>On the day you enroll, 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.</p>

Benefit Plan	Your Coverage Will Begin...
Supplemental Life Insurance	On the day you enroll, 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.
Spouse and Dependent Life Insurance	On the day you enroll, 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.
Special Accident Insurance	On the first day of the month after you enroll.
Business Travel Accident Insurance	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.

Current Employees

The medical and dental coverage, before-tax medical and dental premiums and flexible spending account elections you make during the fall Open Enrollment period will be effective on January 1 of the following year.

If you change your elections because of a Qualifying Life Event, as described in this section, the changes will be effective on the date described on the following page under "Paying for Your Benefits."

If you elect to pay for coverage on a pre-tax basis, the IRS restricts when pre-tax contributions may begin or end during the plan year. Pre-tax payroll deductions can only be changed if you have a Qualifying Life Event and you contact the Benefit Plans Office within 30 days of the Qualifying Life Event. Therefore, if you have a Qualifying Life Event and you do not notify the Benefit Plans Office within 30 days of the Qualifying Life Events, 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 timely and pay your share of any cost. In order 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 which exclusively limit the use of your individual information to the operation of the specific benefit program for which the vendor provides service. Health 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.

Paying for Your Benefits

If you elect to pay for coverage on a pre-tax basis, the IRS restricts when pre-tax contributions may begin. Therefore, the required contributions for coverage you elect to purchase 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 on the payroll following the date your election is processed. Any payments due for coverage from the date your coverage is effective until the date pre-tax deductions begin will be deducted on an after-tax basis.
- 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, 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.

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		before-tax or after-tax contributions	
Employee Assistance Program	X		
Flexible Spending Accounts			before-tax contributions
Short Term Disability	Refer to the "Disability Coverage" section.		
Long Term Disability	Refer to the "Disability Coverage" section.		
Long Term Care			after-tax contributions
Basic Life Insurance		after-tax contributions	
Supplemental Life, Spouse and Dependent Life Insurance			after-tax contributions
Business Travel Accident Insurance	X		
Special Accident Insurance			after-tax contributions
Savings Plan		before-tax or after-tax contributions and Company matching contributions	
Pension Plan	X		

Before-Tax or After-Tax?

Before-tax contributions offer special tax advantages. You do not pay federal, Medicare, Social Security and, in most cases, state or local income taxes on the before-tax Pay you use for buying medical or dental coverage or for participating in the flexible spending accounts. This is also true for before-tax Savings Plan contributions, except Medicare and Social Security taxes will apply.

Even though before-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.

When Coverage Ends

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) and dental coverage, the last day of the month in which your employment terminates
 - for long-term disability coverage, the date your employment terminates for any reason, unless you are totally disabled
 - for basic life insurance coverage, the date 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" section for more information)
- the date you are no longer considered eligible because of a change in your employment status
- the last day of the period for which your last contribution was made (if you fail to make any required contribution)

or

- the date the plan is terminated.

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.

If your coverage ends, you may be eligible to extend medical (including prescription drugs and vision care) and dental coverage, as well as health care spending account participation under COBRA.

See the "Administrative Information" section for information about COBRA.

Your participation in the Savings Plan may continue (with some limitations) after you stop making contributions.

See the Savings Plan section for more information.

See the "Savings Plan" section for more information.

Y-12 BOOK OF BENEFITS

**MEDICAL
PLAN**



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

Depending on where you live, you may enroll for medical coverage under one of the two medical plans – the Point-of Service Plan (POS) or the Open Access Plan. If there is no CIGNA contracted network available, coverage may be available under the Indemnity Plan. The medical plans have different plan designs. CIGNA administers these plans. CIGNA also administers and manages the network of health care providers for the medical plans. You are automatically covered for prescription drug benefits and vision benefits when you enroll in a medical plan

The prescription drug benefit design is based on the medical plan in which you are enrolled. Medco administers the self-funded prescription drug plan.

The vision benefit design is the same regardless of the plan in which you are enrolled. Vision Service Plan (VSP) administers the self-funded vision plan.

Depending on where you live, there may be state law requirements or mandated coverages for health and welfare plans. If the Company-sponsored plans have to comply with those requirements or mandated coverages, your benefits may vary from the benefits described in this summary plan description. Requirements under the law and the terms of benefits are set forth in the insurance company's certificate of coverage for the insured coverage and in a third party or claims administrator's benefit summary for self-funded coverage. In the event of any conflict between this summary plan description and such certificate of coverage or benefits summary the provisions of such certificate of coverage or benefits summary shall control. You may request a copy of such certificate of coverage or benefit summary by following the steps outlined in the "Administrative Section" of this book.

Your Medical Benefits:

- Offer coverage under one of the Point-of-Service plans for most employees

If you have access to the CIGNA point-of-service network, you can enroll in one of the two Point-of-Service Plans available. The network for the Point-of-Service and the Open Access Plans is available across the state of Tennessee. If you temporarily reside outside of Tennessee and CIGNA has a local point-of-service network available, you may be provided use of that network, and receive in-network benefits. CIGNA has discretion to determine network availability.

- Provide coverage under the Indemnity plan for employees who do not have access to a Point-of-Service network
- Let you waive coverage

You may also choose to waive coverage. If you initially waive coverage, you may enroll during the next Open Enrollment period or when you experience a Qualifying Life Event, as described within the "About Your Benefits" section.

- Provide protection for your family

Eligible Dependents may be eligible for coverage under the same plan in which you are enrolled.

What happens to your benefits when?

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

Point-of-Service Medical Plans

How the Point-of-Service Plans Work

Both Point-of-Service Plans center around a network of physicians, hospitals and other health care providers who have agreed to provide care to patients at prenegotiated rates.

In-network primary care physicians are family or general practitioners, internists, and pediatricians, who contract with CIGNA to provide their services and charge only the contracted fee amount. Primary care physicians are responsible for coordinating all health care and, when necessary, for making referrals to in-network specialists. In-network primary care physicians and specialists also handle all inpatient and outpatient precertification.

Preventive care, like simple health screenings and immunizations, can help prevent or detect serious illnesses early – when they are less expensive to treat and you are more likely to fully recover. Primary care physicians provide a full range of preventive care based on recognized medical guidelines for a person’s age, gender, and personal and family health history. This care includes:

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

With a Point-of-Service Plan, you have a choice – at the “point-of-service” – each time you need health care, to use only in-network providers, or to use providers outside the network and receive less benefits.

Under the Point-of-Service Plan:

- You must select a primary care physician for each covered family member. You or your family may designate any licensed/certified participating primary care provider who is available to accept you or your family member. You have the right to designate for any participant or beneficiary that is a child, a licensed/certified participating pediatrician as a primary care provider.
- Your primary care physician must refer you to a specialist physician in order for you to receive in-network benefits (even in-network physicians). Otherwise, your benefits will be considered at the out-of-network rate. If the specialist refers you to another specialist, that referral must be made by the primary care physician. If you need more visits with the specialist than is approved, the primary care physician must get approval for more visits or the additional charges will be denied and you will have to pay them. Make sure you know how many visits are approved.

- A woman may “self-refer” to a network OB/GYN (Obstetrical/Gynecological). OB/GYN care from a licensed/certified OB/GYN physician does not require prior authorization or referral.
- For mental health/substance abuse care, you must contact the mental health/substance abuse number shown on your ID card. Although your primary care physician may make this call for you if you wish, you do not need a referral from your primary care physician to receive mental health/ alcohol and drug abuse care.
- Emergency (as defined in the Glossary) care does not require a primary care physician referral. However, you will need to call your primary care physician within 48 hours after the emergency to ensure in-network benefits and have your primary care physician coordinate any follow-up care.
- You do not need a referral from a primary care physician to see an optometrist for a routine eye exam.
- You can change a primary care physician by calling CIGNA Member Services at the telephone number on your ID card.

Under the Open Access Plan:

- You are not required to choose a primary care physician.
- If you select a primary care physician, the physician helps you get access to a specialist and handles any required precertification for you. These services may help avoid mistakes that can reduce the amount of benefits you receive.
- For maximum coordination of your medical care, it is recommended that you choose a primary care physician.
- You may see a specialist without a referral from a primary care doctor.

Deductibles, Copayments and Coinsurance

You and your Eligible Dependents may be required to pay a portion of the covered expenses for services and supplies. That portion is the deductible, copayment, or coinsurance:

- **Coinsurance** means the percentage of charges for covered expenses that you are required to pay under the plan.
- **Copayments** and **Deductibles** are those expenses to be paid by you or your Eligible Dependents for the services received.
- Deductible amounts are separate from, and not reduced by, copayments.
- Copayments and deductibles are in addition to any coinsurance.

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

If You Have an Emergency

If you have an Emergency, go to the nearest emergency facility for treatment – even if it is not a network facility. After you pay the copayment required by the plan, the plan pays 100% of the cost of emergency room treatment. The copayment is waived if you are admitted to the hospital from the emergency room.

Someone must contact your primary care physician or CIGNA Member Services within 48 hours of your emergency treatment to ensure that in-network benefits are paid and to arrange for follow-up care.

If you go to the emergency room for a non-emergency, your expenses will not be covered.

If the situation is urgent, but not an emergency, you should contact your primary care physician first and follow his or her directions.

Definitions for "Emergency" and "Urgent Care" can be found in the Glossary.

The Network Credentialing Process

All network doctors – primary care physicians and specialists – must meet certain educational and professional requirements before they are admitted into the network. CIGNA has a regular credentialing process to ensure that the doctors in the network meet certain standards, such as:

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

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

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

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

Special Circumstances

The Point-of-Service Plans have certain provisions that apply to special circumstances. If you have any questions about these situations or others not described here, please contact CIGNA Member Services.

If you need care while traveling outside your network area

You are covered for Emergency care or Urgent Care on an in-network basis, as long as you call your primary care physician or CIGNA Member Services within 48 hours of receiving the emergency or urgent treatment. (If you are traveling outside the U.S. you may wait until you return home to contact your primary care physician. You must file a claim for reimbursement as soon as possible when you return.) For other types of care, call your primary care physician to determine your best options.

If you are on an off-site assignment for more than 90 days

Contact the Benefit Plans Office for information.

Residing in another location

If you or your Eligible Dependents will be residing temporarily in another location where there are in-network providers, you may be eligible for Point-of-Service benefits at that location. If you will be permanently residing outside the Point-of-Service network, refer to the "Indemnity Plan" portion of the "Medical Plan" section and contact the Benefit Plans Office for more information.

Out-of-Network Benefits

When you go out-of-network, you can use any physician or facility you like. After you meet an annual deductible, the plan pays the Reasonable and Customary Charges for most kinds of medically necessary services, until the annual out-of-pocket maximum has been reached, depending on which medical plan option you have selected.

The out-of-pocket maximum protects you from excessive medical costs by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of the Reasonable and Customary Charges for the rest of that year.

You must file claims to be reimbursed for out-of-network expenses. Claim forms are available from CIGNA Member Services or the Benefit Plans Office. If your physician recommends any non-emergency hospitalization or surgery, you are responsible for calling CIGNA Member Services for hospital precertification at least seven days, or as soon as reasonably possible, before you are admitted to the hospital. If you do not call for precertification, your benefit will be reduced by 50%. OB/GYN care does not require precertification or referral.

Reasonable and Customary Charges

Any charges above the Reasonable and Customary Charge are not covered by the plan and you will not be reimbursed for that amount. Also, these amounts will not count toward the deductible or out-of-pocket maximum.

"Reasonable and Customary Charge" is defined in the Glossary.

The Family Deductible

Although the deductible applies separately to each covered family member, the plan contains a provision – called the family deductible – that limits the amount your family pays in deductibles each year.

You can also meet the family deductible with any combination of individual expenses. However, once one family member meets his or her individual deductible, any further expenses incurred by that

person may not be applied to the family deductible. Once the family deductible is met, no other family member needs to meet the deductible for that year.

The Out-of-Pocket Expenses and Your Maximum Expenses

The out-of-pocket expenses are covered expenses incurred for in-network and out-of-network charges for which no payment is provided because of any applicable coinsurance. The out-of-pocket maximum limits the amount you pay for medical expenses in one year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses.

Certain expenses do not count toward the out-of-pocket maximum:

- expenses for substance abuse treatment (under the Open Access Plan)
- non-compliance penalties for not following precertification requirements
- copayments
- deductibles
- charges above Reasonable and Customary Charge
- care that is received but not covered by the plan.

Precertification

Precertification helps ensure that all inpatient and certain outpatient services are medically necessary and, in the case of hospital confinement, that the length of stay is appropriate.

If you stay in-network, you do not have to worry about precertification. Your in-network primary care physician or specialist will handle it for you. But, if you go out-of-network for care, you are responsible for calling CIGNA Member Services at least seven days, or as soon as possible, before you are admitted to the hospital or receive outpatient diagnostic testing or procedures. If you do not call, your benefit will be reduced by 50%. OB/GYN care does not require precertification or referral.

When you call CIGNA Member Services for precertification, you need to provide the following information:

- your name, address and telephone number
- your physician's name and telephone number
- the date of your admission or services
- the reason for your admission or services.

For mental health and substance abuse admissions, whether in-network or out-of-network, you must call the mental health/substance abuse (MH/SA) number listed on your ID card. You do not call CIGNA Member Services.

Mental Health/Alcohol and Substance Abuse Treatment

Under the Point-of-Service Plans, you must have mental health/alcohol and drug abuse treatment reviewed and authorized by calling the mental health/substance abuse (MH/SA) number listed on your ID card.

If you prefer, your primary care physician, local employee assistance program, or your site's Health Services Department can make the call for you. A primary care physician referral is not necessary.

CIGNA Member Services

CIGNA Member Services is a customer service line staffed by experienced and courteous representatives trained to answer your questions and provide information about your Point-of-Service Plan participation and benefits. CIGNA Member Services can help you:

- find out more about in-network primary care physicians, specialists and facilities
- get more information about plan features and procedures
- change primary care physicians
- order replacement ID cards
- register comments about network providers and services
- request out-of-network claim forms.

In addition to Member Services:

You may locate participating providers in your CIGNA network by accessing www.cigna.com. Click on the "Provider Directory" link and follow the instructions for locating providers in your area.

As a CIGNA member, you have access to your benefit information through your own personalized CIGNA website – www.mycigna.com. There you can:

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

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

Contacting CIGNA Member Services

For Open Access and Point-of-Service Plans
1-800-CIGNA24 (1-800-244-6224)

Refer to your ID card for the Mental Health/Substance Abuse phone number.

Summary of Benefits: Point-of-Service Plan

	In-Network	Out-of-Network*
Annual Deductible Amount for injury, illness, or maternity	None	\$200/individual \$400/family
Out-of-Pocket Annual Limit (excludes deductible)	\$1,000/individual \$2,000/family	\$3,000/individual \$6,000/family
Pre-Existing Conditions	n/a	n/a
Maximum Lifetime Benefit	Unlimited	Unlimited
Laboratory and X-ray All charges billed by an independent facility	Covered 100%	Covered 80% of R&C* after deductible
Home Health Care (skilled visits only) – 60 days per calendar year, in-network and out-of-network combined Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less. (e.g. maximum of 8 visits per day)	Covered 100%	Covered 80% of R&C* after deductible
Durable Medical Equipment Rental will be evaluated to determine whether to purchase or rent, if medically necessary. Evaluated at least every 6 months.	Covered 100%*	Not covered
External Prosthetic Devices – Excludes orthotics. Requires approval by Health Plan (External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splits.) (Limited to most appropriate and cost effective alternative as determined by the utilization review physician. Covers initial purchase and fitting of any physician ordered or prescribed external prosthetic devices which are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of sickness, injury, or congenital defects).	Covered 100% after \$200 deductible*	Not covered

*R&C — Reasonable and Customary Charges in the geographic area for similar services

Point-of-Service: Hospital Care

	In-Network	Out-of-Network*
Inpatient Services: Semi-private room, Operating room, X-ray, and laboratory services. Includes stand-alone facilities such as Birthing Center	Covered 100%, no copayment	Covered 80% of R&C* after deductible
Outpatient Services:		
• Outpatient surgery. Operating, Recovery, Procedure and Treatment room	Covered 100%	Covered 80% of R&C* after deductible
• Physician's Office	Covered 100% after \$10 office visit copayment per visit	Covered 80% of R&C* after deductible
Organ Transplant Coverage:		
• Inpatient Facility	Covered 100% at approved facilities	Not covered
• Travel Benefit	\$10,000 per transplant per lifetime available when using an approved facility	Not covered

	In-Network	Out-of-Network*
Emergency Room Services (not covered if not true Emergency)	Covered 100% after \$50 copayment (waived if admitted)	Covered 100% after \$50 copayment (waived if admitted)
Ambulance Services (not covered if not true Emergency)	Covered 100%*	Covered 100%
Urgent Care Facility (not covered if not true Emergency)	Covered 100% after \$25 copayment	Covered 100% after \$25 copayment
Inpatient Mental Health	Covered 100%*	Covered 80% of R&C* after deductible
Inpatient Substance Abuse	Covered 100%*	Covered 80% of R&C* after deductible

*R&C — Reasonable and Customary Charges in the geographic area for similar services

Point-of-Service: Physician Care

Services Covered	In-Network	Out-of-Network*
Maternity – Inpatient	Covered 100%	Covered 80% of R&C * after deductible
Skilled Nursing Facility 60 days per calendar year for in-network and out-of-network combined	Covered 100%	Covered 80% of R&C* after deductible, pre-certification applies
Hospice Care (inpatient and outpatient)	Covered 100%, no copayment	Covered 80% of R&C* after deductible
Outpatient (short-term) Rehabilitation – 20 visits per calendar year, in-network and out-of-network combined. Includes cardiac, physical, speech, cardiac occupational, pulmonary, and cognitive therapy.	Covered 100% after \$10 copayment	Covered 80% of R&C* after deductible
Primary Care or Specialist Office Visit	Covered 100% after \$10 copayment	Covered 80% of R&C* after deductible
Physician and Surgeon Services in Hospital	Covered 100%	Covered 80% of R&C* after deductible
Maternity Office Visits	Covered 100% after one-time \$10 office visit copayment	Covered 80% of R&C after deductible
Maternity Delivery (Physician charges)	Covered 100%	Covered 80% of R&C* after deductible
Preventive Health Services:		
• Well-Baby Care	Covered 100% after \$10 copayment (including immunizations)	Not covered
• Periodic Health Assessments	Covered 100% after \$10 copayment	Not covered
• Routine Gynecological Exams	Covered 100% after \$10 copayment	Not covered
• Routine Mammogram	No charge (no referral needed)	Covered 80% of R&C* after deductible
• Hearing Aid Benefits	Not covered	Not covered

Services Covered	In-Network	Out-of-Network*
Chiropractic Care (when medically appropriate) — 25 visit limit per year	Covered 100% after \$10 copayment per visit (no referral needed)	Not covered
Outpatient Substance Abuse	\$10 copayment per visit	Covered 80% R&C* after deductible
Outpatient Mental Health Service	\$10 copayment per visit	Covered 80% of R&C* after deductible
Physician Services in Emergency Room	Covered 100%	Covered 100%
Infertility Treatment: Services not covered include: <ul style="list-style-type: none"> • Physician office visits, tests, counseling to determine cause, or to restore infertility condition • Treatment includes procedures for correction of infertility by surgical or artificial means (for example: invitro fertilization, artificial insemination, GIFT, ZIFT, etc.). 	Not covered	Not covered

*R&C — Reasonable and Customary Charges in the geographic area for similar services

Point-of-Service: Prescription Drugs

Pharmacy benefits for the CIGNA POS medical plan are administered by Medco.

Certain drugs may require a prior authorization in order to receive (or continue to receive) the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, you may refer to the Medco website at www.medco.com, or contact Medco at 1-800-685-8869.

Services Covered	In-Network	Out-of-Network & Direct Claims
Retail Pharmacy (up to 30-day supply)	Generic: 100% after \$5 copayment Preferred Brand: 100% after \$15 copayment Non-Preferred Brand: 100% after \$35 copayment	Covered 80% after \$200 deductible
Mail Order – Home Delivery (up to 90-day supply)	Generic: 100% after \$15 copayment Preferred Brand: 100% after \$45 copayment Non-Preferred Brand: 100% after \$105 copayment	Not covered

Vision Benefit Summary - see Vision section.

Summary of Benefits: Open Access Plan

	In-Network	Out-of-Network*
Annual Deductible Amount for injury, illness, or maternity	\$300/individual \$600/family	\$500/individual \$1,000/family
Out-of-Pocket Annual Limit (excludes deductible)	\$1,500/individual \$3,000/family	\$4,500/individual \$9,000/family
Pre-Existing Conditions	n/a	n/a
Maximum Lifetime Benefit (in-network and out-of-network combined)	Unlimited	Unlimited
Outpatient Short-Term Rehabilitation – 180 visits per year for all conditions, in-network and out-of-network combined. Includes cardiac, physical, speech, occupational, pulmonary, and cognitive therapy.	Covered 100%	Covered 60% of R&C* after deductible
Outpatient laboratory and X-ray All charges billed by an independent facility	Covered 100%	Covered 60% of R&C* after deductible
Home Health Care (skilled visits only) Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day)	Covered 100%; unlimited days	Covered 60% of R&C* after deductible for up to 60 days per calendar year, reduced by any in-network days
Durable Medical Equipment (Rental will be evaluated to determine whether to purchase or rent, if medically necessary. Evaluated at least every 6 months.)	Covered 100%*	Covered 60% of R&C* after deductible
External Prosthetic Devices – Excludes orthotics Requires approval by Health Plan (External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splits.) (Limited to most appropriate and cost effective alternative as determined by the utilization review physician. Covers initial purchase and fitting of any physician ordered or prescribed external prosthetic devices which are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of sickness, injury, or congenital defects.) R&C* applies.	Covered 90% after deductible and \$100 copay per appliance	Covered 60% of R&C* after plan deductible

*R&C — Reasonable and Customary Charges in the geographic area for similar services

Open Access: Hospital Care

Services Covered	In-Network	Out-of-Network*
Inpatient Services: semi-private room, operating room, X-ray, and laboratory services. Includes stand-alone facilities such as Birthing Center.	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Outpatient Services: Outpatient surgery, Operating, Recovery, Procedure, and Treatment Room.	Covered 90% after deductible and \$150 copayment per visit	Covered 60% of R&C* after deductible and \$300 copayment per visit
Organ Transplant Coverage:		
• Inpatient Facility	Covered 90% after deductible and \$250 copayment at approved facilities	Covered 60% of R&C* after deductible and \$500 copayment per admission

Services Covered	In-Network	Out-of-Network*
<ul style="list-style-type: none"> Travel Benefit 	\$10,000 per transplant per lifetime available when using an approved facility	Not covered
Emergency Room Services	Covered 100% after \$100 copayment (waived if admitted)	Covered 100% after \$100 copayment (waived if admitted)
Ambulance Services (not covered if not true emergency)	Covered 100%*	Covered 100%
Urgent Care Facility	Covered 100% after \$50 copayment	Covered 100% after \$50 copayment
Inpatient Mental Health	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Inpatient Alcohol and Drug Abuse	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Maternity – Inpatient	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Inpatient Services at other healthcare facilities: <ul style="list-style-type: none"> Includes Skilled Nursing Facility, Rehabilitation Hospital and Subacute facility 60 days per calendar year for in-network and out-of-network combined 	Covered 90% after deductible	Covered 60% of R&C* after deductible
Hospice Care:		
<ul style="list-style-type: none"> Inpatient 	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
<ul style="list-style-type: none"> Outpatient 	Covered 100%, no copayment	Covered 60% of R&C* after deductible

*R&C—Reasonable and Customary charges in the geographic area for similar services.

Open Access: Physician Care

Services Covered	In-Network	Out-of-Network*
Primary Care office visit	Covered 100% after \$15 copayment	Covered 60% of R&C after deductible
Specialist office visit	Covered 100% after \$30 copayment	Covered 60% of R&C after deductible
Physician and Surgeon services in hospital	Covered 90% after plan deductible	Covered 60% of R&C* after deductible
Maternity office visits	Covered 100% after one-time office visit copayment	Covered 60% of R&C* after deductible
Maternity Delivery (physician charges)	Covered 90% after plan deductible	Covered 60% of R&C* after deductible

Services Covered	In-Network	Out-of-Network*
Preventive Health Services:		
• Well-baby Care	Covered 100% after \$15 copayment (includes immunizations)	Not covered
• Routine Physical exam	Covered 100% after \$15 primary care office copayment.	Not covered
• Routine Gynecological exams	Depends on how doctor is contracted: If Primary Care: \$15 copayment If Specialist: \$30 copayment	Not covered
• Routine Mammogram	Covered at 100% (no referral needed)	Covered 60% of R&C* after deductible
• Hearing Aid benefits	\$750 maximum every 36 months	Not covered
• Hearing Exam	\$30 copayment per visit	Not covered
Chiropractic Care when medically appropriate 25 visits per year	Covered 100% after \$30 copayment	Not covered
Substance Abuse — Outpatient	\$30 copayment per visit	Covered 60% R&C* after deductible
Mental Health — Outpatient	\$30 copayment per visit	Covered 60% of R&C* after deductible
Physician Services in Emergency Room	Covered 100%	Covered 100%
<p>Infertility Treatment:</p> <p>Coverage will be provided for:</p> <ul style="list-style-type: none"> • Testing and treatment in connection with an underlying medical condition. • Testing specifically to determine the cause of infertility. • Treatment specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial insemination, In-vitro, GIFT, ZIFT, etc. <p>If any infertility procedures result in a successful birth, no further benefits are available.</p> <p>\$20,000 lifetime maximum.</p>	<ul style="list-style-type: none"> • \$30 copay per office visit • Inpatient facility: 90% after \$250 per admission copay and deductible • Inpatient physician: 90% after plan deductible • Outpatient facility: 90% after \$150 per visit copay and deductible 	<ul style="list-style-type: none"> • 60% of R&C* after deductible • 60% after \$500 per admission and plan deductible • 60% after deductible • 60% after \$300 per visit and plan deductible

*R&C—Reasonable and Customary Charges in the geographic area for similar services

Prescription Drugs Benefit Summary for Open Access Plan

Pharmacy benefits for: Open Access Plan administered by Medco.

Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization you may refer to the Medco website at www.medco.com, or contact Medco Member Services at 1-800-685-8869.

Services Covered	In-Network	Out-of-Network*
Retail Prescription Drugs – up to a 30-day supply	\$150 deductible Then: <ul style="list-style-type: none"> • Generic: 20% (minimum \$10 copayment) • Brand: 30% (minimum \$10 copayment) • If actual cost is under \$10, then you pay actual cost 	50% of cost after \$150 deductible
Mail Order – Home Delivery up to 90-day supply	<ul style="list-style-type: none"> • Generic: \$15 copayment • Brand: \$35 copayment 	Not covered

*R&C — Reasonable and Customary Charges in the geographic area for similar services

Vision Benefit Summary - see Vision section.

Contacting CIGNA Member Services

For medical precertification, questions, or concerns:
 1-800-CIGNA24 (1-800-244-6224)
This telephone number is also listed on your ID card.

CIGNA Indemnity Plan

If you do not have access to the network providers in the Point-of-Service (POS) or POS Open Access Plan network, coverage may be available under the CIGNA Indemnity Plan benefits. Benefit Plans and CIGNA will make the determination if this coverage is applicable to you and your dependents.

How the Indemnity Plan Works

Under the Indemnity Plan, you may receive care from any provider you choose. After you meet your annual deductible, the plan pays 80% of Reasonable and Customary Charges for medically necessary services and supplies until you reach the annual out-of-pocket maximum.

The out-of-pocket maximum protects you from excessive medical costs by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of Reasonable and Customary Charges for eligible medical expenses for the rest of that year.

You must file claims to be reimbursed for your eligible expenses. Claim forms are available from the Benefit Plans Office or CIGNA Member Services.

You must also call CIGNA Member Services to precertify any nonemergency hospitalization or outpatient diagnostic test or procedure. If you do not call, your benefit will be subject to a penalty.

Reasonable and Customary Charges

All Indemnity Plan benefit payments are subject to Reasonable and Customary Charges. Any charges above Reasonable and Customary Charges are not covered by the plan, and you will not be reimbursed for them. Also, these amounts will not count toward the deductible or out-of-pocket maximum.

See the Glossary for a definition of "Reasonable and Customary Charge."

The Family Deductible

Although the deductible applies separately to each covered family member, the plan contains a provision called the family deductible that limits the total amount you pay in deductibles each year.

You can meet the family deductible with any combination of individual expenses. However, once one family member meets his or her individual deductible, any further expenses incurred by that person may not be applied to the family deductible. Once the family deductible is met, no other family member needs to meet the deductible for that year.

The Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay for medical expenses in one year.

Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses. Certain expenses do not count toward the out-of-pocket maximum:

- expenses for substance abuse treatment
- non-compliance penalties for not following precertification requirements
- charges above Reasonable and Customary Charges
- care that is received but not covered by the plan.

Second Surgical Opinion

Second surgical opinions are not mandatory, but are covered by the plan with certain limitations. If your physician recommends surgery, the plan pays 100% of the Reasonable and Customary Charge for a second surgical opinion, with no deductible. If additional opinions are necessary, they will be covered at 80% of Reasonable and Customary Charges.

Preadmission and Post-Confinement Testing

The plan pays 100% of the cost of preadmission and post-release testing performed on an outpatient basis within 14 days before a scheduled admission, or within 14 days after you leave the hospital, provided the testing is related to your surgery.

If the preadmission tests are performed and your admission is later cancelled, or if the tests are duplicated while you are in the hospital, the plan will pay 80% of Reasonable and Customary Charges for the tests, after you meet the deductible.

Mental Health/Alcohol and Substance Abuse Treatment

After you meet the deductible, the Indemnity Plan pays 80% of Reasonable and Customary Charges for mental health/alcohol and drug abuse treatment, up to the limits described in the chart on the following pages. Inpatient care must be precertified by contacting the mental health/substance abuse (MH/SA) number shown on your ID card.

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

Summary of Benefits: CIGNA Indemnity Plan

Calendar year deductible amount for injury, illness or maternity	\$400 per person \$800 per family
Out-of-Pocket annual limit (includes deductible) Does not apply to: Non-Compliance penalties and charges in excess of Reasonable and Customary.	\$2,000 per person \$4,000 per family
Pre-Existing Conditions	n/a
Maximum Lifetime Benefit	unlimited

Indemnity Plan: Hospital Care

Inpatient Services: semi-private room, operating room, X-ray, laboratory services, and Physician visits/consultations	Covered 80% of R&C* after deductible
Outpatient Services: <ul style="list-style-type: none"> • Physician’s office • Outpatient surgery, Operating, Recovery, Procedure, and Treatment room • Outpatient professional services – Surgeon, Radiologist, Pathologist, Anesthesiologist • X-ray and Laboratory services 	Covered 80% of R&C* after deductible
Organ Transplant Coverage: <ul style="list-style-type: none"> • Medically appropriate • Non-experimental • Inpatient and physician services 	Covered 80% of R&C* after deductible Travel services maximum only at a LifeSource Facility: \$10,000 per lifetime

Multiple Surgical Reductions	Multiple surgeries performed during one operating session will result in payment reduction of 50% of charges to the surgery of lesser charges. The most expensive procedure is paid as any other surgery.
Emergency Room	Covered 80% of R&C* after deductible
Inpatient Mental Health	Covered 80% of R&C* after deductible
Inpatient Substance Abuse	Covered 80% of R&C* after deductible
Maternity – Inpatient	Covered 80% of R&C after deductible
Inpatient services at other health care facilities: Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	Covered 100% of R&C* Up to 60 days confinement per calendar year maximum
Ambulance Services	Covered 80% of R&C* after deductible
Outpatient short-term rehabilitation. Includes Cardiac, Physical, Speech, Occupational, Pulmonary, and Cognitive Therapy Contract year maximum is unlimited	Covered 80% of R&C* after deductible Therapy days, provided as part of an approved Home Health Care Plan, accumulate to the Outpatient Short Term Rehab maximum. If multiple outpatient services are provided on the same day, they constitute one day, but a separate copy will apply to the services provided by each participating provider.

Indemnity Plan: Physician Care

Physician Office Visit: <ul style="list-style-type: none">• Primary Care and Specialist• Surgery performed in the physician's office• Allergy Treatment/Injections• Maternity office visits	Covered 80% of R&C* after deductible
Chiropractic Care	Covered 80% of R&C* after deductible 25 visit limit per year
Emergency or Urgent Care at doctor's office	Covered 100% of R&C*
Urgent Care Facility	Covered 80% of R&C* after deductible
Physician and Surgeon Services in hospital	Covered 80% of R&C* after deductible
Allergy Serum (dispensed by the physician in the office)	Covered 80%* no deductible
Maternity Delivery (physician charges)	Covered 80% of R&C* after deductible
Preventive Health Services: <ul style="list-style-type: none">• Well-Child Care for children to age 3 (including immunizations)• Annual routine physicals, adult immunizations, Well Woman Care• Mammogram, Pap test, or Prostate Specific Antigen Test (PSA)	100% of R&C*
Hearing Aid Benefits	Not Covered

Laboratory, X-ray, Radiology (MRIs, MRAs, CAT Scans and PET scans)	Covered 80% of R&C* after deductible if billed by a separate outpatient diagnostic or independent facility (such as a hospital)
Home Health Care: (skilled care only) Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. Maximum of 8 visits per day).	Covered 100% of R&C*, no deductible Up to 60 days per calendar year maximum
Hospice Care: <ul style="list-style-type: none"> • Diagnosed as having up to 6 months to live • Inpatient Services • Outpatient Services • Bereavement Counseling (excludes services by Mental Health Professional) 	Covered 80% of R&C* after deductible, maximum 60 days per lifetime.
Substance Abuse: <ul style="list-style-type: none"> • Outpatient • Inpatient • Physician Office • Outpatient Facility 	Covered 80% of R&C* after deductible
Mental Health Service: <ul style="list-style-type: none"> • Outpatient • Inpatient • Physician Office • Outpatient Facility 	Covered 80% of R&C* after deductible,
Physician Services in Emergency Room	Covered 80% of R&C* after deductible
Durable Medical Equipment	Covered 80% of R&C* after deductible
Infertility Treatment: <ul style="list-style-type: none"> • Artificial insemination is subject to 3 attempts per menstrual cycle with a maximum of 8 cycles per lifetime. Total attempts is 24per lifetime. Includes tests and counseling. • In Vitro fertilization, GIFT and ZIFT is subject to a separate lifetime maximum of 4 attempts. Includes tests and counseling. 	Covered 80% of R&C* after deductible If any infertility procedures result in a successful birth, no further benefits are available.
External Prosthetic Devices - Requires approval by Health Plan (External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints). Excludes orthotics.	Covered 80% of R&C* after deductible
Dental Care – Limited to charges for a continuous course of dental treatment started within six months of an injury to sound, natural teeth <ul style="list-style-type: none"> • Physician's Office/Services • Inpatient Facility • Outpatient Surgical Facility 	Covered 80% after the deductible

Temporomandibular Joint Disorder (surgical & non-surgical treatment): <ul style="list-style-type: none"> • Physician's Office/Services • Inpatient Facility • Outpatient Surgical Facility 	Covered 80% of R&C* after deductible
Chemotherapy & Radiotherapy	<ul style="list-style-type: none"> • Inpatient services covered 80% of R&C* after deductible • Outpatient services covered 100% of R&C*

*R&C — Reasonable and Customary Charges in the geographic area for similar services

Prescription Drug Benefit Summary for Indemnity Plan

Pharmacy benefit for: Indemnity Plan administered by Medco.

Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, you may refer to the Medco website at www.medco.com, or contact Medco at 1-800-685-8869.

Retail Prescription Drugs – up to a 30-day supply	\$150 deductible Then: <ul style="list-style-type: none"> • Generic: 20% (minimum \$10 copayment) • Brand: 30% (minimum \$10 copayment) • If actual cost is under \$10, then you pay actual cost 	50% of cost after \$150 deductible
Mail Order – Home Delivery Up to 90-day supply	<ul style="list-style-type: none"> • Generic: \$15 copayment • Brand: \$35 copayment 	Not covered

Vision Benefit Summary - see Vision section.

Important Telephone Numbers

For questions on eligibility, plan benefits, claims or certification:
1-800-CIGNA24 (1-800-244-6224)

For Mental Health/Substance Abuse (MH/SA):
1-800-274-4573

These telephone numbers are also listed on your ID card.

Information for All Medical Plans

Certification Requirements

For all medical plans, all inpatient hospital admissions, outpatient diagnostic tests and outpatient procedures must be reviewed to certify the medical necessity of the admission, test or procedure. OB/GYN does not require precertification or referral.

For the Point-of-Service Plans, if you are using an in-network physician for care, the in-network physician is responsible for contacting CIGNA to certify the admission, test or procedure. If you are using an out-of-network physician, you are responsible for requesting certification. If you are using an out-of-network physician and you do not obtain approval through certification, penalties will apply.

For the Indemnity Plan, you are responsible for requesting certification. If you do not obtain approval through certification, penalties will apply.

For certification, call Member Services at 1-800-244-6224.

Preadmission Certification/ Continued Stay Review for Hospital Confinement

Preadmission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of a hospital confinement when you or your Eligible Dependent requires treatment in a hospital:

- as a registered bed patient
- for a partial hospitalization for the treatment of mental health or substance abuse
- for mental health or substance abuse residential treatment services.

PAC should be requested prior to any nonemergency treatment in a hospital described above. In the case of an emergency admission, the Review Organization should be contacted within 48 hours after the admission. For an admission due to pregnancy, the Review Organization should be contacted by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued hospital confinement.

Covered expenses incurred will be reduced for hospital charges made for each separate admission to the hospital unless PAC is received prior to the date of admission, or in the case of an emergency admission, within 48 hours after the date of admission.

Covered expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- hospital charges for bed and board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR
- any hospital charges for treatment listed above for which PAC was requested, but which was not certified as medically necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which CIGNA has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements

Outpatient Certification refers to the process used to certify the medical necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a free-standing surgical facility, other health care facility or a physician's office. The toll-free number on the back of your ID card should be called to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures.

Outpatient Certification is performed through a utilization review program by a Review Organization with which CIGNA has contracted. Outpatient Certification should be only requested for nonemergency procedures or services, and should be requested at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered expenses incurred will be reduced for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as medically necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Diagnostic tests and outpatient procedures that require certification include, but are not limited to advanced radiological imaging – CT scans, MRI, MRA, or PET scans; and hysterectomy.

Prior Authorization/Pre-Authorized/Precertification

These terms mean the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require prior review and approval include, but are not limited to:

- inpatient hospital services
- inpatient services at any participating other health care facility
- residential treatment
- outpatient facility services

- advanced radiological imaging
- nonemergency ambulance
- transplant services.

Emergency Hospitalization

If you have a medical emergency and are admitted to the hospital, someone must call for precertification within two days of your admission or on the first business day following your admission, if later.

For precertification call:

CIGNA Member Services (1-800-244-6224)

Expenses Not Covered and General Limitations

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

- expenses for supplies, care, treatment, or surgery that are not medically necessary
- to the extent that you or any one of your Eligible Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- to the extent that payment is unlawful where the person resides when the expenses are incurred
- charges made by a hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected injury or sickness
- for or in connection with an injury or sickness which is due to war, declared or undeclared
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services (as defined and determined by CIGNA and/or the Institutional Review Board, the Food and Drug Administration).
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance
- macromastia or gynecomastia surgeries; surgical treatment of varicose veins
- Regardless of clinical indication for: abdominoplasty/panniculectomy;

- rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:
 - charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth
 - charges made by a hospital for bed and board or necessary services and supplies
 - charges made by a free-standing surgical facility or the outpatient department of a hospital in connection with surgery
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision
- excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to restrict food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejuna bypass
- unless otherwise covered by the plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this plan
- infertility services except as provided by the plan including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage
- reversal of male or female voluntary sterilization procedures
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation – except as provided by the plan
- medical and hospital care and costs for the infant child of an Eligible Dependent, unless this infant child is otherwise eligible under this plan

- nonmedical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected
- consumable medical supplies other than ostomy supplies and urinary catheters, except as provided by the plan
- private hospital rooms and/or private duty nursing unless determined by the utilization review physician to be medically necessary
- personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an injury or sickness
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs
- hearing aids, except as provided by the plan, including but not limited to semi-implantable hearing devices, audiant bone conductors and bone anchored hearing aids (BAHAs). A hearing aid is any device that amplifies sound
- aids or devices that assist with nonverbal communications
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that covered expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- treatment by acupuncture
- all non-injectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the plan
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease

- dental implants for any condition
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- blood administration for the purpose of general improvement in physical condition
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
- cosmetics, dietary supplements and health and beauty aids
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism and professional medical services under the supervision of a physician and special dietary formulas medically necessary for therapeutic treatment of PKU
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider
- medical treatment when payment is denied by a primary plan because treatment was received from a nonparticipating provider
- for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit (including workers compensation).
- telephone, e-mail, and Internet consultations, and telemedicine
- massage therapy
- for charges which would not have been made if the person had no insurance
- to the extent that charges are more than Reasonable and Customary Charges
- expenses incurred outside the United States, unless you or your Eligible Dependent is a U.S resident and the charges are incurred while traveling on business or for pleasure
- charges made by any covered provider who is a member of your family or your Eligible Dependent's family
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Filing Claims

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

To file a claim for out-of-network treatment under the Point-of-Service Plans or for any treatment under the Indemnity Plan, you must complete a claim form and send it to CIGNA within 90 days after the plan year in which services have been rendered. Be sure to:

- include the account number listed on your ID card
- use a separate form for each covered dependent
- indicate whether you would like reimbursement of a payment you have made sent to you. Otherwise, it will be sent to the provider.

You can either attach itemized bills or have your physician complete the physician's section of the form. Either way, the following information must be provided:

- patient's full name, date of birth and relationship to you
- physician's full name, address and tax identification number
- diagnosis code
- date and charge for each service.

Claims forms can be obtained from CIGNA Member Services or the Benefit Plans Office.

Coordination of Benefits

If you or any of your Eligible Dependents are covered under another medical plan, CIGNA determines how benefits from all such plans will be coordinated, as described in the plan document that governs the company plan under which you are covered (refer to the "Administrative Information" section in this book on how to obtain a plan document).

Medicare Eligible

Benefits will also be coordinated with benefits you or a covered dependent receives or is eligible to receive under Part A and Part B of Medicare in accordance with Medicare Secondary Payor rules. This means that your plan benefit will be reduced to account for Medicare benefits you are eligible to receive – whether you are enrolled or not.

It is your and/or your eligible dependents obligation to determine the earliest date any coverage under Medicare could become effective for yourself/your dependent. Contact the Social Security Office and Medicare for assistance. These plans will pay as secondary to Medicare as permitted by law – whether you are enrolled in Medicare or not – including such Medicare eligibility due to age, disability, or End Stage Renal Disease after that person has been eligible for Medicare 30 months.

Company Right to Reimbursement (Subrogation)

If you or a covered dependent receives benefits for a covered expense and then collects payment for the same expense from a third party by settlement, judgment or otherwise, you or your dependent must reimburse the Company for the amount of benefits paid by the plan or the amount received from the third party, whichever is less. This is called "subrogation."

The plan is also granted a right of reimbursement of any recovery, whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and exclusive of the subrogation right granted under subrogation, but only to the extent of the benefits provided by the plan.

As a condition of participation in the medical plan, you and your covered Eligible Dependents agree to cooperate with the plan fully to permit the plan to recover the amounts it has paid or will pay on you or your covered Eligible Dependents' behalf for an injury caused by a third party, but not more than these amounts. You or your covered Eligible Dependent may keep the portion of any recovery from or settlement with the third party or its insurer for your out-of-pocket medical expenses not covered by the plan such as copayments and deductibles, and your reasonable attorney's fees to obtain the recovery. The plan is entitled to recover these amounts regardless of whether the recovery is designated as compensation for medical expenses. It is your responsibility to notify the Plan Administrator when you or your covered dependent may have an injury which may entitle the plan to assert subrogation rights.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, 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 may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Insurance After Age 65 – During Active Service

If you continue working after age 65, you have the right to make one of the following elections:

- **Continue primary coverage under the Company medical plan.** In this case, the plan will pay benefits first. If your claim is for an item or service that is also covered by Medicare, you may receive all or part of the unpaid balance of the claim, up to Medicare limitation.
- **Elect primary coverage under Medicare.** In this case, Medicare will pay your medical claims. If you elect primary coverage under Medicare, you must, under the law, cancel your coverage under the Company plan.

Continuation of Medical Coverage (COBRA)

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

Proof of Prior Coverage

After your coverage terminates, a certificate of health insurance coverage will automatically be provided and mailed to your last known address within a reasonable period of time. If applicable, another certificate will be provided after the COBRA continuation coverage ends. In addition, you may request another certificate within 24 months after coverage terminates.

Certificate of Creditable Coverage

Upon loss of coverage under these Plans, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your Eligible Dependent may also request, without charge, a Certificate of Creditable Coverage, at any time while enrolled in the Plan; and for 24 months following termination of coverage.

Health Insurance Portability and Accountability Act

If you or your Eligible Dependent experiences a special enrollment event, you or your Eligible Dependent may be entitled to enroll in one of these plans outside of a designated Open Enrollment period. If you are already enrolled, you may request enrollment for you and your Eligible Dependent under any of these plans for which you are eligible. You must request special enrollment within 30 days of the qualifying event. The special enrollment events may include:

- acquiring a new dependent
- loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP)
- loss of eligibility for other coverage, including COBRA exhaustion
- termination of active employee employer contributions

Coverage for Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the health plan will comply with coverage requirements by the Women's Health and Cancer Rights Act, to include:

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

This coverage must be the same as for any other benefit under the plan.

Genetic Non-Discrimination Act (GINA)

In accordance with GINA, in no event will the group health plan discriminate against any participant on the basis of genetic information with respect to eligibility, premiums, or contributions.

Conversion Privileges

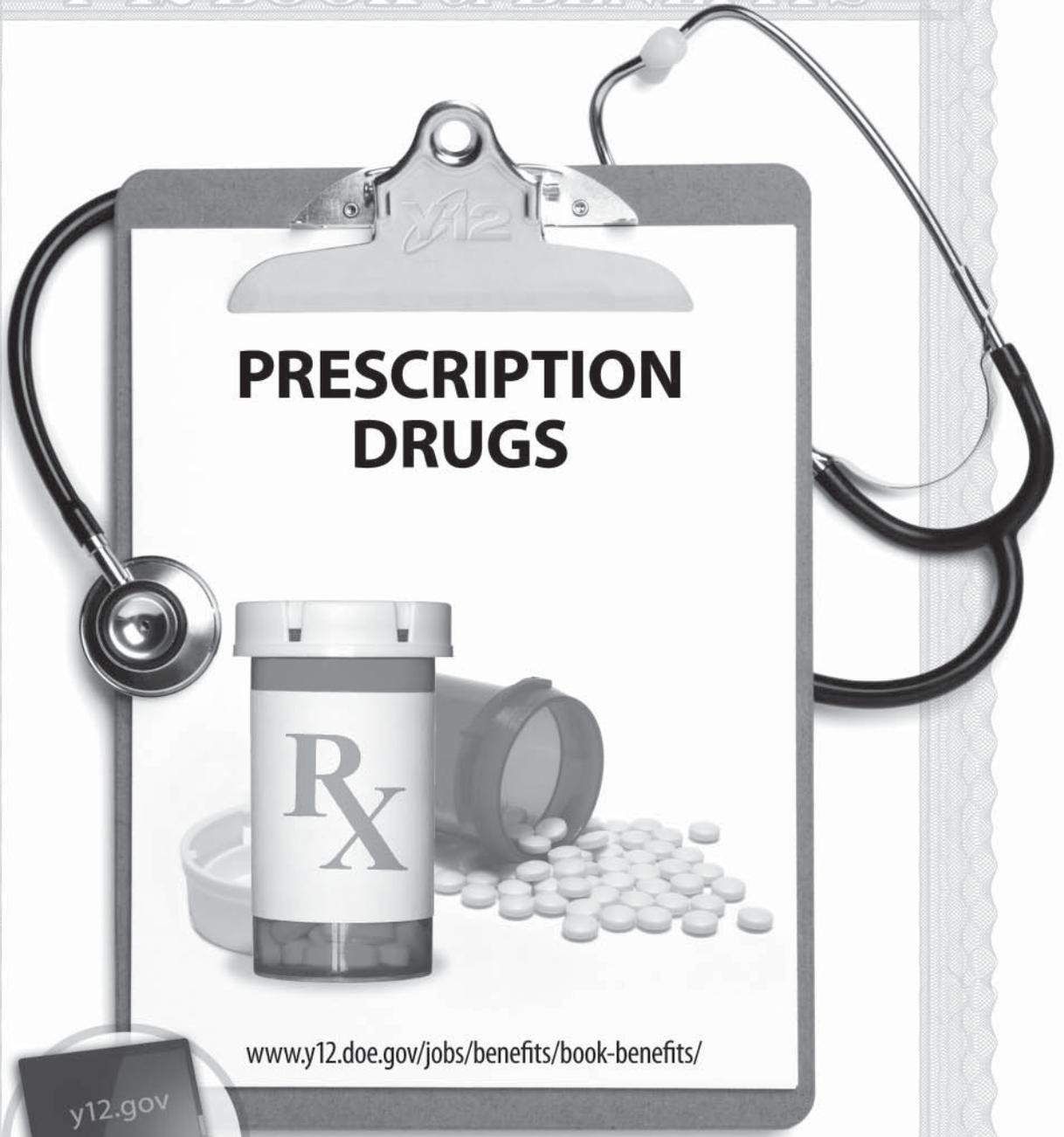
You may convert your coverage to an individual policy within 30 days after plan coverage terminates or during the final 180 days of continued contributory COBRA coverage (see the "Administrative Information" section), without taking a medical examination.

To convert your coverage, you must submit the appropriate form to the insurance company. Your cost for this coverage will be based on the insurance company's regular premium rates for the type of

coverage you elect. Your coverage may differ from the coverage provided under this plan.

Conversion of plan coverage is also available to your Eligible Dependents if you die or if your Eligible Dependents no longer meet the plan's eligibility requirements. Your spouse may also convert coverage in the case of divorce or annulment.

Call CIGNA Member Services at 1-800-CIGNA24 (1-800-244-6224) to obtain forms and instructions for converting coverage to an individual policy.



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YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

PRESCRIPTION DRUGS

The self-funded prescription drug plan is administered by Medco, who also administers and manages the network of pharmacies. Your out-of-pocket costs will be higher if you fill your prescription at a pharmacy that is not in the Medco pharmacy network.

The Medco mail order pharmacy offers a convenient way for you to save money on medication you need on an on-going basis. You can order up to a 90-day supply of a drug at mail order. Order forms are available on the www.medco.com website after you register on the site as a plan participant. You need to mail the completed form with your prescription to Medco. You may also ask your doctor to fax the prescription to Medco. You can register on the Medco website to request refills, or call Medco Customer Service.

Mail: Medco
P. O. Box 650322
Dallas, TX 75265-0322

Fax: Your doctor may fax your prescription to Medco by calling 1-888-327-9791.

Refills: www.medco.com or call 1-800-473-3455. Have your ID card and your refill bottle with the prescription information ready.

Your Prescription Drug Benefits:

There are two prescription drug benefit designs. The design available to you is based on the medical plan in which you are enrolled – the **Point-of-Service**, the **Open Access**, or the **Indemnity Plan**. The prescription design with the Point-of-Service Plan has a 3-tier design structure, and is the same for the retail network or mail pharmacy. The design with the Open Access Plan or the Indemnity Plan is different at retail versus mail order. Regardless of the benefit design that is applicable to your coverage, you can get up to a 30-day supply at a retail network pharmacy, and a 90-day supply at the mail order pharmacy.

When you fill a prescription at a non-network pharmacy, or file a direct claim, you pay a deductible plus a percentage co-insurance, as stated in the Benefit summary table below.

Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization you may refer to the Medco website at www.medco.com or contact Medco Member Services at 1-800-685-8869.

A group health may limit or exclude coverage for specific diseases or for specific treatments or drugs. However, any restriction must apply uniformly to all similarly situated individuals and not be directed at individuals based on health factor. For example, prescription drug benefits may be limited to generics, a formulary list, require prior authorization, or deny coverage, and manage cost and quality of care issues. A number of clinical programs are offered by Medco to promote appropriate utilization of drug therapy. All of these programs have been implemented to assist in controlling costs and providing coverage that is clinically appropriate and consistent with the plan's intent. The programs and coverage criteria are subject to change.

The Company reserves the right to amend, terminate, or require cost and utilization management programs, or change the prescription drug plan features to any degree. You will be notified of such changes.

Refer to the "Administrative Information" section for your rights to review and appeal claims decisions.

Summary of Benefits: Prescription Drugs

Prescription Drug Benefit Summary for Point-of-Service Plan

Services Covered	In-Network	Out-of-Network
Retail Pharmacy (up to 30-day supply)	Generic: 100% after \$5 copayment Preferred Brand: 100% after \$15 copayment Non-Preferred Brand: 100% after \$35 copayment	Covered 80% after \$200 deductible
Mail Order – Home Delivery (up to 90-day supply)	Generic: 100% after \$15 copayment Preferred Brand: 100% after \$45 copayment Non-Preferred Brand: 100% after \$105 copayment	Not covered

Prescription Drugs Benefit Summary for Open Access and Indemnity Plans

Services Covered	In-Network	Out-of-Network
Retail Prescription Drugs (up to 30-day supply)	\$150 deductible, then Generic: 20% (minimum \$10 copayment) Brand: 30% (minimum \$10 copayment) If actual cost is under \$10, then you pay actual cost	50% of cost after \$150 deductible
Mail Order – Home Delivery (up to 90-day supply)	Generic: \$15 copayment Brand: \$35 copayment	Not covered

Medco Pharmacy Features

Consultation with a Pharmacist

A Medco pharmacist is available 24/7 for consultation. You also have available to you 24/7, pharmacists that are trained in specific medical conditions such as diabetes or rare and chronic diseases.

To contact a pharmacist, call the member service number on the back of your ID card: 1-800-473-3455.

Disease Management

Clinical support and counseling is available for specific health conditions:

- Asthma
- Cardiac Obstructive Pulmonary Disease
- Congestive Heart Failure
- Diabetes
- Low Back Pain

Mail Order for 90-Day Supply

Mail: Medco
 P. O. Box 650322
 Dallas, TX 75265-0322

Fax: Have your doctor call 888-327-9791

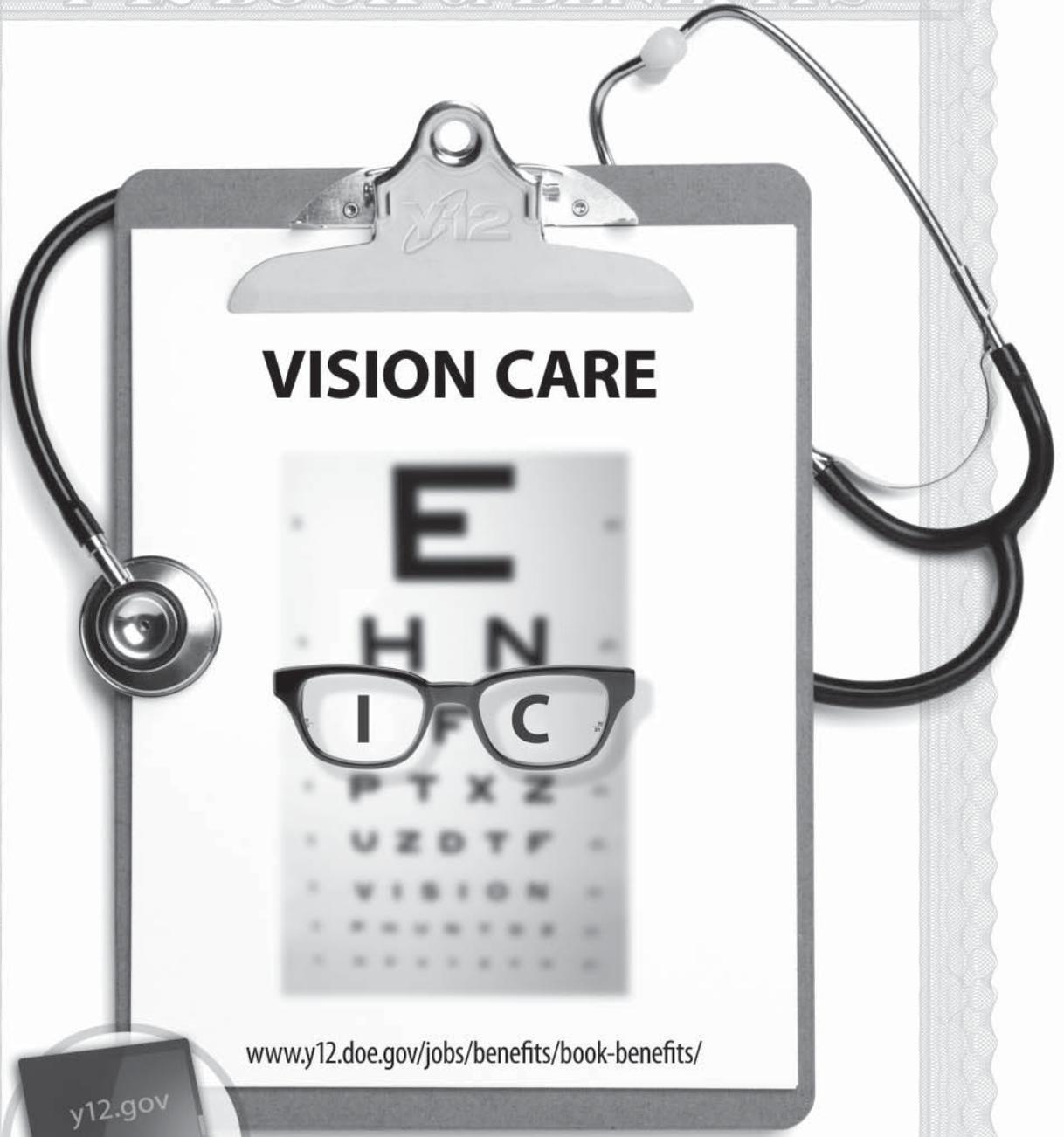
Web: www.medco.com

Telephone: 1-800-473-3455

Customer Service

1-800-473-3455 or see your ID card

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YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

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The Vision Plan

You are automatically enrolled in the Vision Plan when you enroll for medical coverage. Vision benefits are the same when enrolled in either medical plan: Point-of-Service, Open Access, or Indemnity.

The self-funded vision plan is administered by Vision Service Plan (VSP). VSP also administers and manages the network of vision service providers. Your out-of-pocket costs will be higher if you use an out-of-network provider.

Your Vision Benefits

When you need vision care, you can go to a VSP network provider or a non-network provider. Network providers will file your claim with VSP. You will have to mail your claim to VSP at the address below for out-of-network providers. A list of VSP network providers is available as noted below:

Web: www.vsp.com

Customer Service: 1-800-877-7195

To file a claim:

Mail: Vision Service Plan
Out-of-Network Provider Claims
P. O. Box 997100
Sacramento, CA 95899-7100

Exclusion for Surgery or Disease

The vision plan does not cover eye surgery or diseases of the eye. Generally, these conditions are under the medical plan. If you have questions about available vision care benefits not listed in this Vision Plan summary, contact VSP at:

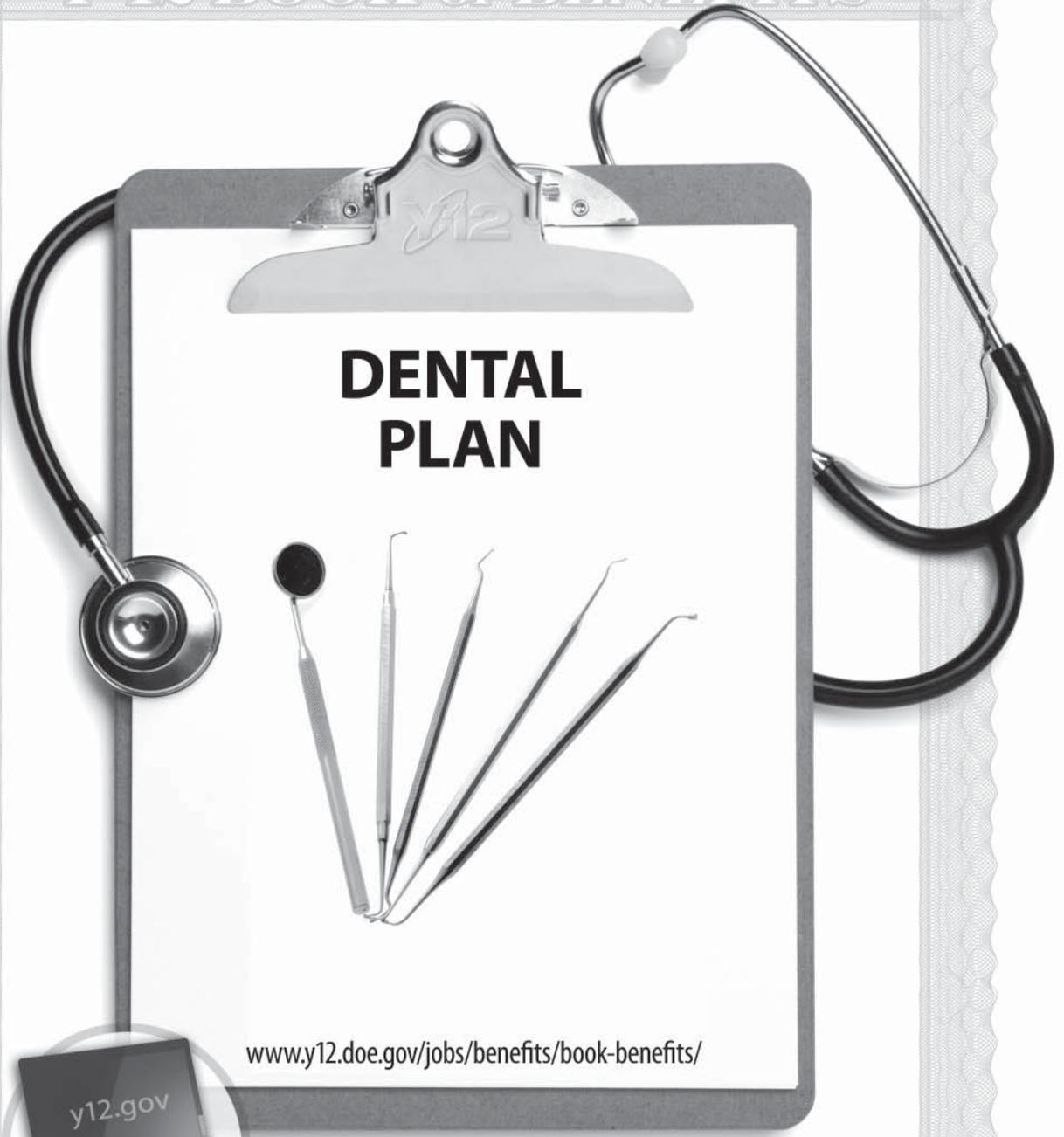
VSP Customer Service: 1-800-877-7195

VSP Vision Features:

- No claim forms (in-network)
- No ID cards
- Access to large national network

Summary of Benefits: Vision Plan

Services Covered	In-Network	Out-Of-Network
Exam every 12 months	Covered in full	Exam \$29.75
Lenses every 12 months:		
• Single vision	Covered in full	Single Vision \$21.25
• Bifocal	Covered in full	Bifocals \$34.00
• Trifocal	Covered in full	Trifocals \$46.75
Polycarbonate for dependent children	Covered in full	
Frames every 24 months	Covered up to \$120 Plus, 20% off amount exceeding \$120	Frame \$38.25
OR		
Contact Lens every 12 months	Covered up to \$120, allowance applies to the cost of contacts and contact lens exam Plus, 15% off cost of contact lens exam OR Eligible members may take advantage of VSP Contact Lens Care program, in which Contact Lens Exam and up to 4 boxes (6 mo. supply) are covered in full	Elective Contacts \$105
Lens Options	20% discount on lens enhancements and upgrades	
Additional Discounts	20% discount on additional prescription glasses and sunglasses Laser vision correction services are provided at a reduced cost through VSP network doctors and contracted laser surgery centers	



**DENTAL
PLAN**

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YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

There are two dental plans to choose from – the Metropolitan Life Plan (MetLife) and the Delta Dental Plan of Tennessee (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.

The 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, 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 24.

What happens to your benefits when?

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

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 COBRA within the “Administrative Information” section.

Some facts to remember about your dental plans:

- Dependents in military service are not eligible for dental coverage.
- A predetermination of benefits is recommended for costs that are expected to exceed \$100.

MetLife Dental Plan—How the MetLife 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 a network provider versus a non-network provider bills for their services.

Network Provider

MetLife has a Preferred Dentist Program (PDP) 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

The Plan pays benefits to non-network providers based on “Reasonable and Customary Charges.”

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

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

Briefly, the plan covers four types of dental services:

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

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

Annual Deductible

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

Maximum Benefits

The plan pays up to a maximum of \$1,500 per year and \$20,000 in a lifetime for each covered person for Type A, Type B, and Type C expenses combined. For Type D (orthodontic) services, there is a separate lifetime maximum of \$1,500 in benefits for each covered person.

MetLife Dental Plan

(Refer to the “Covered Expenses” section for details.)

Services covered	Amount of coverage*
Calendar year maximum	\$1,500
Lifetime orthodontic maximum	\$1,500
Lifetime maximum	\$20,000
Annual deductible (applies to Type B and Type C services)	\$50 per member
Type A: Preventive and diagnostic services	
Oral examinations	Covered 100%, once every 6 months
Prophylaxis (cleanings)	Covered 100%, once every 6 months
Full mouth X-rays	Covered 100%, once every 24 months
Bite-wing X-rays	Covered 100%, one set every 6 months
Fluoride	Covered 100% once every 6 months under age 19
Space maintainers	Covered 100%
Type B: Oral and restorative services	
Fillings (other than gold), general anesthesia, occlusal guards, extractions and oral surgery,* periodontics, endodontics (root canal therapy)	Covered 80% after deductible
Sealants	Not covered
Type C: Prosthodontic services	
Prosthodontic services (no age limit for bridges, partial dentures, or full dentures)	Covered 50% after deductible
Type D: Orthodontic services	
Orthodontic services: braces, surgical repositioning to correct malocclusion, surgical extractions, X-rays, retention checking	Covered 50% for dependents up to age 24 Lifetime maximum: \$1,500

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

Covered Expenses

Type A – Preventive and Diagnostic Services

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

Covered expenses for preventive and diagnostic services include Reasonable and Customary Charges for:

- oral examinations (once every six months)
- cleaning and scaling of teeth (once every six months)
- bitewing X-rays (one set every six months)
- full mouth X-rays (one set every 24 months)
- topical fluoride applications for Children under age 19 (once every six months)
- space maintainers
- emergency treatment
- Periodontal Maintenance (no limit, but must have history of periodontal).

Type B – Oral Surgery and Restorative Services

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

Covered expenses for oral surgery and restorative services include Reasonable and Customary Charges for:

- amalgam fillings (charges for precious metals such as gold and for castings are considered based on Reasonable and Customary Charges for amalgam fillings)
- treatment of gum disease (periodontics)
- endodontic treatment, including root canal services
- extractions (except in connection with orthodontic treatment)
- oral surgery
- general anesthesia when determined necessary under the plan's dental provisions
- Repair or recementing of crowns, inlays, onlays, dentures, or bridgework.

Type C – Prosthodontic Services

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

Covered expenses for prosthodontic services include Reasonable and Customary Charges for:

- inlays, onlays, crowns, 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
- full or partial dentures installed for the first time to replace missing natural teeth and adjacent structures and any adjustments required during the six-month period following installation
- 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 five years 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 23 are eligible to receive benefits for orthodontic services. At age 24, all coverage under the plan ends, even if a course of orthodontic treatment is ongoing.

The plan payment for covered expenses (initial and monthly) is based on a schedule of allowances for non-network providers. This schedule is available from the Benefit Plans Office. A PDP network provider is paid based on the PDP fee schedule.

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.

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
- implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth)
- 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 termination 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 termination.

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 two calendar months following the end of coverage

- **crowns** – tooth preparation must be completed before the coverage ends and the crowns installed within two calendar months following the end of coverage
- **root canal therapy** – the tooth must be opened before coverage ends and treatment completed within two calendar months following the end of coverage
- **orthodontia** – not extended, under any circumstance.

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 only pay 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 to be appropriate by MetLife, you will be required to pay the difference between the dentist’s bill and the costs covered by the plan.

Treatment in Progress

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

Claiming Benefits

You should file a claim whenever you and your covered Eligible Dependents incur covered dental expenses. Claim forms are available from the Benefit Plans Office. Claims must be filed no later than 90 days after the plan year in which the services were rendered.

Completed forms should be mailed to MetLife at the address listed on the claim 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. You will receive a copy of the explanation if you have a balance due. Detailed claim information is available on MyBenefits website at www.metlife.com/mybenefits.

Coordination of Benefits

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

Under this provision, when coverage is provided both by 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. 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.

Delta Dental Plan—How the Delta Plan Works

Eligibility and Enrollment

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

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

Choosing a Dentist

Delta Dental does not directly provide dental services and therefore is not liable for a dentist’s refusal to provide services. It has contracted with “Participating Dentists.” These dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists that have not contracted with Delta Dental are referred to as “Non-Participating Dentists.”

Although you are free to choose any dentist, your out-of-pocket expenses may be less if you choose a Participating Dentist. Therefore, you should always ask your dentist if he is a Participating Dentist or verify with Delta Dental that your dentist is a Participating Dentist before receiving any dental services.

Participating vs. Non-Participating

A Participating Dentist’s charges are paid based on Delta Dental’s maximum fee schedule, which providers agree to accept, with no balance billing. This is the Maximum Plan Allowance (“MPA”).

You are responsible for charges exceeding the MPA if you go to a Non-Participating Dentist. The MPA charges are based on fees charged in your geographic area. For example, non-participating providers are generally reimbursed at the 51st percentile of Delta Dental’s prevailing fee schedule as submitted by all providers (based on an overall scale of 100, the maximum payment is paid at or below the 51st percentile).

Annual Deductible

You and each covered dependent must satisfy a \$50 individual deductible each calendar year before benefits become payable toward Type B (basic) services and Type C (major) services covered by the plan. There is no deductible for Type A (preventive and diagnostic) services or Type D (orthodontic services).

Maximum Benefits

The plan pays up to a maximum of \$1,500 per year for each covered person for Type A, Type B, and Type C expenses combined. There is no lifetime maximum limit for Type A, Type B, and Type C covered expenses. For Type D (orthodontic) services, there is a separate lifetime maximum of \$1,500 in benefits 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 may be less if you choose a Participating Dentist.

Four Types of Dental Services

Type A: Preventive and diagnostic benefits

Type B: Basic Benefits

Type C: Major Benefits

Type D: Orthodontic services

The Delta Dental plan pays different benefits for each of these types of coverage – with an annual deductible required for Type B and Type C services only.

Delta Dental Plan

(Refer to the “Schedule of Benefits” section for details.)

Services covered	Amount of coverage
Calendar year maximum	\$1,500
Lifetime orthodontic maximum	\$1,500
Lifetime maximum	n/a
Annual deductible (applies to Type B and Type C services only)	\$50 per member
Type A: Preventive and diagnostic services	
Oral examinations	Covered 100%, twice every 12 months
Prophylaxis (cleanings)	Covered 100%, twice every 12 months
Full mouth X-rays	Covered 100%, once every 24 months
Bitewing X-rays	Covered 100%, once every 3 years
Fluoride	Covered 100%, under age 19
Space maintainers	Covered 100%, under age 15
Type B: Basic services	
Fillings (other than gold), general anesthesia, occlusal guards, extractions and oral surgery, periodontics, endodontics (root canal therapy)	Covered 80% after deductible
Sealants	Covered 80% under age 16, one benefit per tooth. Chewing surfaces for permanent first and second molars only.
Type C: Major services (no age limit for bridges, partial dentures, or full dentures)	
Crowns	Covered 50% after deductible, excluding porcelain, gold or veneer crowns for children under age 12
Bridges	Covered 50% after deductible, excluding fixed bridges or cast partials for children under age 16
Partial dentures/full dentures	Covered 50% after deductible
Type D: Orthodontic services	
Orthodontic services: braces, surgical repositioning to correct malocclusion, surgical extractions, X-rays, retention checking	Covered 50% for dependents up to age 24 Lifetime maximum: \$1,500

Delta Dental Schedule of Benefits

In addition to the limitations and exclusions listed in this "Schedule of Benefits" section, the "General Limitations and Exclusions" section also applies.

Type A – 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.

Limitations and Exclusions on Preventive and Diagnostic Benefits:

- Two oral exams and cleanings, to include periodontal maintenance procedures, in any 12-month period.
- Full mouth X-rays are covered once within 3 years, unless special need is shown.
- Two sets of bitewing X-rays in a 12-month period.
- Topical application of fluoride for members up to 19 years of age.
- Adult prophylaxis for members under 14 years of age is not allowed.
- Space maintainers for members more than 14 years of age are not allowed.

Type B – Basic Benefits Services

- Oral Surgery – extractions and other surgical procedures (including pre- and postoperative care).
- General Anesthesia & I.V. 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.

Limitations and Exclusions on Basic Benefits:

- Restorative benefits are allowed once per surface in a 24-month period, regardless of the number or combinations of procedures requested or performed.
- 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 by the same dentist or dental office.

- Payment for periodontal surgery shall include charges for three months postoperative care and any surgical re-entry for a three-year period. Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
- The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not a benefit.
- 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.
- 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.
- Gold foil restorations are an Optional Service.
- Porcelain, composite, and metal inlays are Optional Services.
- 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.

Type C – Major Benefits

- 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.
- Prosthodontics – 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.

Limitations and Exclusions on Major Benefits

- Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12-month period.
- A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
- Procedures for purely cosmetic reasons are not benefits.
- Porcelain, gold or veneer crowns for Children under 12 years of age are not a benefit.
- Replacement of any fixed bridges, or partial or complete dentures, that the member received in the previous five years is not a benefit.

- Payment for a complete or partial denture shall include charges for any necessary adjustment within a six-month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a three-year period and includes all adjustments required for six months after delivery.
- 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.
- Payment for implants (artificial materials implanted into or on bone or gums) or their removal is not a benefit. However, an allowance for a standard complete or partial denture toward the cost of replacing multiple missing teeth will be made. For single tooth implants, Delta Dental will make an allowance for a crown but not for the placement of the implant.
- Payment for fixed bridges or cast partials for Children under 16 years of age is not a benefit.
- A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
- Temporary partial dentures are a benefit only when upper anterior teeth are missing.

Type D – 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.

Limitations and Exclusions on Orthodontic Benefits

- Orthodontic benefits are limited to Eligible Dependent Children to age 24.
- Delta Dental shall make regular payments for orthodontic benefits.
- If orthodontic treatment began prior to enrolling in this plan, Delta Dental will begin benefits with the first payment due the orthodontist after the subscriber or covered Eligible Dependent becomes eligible.
- Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
- Benefits are not paid to repair or replace any orthodontic appliance received.
- 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.

Orthodontic Payment Method

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

Predetermination of Benefits

You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a 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.

Optional Services

In cases where alternate or optional methods of treatment exist, Delta Dental will pay for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the subscriber's coverage. The dentist and subscriber or dependent should decide the course of treatment.

If the treatment rendered is other than the covered benefit, the difference between the Delta Dental allowance and the dentist's fee, up to the approved amount, for the actual treatment rendered is due from the subscriber.

For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, Delta Dental will pay for only the cost of the amalgam.

General Provisions

- Participating Dentists will file your claim with Delta Dental. If you need a claim form for services provided by a Non-Participating Dentist you may contact Delta Dental which will provide you with a claim form. To be considered for benefits, a claim must be filed within 15 months of the date of service.
- If you require emergency dental care, you may seek services from any dentist. Your out-of-pocket expenses may be less if you choose a Participating Dentist.
- You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a 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. 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.
- If you or your covered Eligible Dependent receive an injury requiring dental treatment because of the action or fault of another person, and if Delta Dental is unaware of other coverage, Delta Dental may pay benefits but would assume the subscriber's or covered Eligible Dependent's rights to recover from the other person. The subscriber and covered Eligible Dependent would be required to help Delta Dental in making such a recovery. This dental plan does not replace any workers' compensation coverage.

- If a subscriber or covered Eligible Dependent has two dental coverages, Delta Dental will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
- The program covering the patient as an employee is primary over a program covering the patient as a dependent.
- Where the patient who is a Child who is an Eligible Dependent, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a Child who is an Eligible Dependent of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e. stepparent) will be primary.
- If there is a court decree stating that one parent has financial responsibility for a Child's dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.
- After a claim is processed, an Explanation of Benefits ("EOB") will be sent to the subscriber. If any payment for services was denied, the EOB will give the reason why. If the subscriber disagrees with the denial, he or she must submit a request in writing asking that the claim be reviewed. Such request should include the reason why the subscriber believes the claim was wrongly denied. The request must be received by Delta Dental within 180 days of the subscriber's receipt of the EOB. Delta Dental will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after Delta Dental receives the request for review.

If the subscriber does not agree with the first level review decision, he or she may refer the request for review to the Professional Relations Advisory Committee of Delta Dental. This second level review request must be in writing and received by Delta Dental within a reasonable time after the subscriber receives the first level review decision. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after Delta Dental receives the request for second level review.

If the subscriber does not agree with the second level review decision, he or she may file civil action in court.

General Limitations and Exclusions

In addition to the limitations and exclusions shown in the Schedule of Benefits section, Delta Dental does not pay for the following:

- Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
- Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.

- Treatment to restore tooth structure lost from wear.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
- Services by a dentist beyond the scope of his or her license.
- Dental services for which the patient incurs no charge.
- Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
- Delta Dental will apply the limitations and exclusions of this benefit plan based upon the member's complete and prior history as reflected in Delta Dental's records.

In the event a member transfers from one dentist to another during the course of treatment, payment by Delta Dental will be limited to the amount that would have been paid had only one dentist rendered the service.

Extended Dental Care Benefits

Coverage for any subscriber or Eligible Dependent terminates when they are no longer eligible for benefits as a member of the group.

Specific state or federal laws or group policies may allow an extension of benefits for a limited time. Delta Dental will determine whether any benefits are available and how long the benefits could be extended.

EMPLOYEE ASSISTANCE PROGRAM



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

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

The Employee Assistance Program:

- Offers services at no cost to you and your eligible dependents

Consultations with program counselors are provided free of charge, and you may have up to five sessions per personal problem or concern, per year.

- Is available 24-hours a day, 7 days a week

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

- Ensures complete confidentiality

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

What happens to your benefits when?

For more information about what happens to your employee assistance program coverage when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” section.

How the Employee Assistance Program Works

The employee assistance program is administered by an outside firm. The provider offers confidential, professional assessment, referral and counseling services on a one-on-one basis.

The employee assistance program 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 employee assistance program, 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 five 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 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 employee assistance program 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.

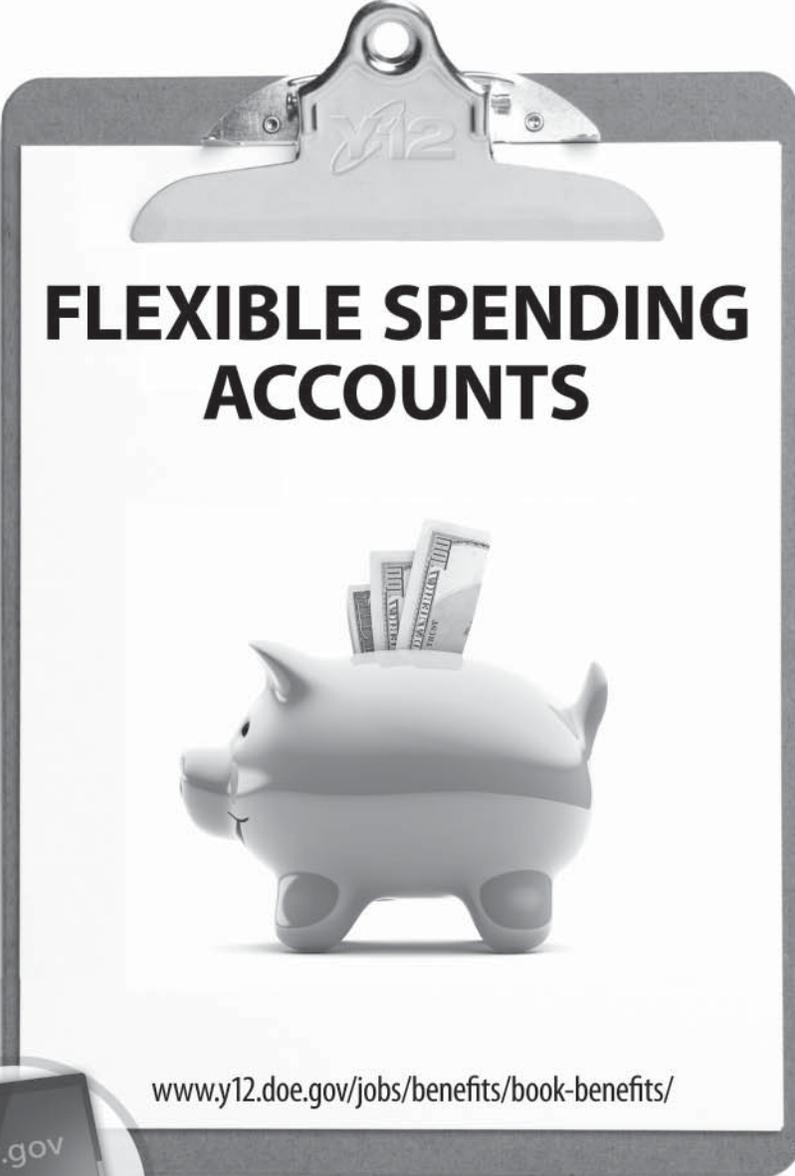
Confidentiality

Using the employee assistance program 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.

How to Contact the Employee Assistance Program

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

Y-12 BOOK OF BENEFITS



**FLEXIBLE SPENDING
ACCOUNTS**



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

Flexible Spending Accounts offer a convenient way to pay for health and dependent care expenses on a before-tax basis.

The Flexible Spending Accounts:

- Give you choices

You can contribute to the health care spending account, the dependent care spending account, or both. Each year, you can contribute up to \$5,000 to the health care spending account to pay for certain medical, dental, vision care, prescription and prescribed over-the-counter drug expenses which have not been otherwise reimbursed, and up to \$5,000 to the dependent care spending account to pay for day care and elder care expenses for Eligible Dependents.

- Offer convenience

Your flexible spending account contributions are automatically deducted from each paycheck and credited to your flexible spending accounts.

- Save you money in taxes

The money in your accounts is not subject to federal income taxes, Social Security taxes or Medicare taxes. And, in most places, state and local taxes also do not apply. This means that many of your routine health and dependent care services will actually 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 flexible spending accounts. According to Internal Revenue Service rules, any money left in your account after March 15th of the following year will be forfeited.

What happens to your benefits when?

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

How the Flexible Spending Accounts Work

Follow these steps to put the flexible spending accounts to work for you:

- **Estimate your expenses.**

Each year, you calculate these expenses for the upcoming year: any out-of-pocket medical, dental, vision care, prescription and prescribed over-the-counter drug expenses and your dependent care expenses. You should estimate carefully because you will forfeit any unused funds.

- **Decide on your annual contribution.**

You can contribute from \$100 to \$5,000 before-tax to the health care spending account and from \$100 to \$5,000 before-tax to the dependent care spending account. The two accounts are separate, and you may not transfer funds between the two. Once you begin contributing, you may not change or stop your contributions during the year unless you have a Qualifying Life Event as described in the "About Your Benefits" section.

- **File a claim.**

When you have eligible expenses, you pay for them as you normally would. Then you submit a receipt, reimbursement request and any other supporting documentation to the claims administrator. The address is on the bottom of the form. Expenses must be incurred by March 15th of the following year and while you were an active participant in the plan.

The deadline for filing claims is June 30th following the plan year for which the election was made.

- **Receive reimbursement.**

Reimbursements from your accounts are made with before-tax dollars.

Worksheets and reimbursement forms are available from the Benefit Plans Office, or on your company's Benefit Forms website.

Should You Participate?

Here are some questions you may want to ask yourself before you decide to contribute to a flexible spending account:

- What do you expect your out-of-pocket health care expenses will be?

Start with your deductibles, and then add any medical, dental, vision care, prescription or prescribed over-the-counter drug expenses that are not covered—like copayments, charges above Reasonable and Customary Charges or charges above plan maximums.

- 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 13th birthday.

Changing your Contribution

You may not change or stop your contributions to the flexible spending accounts during the year unless you have a Qualifying Life Event, such as a birth, 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.

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

Tax Savings

The health care and dependent care spending accounts are designed for one purpose: to allow you to pay for certain medical expenses on a pre-tax basis. Your taxable income is reduced by the amount you contribute to the accounts.

Your participation in the flexible spending accounts may reduce your Social Security retirement benefits. But the current tax advantages generally offset any reduction in Social Security benefits.

How much can you save on taxes?

Take the amount you will contribute to the dependent care and health care spending accounts times your federal tax percentage bracket to determine how much federal taxes you save. You may also save on Social Security and Medicare taxes—and depending on where you live, state and local taxes.

Health Care Spending Account

Contributions

You can contribute from \$100 to \$5,000 annually to the health care spending account. Contributions are deducted from your Pay each pay period and credited to your flexible spending account.

Limit for Highly Compensated Employees

Certain highly compensated employees may be limited by the Internal Revenue Service as to how much they can contribute to the health care spending account each year. You will be notified if this limit applies to you.

Eligible Expenses and Dependents

You can use the health care spending account to pay for certain medical, dental, vision care, prescription and prescribed over-the-counter drug expenses for you and your Eligible Dependents which have not been otherwise reimbursed.

Expenses for medicine or drugs are reimbursable only if the medicine or drug (i) requires a prescription, (ii) is available without a prescription and you obtain a prescription for it, or (iii) is insulin.

The term "Eligible Dependents" is defined in the Glossary.

You and your Eligible Dependents do not have to be covered under the Company's medical or dental plans to participate in the health care spending account. In general, you may be reimbursed for any health care expense that is not paid for by an insurance plan and is considered a deductible medical expense by the Internal Revenue Service, except health care insurance premiums. However, you cannot claim, as an income tax deduction, any expenses reimbursed or payable through the health care spending account.

Refer to Internal Revenue Service Publication 502 for more information about what items are – and are not – medical care expenses. To order a copy, call the Internal Revenue Service toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.

Note: Use IRS Publication 502 with caution. It was intended only to help taxpayers figure out what medical expenses can be deducted on their tax return, not what is reimbursable under a healthcare spending account. Some of the statements in IRS Publication 502 are not correct when determining whether that same expense is reimbursable from your health care spending account. Not all expenses that are deductible are reimbursable under the health care spending account and vice versa.

Examples of eligible expenses that are currently allowable by the Internal Revenue Service include medically necessary:

- fees for physicians, surgeons, dentists, ophthalmologists, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, social workers, and Christian Scientist practitioners
- fees for hospital services, therapy, nursing services, ambulance fees, laboratory, surgical, obstetrical, diagnostic, dental, and X-ray services
- rehabilitation services
- special equipment such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf
- special items such as dentures, artificial limbs, contact lenses, eyeglasses, hearing aids, crutches, and guide dogs for the vision or hearing impaired
- prescription medicines, drugs, and insulin
- cost of vasectomies, hysterectomies, and birth control
- acupuncture
- radial keratotomy and laser vision correction
- non-elective cosmetic surgery
- smoking cessation programs
- over-the-counter drugs that treat a medical condition, provided that you have a prescription for such drugs
- weight loss programs prescribed by a physician to treat a medical condition.

Expenses Not Eligible

Examples of health care expenses that are ineligible for reimbursement through the account include:

- expenses incurred before your date of participation
- expenses reimbursed or reimbursable through any other policy, plan, or program
- expenses claimed as a deduction or credit on your federal income tax return
- elective cosmetic surgery
- orthodontia for cosmetic purposes
- tooth-whitening procedures
- marriage or family counseling fees
- household and domestic help, even if recommended by a doctor
- custodial care in an institution
- funeral and burial expenses
- illegal operations or treatments
- weight-loss programs, unless prescribed by a doctor to treat an existing disease/medical condition
- maternity clothes, diaper services, etc.
- vitamins or food supplements taken for general health purposes
- cosmetics, toiletries, etc.
- health care insurance premiums
- hair transplant or removal
- transportation expenses to and from work, despite a physical handicap
- expenses merely beneficial to health, such as vacations or fitness programs, even if recommended by a doctor
- any expenses incurred after you stop making contributions
- over-the-counter drugs that are not prescribed.

Filing Claims

When you incur an eligible medical, dental, vision care or prescription drug expense, you must pay the provider, file a claim with the insurance company and then submit a flexible spending account reimbursement request form, along with the explanation of benefits you receive from the insurance company, to the claims administrator, at the address on the bottom of the form.

Your claim must include a copy of the Explanation of Benefits (EOB) you receive after filing your insurance claim. For expenses that are not covered by your insurance, including copayments and eligible prescribed over-the-counter drugs, you will need to include other evidence clearly showing that you have paid the expense, such as a receipt from the provider. Eligible medically necessary items that you bought over-the-counter require the store receipt, the description and the dollar amount of the item, and the applicable sales tax amount.

The third-party administrator for the plan releases reimbursement payments weekly for eligible expense claims which have been received and processed. If you have incurred eligible health care expenses, you may be reimbursed up to the total contribution amount you have elected for the plan year, regardless of your account balance.

Dependent Care Spending Account

Contributions

You may contribute to the dependent care spending account 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 five 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, you should contact your company's benefit office immediately because you may no longer be eligible to participate in this account.

You can contribute from \$100 to \$5,000 annually in before-tax dollars to your dependent care spending account. In some cases, however, the Internal Revenue Service limits the amount you can contribute, as shown in the following chart. Dependent care contributions are reported on your W-2, according to Internal Revenue Service rules.

Special dependent care spending account 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 five 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.

Limit for Highly Compensated Employees

Certain highly compensated employees may be limited by the Internal Revenue Service as to how much they can contribute to the dependent care spending account each year. You will be notified if this limit applies to you.

Eligible Dependents

You may use the dependent care spending account to pay for the care of your Eligible Dependents so that you or, if you are married, you and your spouse, can work. Eligible Dependents include:

- your children under age 13
 - your spouse, if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year
- or*
- a disabled dependent of any age (including parents) if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year.

An Eligible Dependent is someone you can claim as a dependent on your federal income tax return. A modified definition of dependent applies when determining whether a person who is incapable of self-care (other than a spouse) is a tax dependent. The married dependent limitations and gross income limitation do not apply.

If you are divorced or legally separated and have custody of your eligible child, you may use the dependent care spending account 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 spending account provided you have custody of your child for a longer period during the year than your spouse.

Eligible Expenses

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

- services provided in your home by a babysitter or companion, including wages and related taxes
- services provided by a dependent care center that meets local regulations, cares for more than six nonresidents and receives a fee for such services, whether or not for profit
- services provided outside your home, such as day camp, preschool tuition or other outside dependent/child care services, such as before and after-school programs, but only if the care is for a dependent under age 13 or other Eligible Dependent who regularly spends at least 8 hours a day in your home.

Generally, eligible child care costs include only those for the actual care of your child, not costs for education, supplies or meals – unless those costs cannot be separated.

Expenses Not Eligible

Expenses that are not eligible for reimbursement through the dependent care spending account 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 Spending Account vs. the Federal Tax Credit

Under the current tax law, you can save taxes on dependent care expenses by either claiming a tax credit on your federal income tax return or by participating in the dependent care spending account. Both are intended to offer you tax savings. The best method for you depends on your income, the number of Eligible Dependents you have, and other factors. However, for most people, using the dependent care spending account 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. This means:

- If you have one Eligible Dependent, your total expenses eligible for the tax credit are \$3,000 in 2008 (or your actual expenses, if less) minus any amount received through the dependent care spending account.

- If you have two or more Eligible Dependents, your total expenses eligible for the tax credit are \$6,000 in 2008 (or your actual expenses, if less) minus any amount received through the dependent care spending account.

These amounts are subject to change annually.

You should consult a personal financial or tax advisor to help you decide whether the tax credit or the dependent care spending account is more favorable for you.

**Refer to Internal Revenue Service Publication 503 for a discussion of the tax credit.
To order a copy, call the Internal Revenue Service 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 flexible spending account reimbursement request form, along with a bill or receipt, to the claims administrator, at the address on the bottom of the form. Be sure to include the dependent care provider's Social Security or tax identification number on the form. The annual deadline for filing prior year claims is June 30th.

Dependent Care Provider Identification

When you file a claim for reimbursement through the dependent care spending account, 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 Internal Revenue Service 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 Internal Revenue Service at 1-800-829-3676 or visit the IRS website at www.irs.gov.

You will be reimbursed only for dependent care services you have already received. For example, if you pay in advance for three months of care, you cannot be reimbursed for the entire amount until after the end of the three-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.

Flexible spending account reimbursement request forms are available on your company's website.

Remaining Funds

No Transfers Allowed

Remember, you may not transfer money between flexible spending accounts. Money set aside in your health care spending account cannot be used to reimburse dependent care expenses and vice versa.

Estimate your flexible spending account contributions carefully. You may continue to file claims for expenses incurred during the plan year until June 30th of the following year. According to Internal Revenue Service rules, you must “use up” amounts deducted from your pay by incurring and filing claims for eligible expenses up to the amount of your annual election by March 15th of the following year. 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

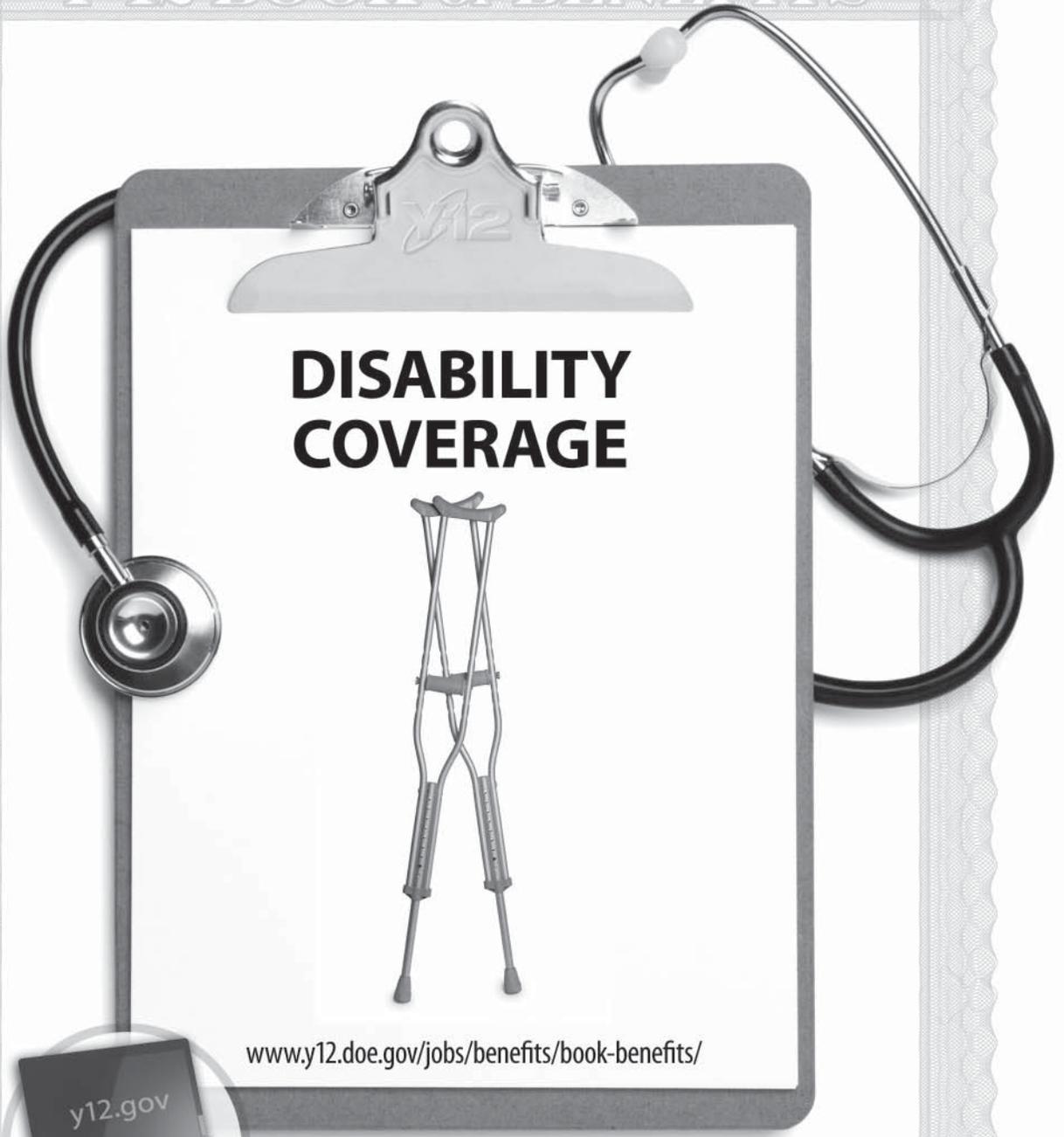
You may obtain account information any time by phone or by accessing the website.

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

Continuation of Coverage

You may be eligible to continue your health care spending account participation in certain cases when your participation would otherwise end. You may not, however, continue your participation in the dependent care spending account. Refer to COBRA within the “Administrative Information” section.

Y-12 BOOK OF BENEFITS



**DISABILITY
COVERAGE**



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

Your Disability benefits are designed to provide continuing income if you experience an illness or injury or become pregnant, and are unable to work.

Your Disability Benefits:

- Are automatically provided by the Company

The Company automatically provides some coverage under the short-term and long-term disability plans. The benefit amount for hourly versus salaried employees varies and is explained under the section "Benefit Amount." Part-time employees are not eligible for either short-term or long-term disability benefits. ARRA (American Recovery and Reinstatement Act) employees are not eligible for long-term disability benefits.

- Replace part of your pay for disabilities that continue past six months

The long-term disability plan continues part of your Pay after you have been determined disabled for six months (or 130 cumulative 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, benefits may continue for five years, or until you reach age 70, whichever comes first. If you become disabled on or after reaching age 70, benefits may continue for 12 months.

- 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 that 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" section.

Short-Term Disability Plan

It is your obligation to establish that you are disabled, or that you have a continuation of disability. If you are unable to work due to an illness or injury, or become pregnant, the short-term disability plan may continue 100% of Pay for up to six months of your medically determined disability. Claims covered by Workers' Compensation are not covered. There are different short-term disability benefits for salaried and hourly employees. It is your obligation to establish that you are disabled.

Benefit Amount

If you are unable to work due to an illness or injury, or become pregnant, the short-term disability plan continues up to 100% of your Pay for up to six months of your disability.

"Pay" is defined in the Glossary

The benefit amount and period of benefits you receive depends on your length of service.

Salaried Employees

- If you have six months of Company Service or more, you will receive 100% of Pay for six months.
- If you have between one and six months of Company Service, you will receive 100% of Pay for each completed month of service.

Hourly Employees

- Payment will be at 100% of straight time earnings, following a two (2) consecutive work day waiting period for disability pay in accordance with the eligibility schedule contained in the current contract for bargaining unit employees.
- Eligibility schedule for employees offered and hired after June 22, 2004, will be in accordance with the following schedule:

Company Service	Maximum payment weeks
> 3 months but < 6 months	1
> 6 months but < 1 year	2
> 1 year but < 2 years	4
> 2 years but < 3 years	6
> 3 years but < 4 years	8
> 4 years but < 5 years	10
> 5 years but < 6 years	12
> 6 years but < 7 years	14
> 7 years but < 8 years	16
> 8 years but < 9 years	18
> 9 years but < 10 years	20
Over 10 years	26

No payments will be made for the first two (2) consecutive work days of the absence for any disability, unless such period of disability extends beyond twelve (12) consecutively scheduled work days.

Certification by a licensed practicing physician is required. If an employee is admitted to the hospital as an in-patient or receives treatment as a day surgery patient during the first two (2) waiting days of a certified disability absence, the remaining day(s) of the two (2) day waiting period will be waived.

Plan benefits will be reduced by income benefits you are eligible to receive from other sources because of your disability, such as workers' compensation, the Occupational Disease Act, or the disability laws of any state.

If your absence extends beyond six months, benefits may become payable from the Company's long-term disability plan.

Successive Disabilities

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

- due to unrelated causes and are separated by your return to active work for at least eight consecutive Hours of Work
- due to related causes and are separated by a return to active work of at least 520 Hours of Work or three calendar months, whichever is longer.

"Hour of Work" is defined in the Glossary.

Claiming Short-Term Disability Benefits

If you are unable to come to work because of a qualifying absence, in order to receive benefits, you must furnish periodic medical evidence of your illness or injury if requested by the Company.

The Company reserves 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, the Company may require a physician's statement indicating your fitness to resume normal work duties.

In addition, during your disability, you may be required to undergo periodic evaluations by your Company's Occupational Health Services Department in order for the Company to determine if you are able to return to light duty. If the Company's Occupational Health Services Department and your physician determine that you are able to return to light duty, and you do not return to work for light duty, benefits for short-term disability will end.

When Short-Term Disability Benefits End

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

- when you return to work
- when you do not provide requested satisfactory evidence of your continuing illness or injury

- when you do not return to work for light duty if you are able
- when you have received the maximum number of benefit payments
- when the Company terminates your employment for cause.

Long-Term Disability Plan

It is your obligation to establish that you are disabled, or that you have a continuation of disability. Your long-term disability benefits are designed to provide continuing income if you have an illness or injury and are unable to work. Claims covered by Workers' Compensation are not covered. You become eligible to apply for benefits after you have been Totally Disabled (as defined in the Glossary) for six months or 130 cumulative days. Long-term disability benefits pick up where short-term disability benefits leave off, provided you have at least six months prior service with the Company to the beginning date of your Total Disability. It is your obligation to establish that you are Totally Disabled.

Benefit Amount

If you are an **hourly employee**, your monthly long-term disability plan benefit equals 60% of your monthly Pay, up to a maximum monthly benefit of \$5,000, reduced by income benefits you are eligible to receive from other sources, as described under "Reduction of Benefits."

If you are a **salaried employee**, you automatically receive a base benefit of 30% of your monthly Pay, up to \$5,000 per month. You may elect to purchase an additional 30% benefit as long as you complete and return the enrollment form to Benefit Plans within 30 days of becoming eligible. The maximum monthly benefit amount, at the 30% or 60% benefit level, is 60% of monthly Pay up to a maximum of \$5,000 per month, reduced by income benefits you are eligible to receive from other sources, as described under "Reduction of Benefits."

The company which administers the long-term disability benefits plan will instruct you on how to apply for Social Security benefits.

"Pay" is defined in the Glossary.

Duration of Benefits

Benefits under the long-term disability plan are payable to you once you have been Totally Disabled (as defined in the Glossary) for six months or 130 cumulative days.

During the first 24 months of long-term disability payments, you may be required to undergo periodic evaluations at your Company's Occupational Health Services Department in order for the Company to determine whether you are able to return to work. The results of any evaluation will be discussed with you and your physician.

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

The Company does not hold your employment or a job position open for you when you are on long-term disability. The decision on whether you return to work will be based on the results of this medical

evaluation and the availability of an open position for which you qualify. If a position is available, the Benefit Plans Office will coordinate a return to work medical evaluation by your Company's Occupational Health Services Department.

During the time receiving long-term disability benefits for 24 months, you must furnish periodic medical evidence of your illness or injury if requested by the Company in order to continue receiving benefits.

You may be eligible for severance pay after receiving long-term disability benefits for 24 months. Severance pay benefits are calculated based on your last day worked. See the "Severance Plan" section for details.

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

- between ages 60 and 69, benefits are payable for up to five years or until age 70, whichever comes first
- at or after age 69, benefits are payable for up to 12 months.

Reduction of Benefits

Your long-term disability benefits are reduced by other sources of income that are payable to you because of your Total Disability. Income that will reduce your long-term disability benefits includes:

- 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
- any Social Security benefits for which you are eligible (refer to the Social Security and "Long-Term Disability Benefits" chart that follows).

If any of these benefits are payable as a lump sum, your long-term disability benefit will be calculated as if these benefits are paid monthly. The insurance company has the right to recover advanced Social Security benefits by direct payment or by offset against future long-term disability payments.

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

Determining Your Long-Term Disability Benefit

To calculate the amount you are eligible to receive under the long-term disability plan, follow these steps:

1. Multiply your monthly Pay by 60% (or 30% if salaried and not electing the additional 30% benefit) to determine your maximum monthly benefit from the plan up to \$5,000.

2. Subtract other income you are eligible to receive to find your adjusted monthly benefit from the plan. Continue on to Step 3 only if you are eligible to receive family Social Security.
3. If the resulting total of all income benefits you are eligible to receive is more than 75% of your monthly Pay, or 45% if salaried and not electing the additional 30% benefit, your monthly long-term disability benefit will be reduced to bring your total disability income to 75% of your monthly Pay (or 45% if salaried and not electing the additional 30% benefit).

Disability Example

Assume you earn \$3,000 a month and your benefit level is 60%.	
<i>Monthly Pay</i>	\$3,000
<i>Long-term disability benefit percentage</i>	x 60%
Maximum monthly long-term disability benefit	\$1,800

Assume you are eligible for primary Social Security of \$800 a month.	
<i>Maximum monthly long-term disability benefit</i>	\$1,800
<i>Primary Social Security</i>	-\$800
Adjusted monthly long-term disability benefit	\$1,000

or

Assume you are eligible for family Social Security of \$500 a month.	
<i>Assume earnings of \$3,000 per month</i>	\$3,000
<i>75% disability benefit</i>	x 75%
	\$2,250
<i>Primary Social Security</i>	-\$800
<i>Family Social Security</i>	-\$500
Total family disability income	\$950

Social Security and Long-Term Disability Benefits

You are required to apply for Social Security disability benefits within the first twelve months of disability.

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 a timely appeal, then your long-term disability benefits will be reduced by your estimated Social Security benefits.

If...	Then...
You later complete the Social Security appeals process and are denied benefits	Your long-term 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 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, or 45% if salaried and not electing the additional 30% benefit.

Medicare, Social Security, and Long-Term Disability

Generally, you will automatically get Medicare Part A and Part B after you get SSDI benefits. If you disenroll in Part B, you could be left paying for healthcare that would otherwise be paid by Part B. This is because of Medicare Coordination of Benefit rules and specific enrollment period for Medicare Open Enrollment.

You are responsible for communicating with the Social Security office and understanding how Medicare eligibility and enrollment fit your, or your dependent's, personal situation. It is your and/or your dependent's obligation to timely enroll in Medicare so that your out-of-pocket expenses are minimized. The Company's medical plan will coordinate claims payments as though Medicare is in effect, even if not enrolled.

See the "Contacts Information" section on how to contact Social Security or Medicare to get SSDI, or Medicare questions answered.

Taking a Job While Disabled

If you return to work at the Company on a reduced-hour basis, you may be eligible to continue receiving up to 50% of your long-term disability benefit level (60% of the total benefit level for hourly or the 30% or 60% benefit level for salaried).

If you participate in a rehabilitative employment program outside the Company that is approved by both the Company and the third-party administrator, you may continue to receive part of your long-term disability income for up to 12 months. Your monthly long-term disability benefits will be reduced by 70% of any money received from your rehabilitative earnings. If you want to participate in a rehabilitative employment program, it is your responsibility to apply for any such approved program.

"Approved Rehabilitative Employment Program," is defined in the Glossary.

Successive Disabilities

If you receive long-term disability benefits, return to work for less than 520 Hours of Work or three calendar months (whichever is longer) and again become disabled due to the same illness or injury, long-term disability income will resume without a six-month waiting period, provided proper physician documentation is received and approved by the claims administrator. However, if you have been working for at least 520 Hours of Work, or more than 3 months (if longer), you will need to satisfy the waiting period before benefits begin.

"Hour of Work" is defined in the Glossary.

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 eight (8) consecutive hours.

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 before your plan coverage became effective
- covered by Workers' Compensation
- if you are not under the care of a licensed practicing physician
- due to an intentional self-inflicted injury
- resulting from your commission of a felony

or

- due to war, declared or undeclared.

Claiming Long-Term Disability Benefits

Within 90 days after your disability begins, the Benefit Plans Office will mail applicable forms to your home address to be completed by you and your physician.

If forms are not received within 100 days, contact the Benefit Plans Office.

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.

If you fail to complete the appeals process, your long-term disability benefit will be reduced by the estimated Social Security benefit that might have been available.

Y-12 BOOK OF BENEFITS

LONG TERM CARE



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

Closed to New Enrollees effective April 30, 2011

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

This benefit is underwritten by Metropolitan Life Insurance Company (MetLife). Effective April 30, 2011, MetLife no longer accepts new applicants for this Long Term Care benefit. Coverage is guaranteed renewable if you are insured for this benefit. This means as long as premiums are paid on time, coverage cannot be cancelled; although premiums can be raised. Any insured can continue to make coverage changes in accordance with your Certificate of Coverage provided to you by MetLife.

For questions or service contact:

Metropolitan Life Insurance Company
P.O. Box 937
Westport, CT 06881

Member Service: 1-800-438-6388

Long Term Care Benefits:

- Protect you and your family from the potentially high costs associated with long term care.
- Help you maintain your independence.
- Provide care that will be comfortable for you and your family.
- Protect your assets and savings.

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

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

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

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

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

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

How the Plan Works

Eligibility

You were eligible to purchase long term care insurance on your first day of work if you were a full-time employee, a temporary full-time employee hired to work at least 12 months, or a part-time employee working more than 50% of a regular full-time schedule and were hired prior to April 30, 2011.

These eligible family members could also request enrollment:

- spouses or surviving spouses
- parents and parents-in-law
- grandparents and grandparents-in-law.

You did not have to be enrolled in the plan in order for your spouse, parents, or grandparents to participate. This plan was also available to retirees of the Company. Spouses or surviving spouses of retirees could also participate.

Enrollment – (Prior to April 30, 2011)

As an eligible employee, you did not have to complete a statement of health for your coverage if you enrolled within 90 days of the date you were hired and you were Actively at Work (as defined in the following paragraphs) on your effective date of coverage.

If you did not enroll within 90 days of the date you were hired, you had to complete a statement of health. Eligible family members had to also complete a statement of health when they requested enrollment.

If you completed a statement of health and your request for enrollment was denied by MetLife, the notice of denial included instructions on how to appeal the decision.

Actively at Work means you are employed and meet all of the following conditions:

- You are reporting for work at your usual place of employment or other location to which the Group Policyholder's business requires you to travel, or you are on vacation.
- You are able to perform all the usual and customary duties of your occupation on a regular full-time basis or regular part-time basis.
- You are not absent from work due to sickness, injury, medical leave of absence, or long-term disability.

When Coverage Begins

As an eligible employee who enrolled without completing a statement of health, your coverage began on the first day of the month after your request for enrollment was received, as long as you were Actively at Work on that day. If you were not Actively at Work, your coverage began the first of the month after your return to work.

If you enrolled with a statement of health, your coverage began the first of the month following the date MetLife accepted your request for enrollment.

If you enrolled with a statement of health and you were accepted into the plan, once you were authorized for benefits and completed the waiting period, benefit payments began even if you had a pre-existing condition.

 This benefit closed to new enrollment on April 30, 2011.

Premium Payments

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

Employees and spouses pay for their coverage by having their premiums deducted from the employee's paycheck on an after-tax basis. All other eligible family members will pay MetLife directly.

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

Changes in Premiums

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

No Premiums While Benefits are Paid

You will not be required to pay premiums during any period in which you are receiving benefits.

Premiums are waived as of the first day of the month following the date you begin receiving benefits. Your premiums will resume as of the first of the month on or after the date your eligibility for benefits ceases. If you die while covered by the plan, all or a portion of your premiums may be returned to your estate.

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

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

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

If You Stop Paying Premiums

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

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

When Benefits are Paid

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

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

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

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

Waiting Period

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

What the Plan Pays

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

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

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

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

Coordination of Benefits

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

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

Covered Services

Initial Care Planning Visit

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

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

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

Nursing Home Care

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

- room and board
- custodial care services.

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

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

Assisted Living Facility Services

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

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

Home Care Services

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

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

It also includes:

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

Respite Care Services

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

Transition Benefit

The plan will pay 100% of the charges incurred, up to 5 times the daily benefit amount for expenses incurred while chronically ill for items that were required to provide qualified services during and after the waiting period. Such expenses may include personal emergency response systems or durable medical equipment. However, the plan will not pay for home modifications that would otherwise qualify as covered expenses if they would increase the value of your home.

Claiming Benefits Once You Are Authorized

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

To File a Claim

- You will receive a claim form with your authorization letter.
- When you have received covered services, complete the form and mail it to MetLife at the address printed on the form.
- You will receive payments after the waiting period from MetLife, unless you have asked for your provider to be paid directly by filling out an area of the claim form for assigning benefits to your provider.

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

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

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

MetLife Long Term Care
P.O. Box 937
Westport, CT 06880

What the Plan Does Not Cover

This plan does not provide benefits for the following:

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

Concurrent Review

While you receive covered services, MetLife reviews your condition to determine whether the authorization for benefits can be continued. This review may require that MetLife examine your

medical records or request additional information from your doctor or other care provider. You and your doctor will be notified if MetLife made a determination to change your benefit eligibility.

Changing Your Selections

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

Inflation Increases

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

Reinstatement

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

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

When Coverage Ends

Your coverage under the plan ends on the earliest of:

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

If you leave the Company for any reason while participating in the plan, you can take your coverage with you by simply making payments directly to MetLife. Even if you leave, you will still pay the same group rate.

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

Continuation Coverage

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

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

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

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

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

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

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

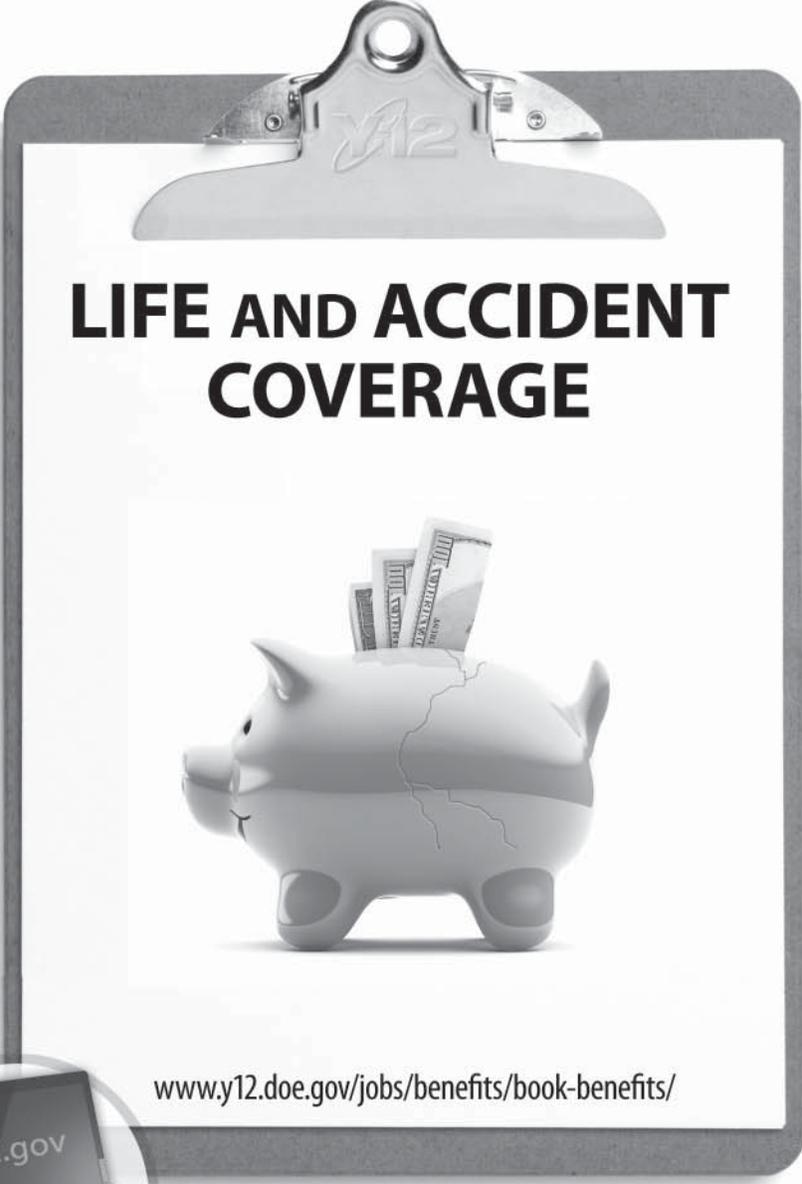
- is effective on the day following your termination of coverage
- provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy
- calculates premium based on your age at inception of coverage under the group policy.

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

Certificate of Insurance

In case of conflict among the terms contained in this summary plan description and the Certificate of Insurance, the Certificate of Insurance will govern.

Y-12 BOOK OF BENEFITS



LIFE AND ACCIDENT COVERAGE



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

Life and Accident benefits are designed to provide beneficiaries some financial security when a life-altering event occurs.

Life and Accident Coverage:

- Provides security for your family through basic life coverage

Your basic life insurance coverage pays a benefit of at least two times your Pay before age 65 to your beneficiary in case of your death from any cause. At age 65, your coverage is reduced. You and the Company share the cost of this coverage.

- Offers the opportunity for added protection through supplemental, spouse and dependent life coverage

You may purchase supplemental life insurance coverage from one to five times your Pay 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 provides business travel accident coverage

Business travel accident insurance coverage pays a benefit of four times your Pay, up to \$500,000, to you or your beneficiary in case of accidental death, dismemberment, or Total and Permanent Disability (as defined in the Glossary) while you are traveling on a Business Trip (as defined in the Glossary). This coverage is provided automatically, at no cost to you.

- Gives 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” section.

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.

Benefit Amounts

During Active Service – Before Age 65

If you are actively working at the Company and are under age 65, 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).

“Pay” is defined in the Glossary.

When your Pay increases enough to put you in a new insurance bracket, your insurance amount will automatically increase. If your Pay decreases, your insurance amount will not change unless the decrease is enough to put you in a new bracket and you request in writing to be insured for the lower amount. There is one important exception to this “no change” rule. If the decrease is part of a general reduction in Pay or hours affecting all employees in your plant, department or other identifiable group, 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 Active Service – At Age 65 and After

If you continue working after you reach age 65, your basic life insurance coverage in effect at age 65 will be reduced 10% a year until it reaches 50% of the amount in effect on your 65th birthday. Any Pay increases you receive after age 65 will not increase your insurance coverage.

The initial 10% reduction will become effective on the first day of the month following your 65th birthday. Subsequent reductions will become effective on the anniversary of that date each year.

Your contributions for basic life insurance will be reduced when your insurance coverage is reduced.

The balance between your reduced amount and the original amount of coverage can be converted to an individual policy. Refer to “Conversion Privileges” at the end of this section for more information.

During Disability

If you become Totally Disabled, as defined in the Glossary, during active service and before age 63, your basic life insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled, or until you reach age 65, whichever is earlier. After you have been continuously disabled for 13 weeks, this coverage will continue providing you pay any required cost. For hourly employees, the 13 weeks’ coverage continues at no cost.

However, if your Total Disability begins after your 63rd birthday your insurance will continue for two years, but not beyond age 70. At age 65, or at the expiration of the two-year period, if later, you may be eligible to continue a portion of your insurance amount or convert the coverage to an individual policy.

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:
\$24,000.01 to \$25,000	\$50,000
\$25,000.01 to \$26,000	\$52,000
\$26,000.01 to \$27,000	\$54,000
\$27,000.01 to \$28,000	\$56,000
\$28,000.01 to \$29,000	\$58,000
\$29,000.01 to \$30,000	\$60,000
\$30,000.01 to \$31,000	\$62,000
\$31,000.01 to \$32,000	\$64,000
\$32,000.01 to \$33,000	\$66,000
\$33,000.01 to \$34,000	\$68,000
etc. in steps of \$1,000	etc. in steps of \$2,000

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 one 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 one year but less than five years immediately preceding your retirement, your reduced insurance will be \$625.

If you had basic life insurance coverage for at least five years immediately preceding your retirement, the amount of your reduced insurance will be the greater of:

- 1% of your basic life insurance amount just before retirement times 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
- 20% of your basic life insurance just before retirement.

If you continue working after age 65, the amount of your reduced life insurance will be calculated using the amount of your basic life insurance in force at age 65.

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 one year immediately preceding retirement, you can:

- continue your full basic life insurance amount until age 65 by continuing to make your regular premium payments
- take the reduced basic life insurance amount (as described under “During Retirement – At Age 65 and After”) immediately at no cost to you.

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.

In addition, you may purchase supplemental life insurance coverage for **your spouse** (up to age 70) and **your eligible dependent children from 6 months to 19 years** (up to age 24 years if a full-time student). 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 and/or eligible children if:

- you are enrolling for coverage after the 30 days of becoming eligible
- the dependent was hospitalized within 90 days prior to enrolling
- you are requesting more than \$10,000 in coverage for your spouse.

Eligible dependent coverage ends when an active employee terminates employment. It would also stop at retirement, 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.

Benefit Amounts

During Active Service – Before Age 65

If you are actively working and are under age 65, you can elect a supplemental life insurance amount equal to 1 to 5 times your annual Pay (rounded to the next higher \$1,000 if not an even multiple of \$1,000) up to a maximum of \$500,000 with evidenced insurability.

"Pay" is defined in the Glossary.

When your Pay increases enough to put you in a new insurance bracket, your insurance amount will automatically increase. If your Pay decreases, your insurance will decrease if you request the change in writing, or if the Pay decrease is part of a general reduction.

During Active Service – At Age 65 and After

If you continue working after you reach age 65, your supplemental life insurance coverage in effect at age 65 will be reduced 10% a year until it reaches 50% of the amount in effect on your 65th birthday. Any Pay increases you receive will not increase your insurance coverage.

The effective dates for the reductions are the same as those for reductions in your basic life insurance.

Your contributions for supplemental life insurance will not be reduced when your insurance is reduced. This means that your cost per \$1,000 in supplemental life insurance coverage will increase.

Your supplemental coverage can be converted to an individual policy when your employment ends.

During Disability

If you become Totally Disabled, as defined in the Glossary, during active service and before age 63, your supplemental life insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled, or until you reach age 65. After you have been continuously disabled for 13 weeks, this coverage will continue providing you pay any required cost. For hourly employees, coverage continues during the 13 weeks at no cost.

However, if your Total Disability begins after your 63rd birthday your insurance will continue for two years, but not beyond age 70. At age 65, or at the expiration of the two-year period; if later, you may be eligible to continue a portion of your insurance amount or convert to an individual policy.

During Retirement – At Any Age

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.

Living Benefit

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

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

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

If you wish to apply for a living benefit, please contact the Benefit Plans Office for forms and instructions.

Payment of Benefits

Basic and Supplemental Life death proceeds are deposited into a Total Control Account (TCA) Money Market Option. Interest is paid on the fund from the date of death.

The beneficiary can choose among other long term settlement options at any time including:

- guaranteed interest certificates (6 months – 7 years)
- annuity options, which provide a guaranteed income for life.

Business Travel Accident Insurance

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

Coverage is provided 24 hours a day during a "Business Trip" (as defined in the Glossary), starting when you leave your home or place of business (whichever is later) and continuing until you return to your home or place of business (whichever is earlier). Coverage is also provided while you are on a side trip or vacation that is taken in conjunction with a business trip, 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 \$50,000 and a maximum benefit of \$500,000. In a Company aircraft accident, your minimum benefit is \$100,000.

Your spouse's benefit amount is \$50,000, and the benefit amount for each eligible dependent child is \$25,000. In a Company aircraft accident, however, their individual benefits increase to \$100,000.

A combined maximum benefit of \$5,000,000 is payable on behalf of all covered individuals in one aircraft accident. Therefore, for any aircraft accident in which more than \$5,000,000 is claimed, there will be a proportionate distribution of the \$5,000,000 maximum. In addition, a combined maximum benefit of \$10,000,000 is payable on behalf of all covered individuals involved in one On Premises Terrorism, On Premises Bomb Scare, Search, Explosion or On Premises Felonious Assault Accident. Therefore, for any such accident in which more than \$10,000,000 is claimed, there will be a proportional distribution of the \$10,000,000 maximum for those eligible.

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

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

Dismemberment Benefits

If you, your spouse or your eligible dependent children should lose sight, speech, hearing or limb or become paralyzed as a result of and within one year after an accident which occurs while you are

traveling on a Business Trip, you, your spouse and your eligible dependent children will receive the following benefits in a lump sum:

For loss of:	The plan pays:
Any combination of one hand, one foot, or sight of one eye	100% of the benefit amount
Both hands, both feet, or sight of both eyes	100% of the benefit amount
Both speech and hearing (both ears)	100% of the benefit amount
Quadriplegia (total paralysis of both upper and lower limbs)	100% of the benefit amount
One hand, one foot, sight of one eye, speech, or hearing (both ears)	50% of benefit amount
Paraplegia (total paralysis of both lower limbs) or Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50% of benefit amount
Thumb and index finger of same hand	25% of benefit amount

If two or more of these losses are sustained in the same accident, your benefit amount will be for the loss with the largest percentage amount payable. For example, if you sustain an injury that entitles you to 25% of your benefit amount and another from the same accident that entitles you to 50%, you will be paid 50% of your benefit amount.

"Loss" is defined in the Glossary.

Payment of Benefits

Death Benefits

If you should die as a result of and within one year after an accident which occurs while you are traveling on a Business Trip, the full amount of your business travel accident benefit will be paid to your beneficiary in a lump sum. In the event of your spouse's or eligible dependent child's death, you will receive their full benefit amount.

Unless you have otherwise submitted in writing, your beneficiary will be the beneficiary designated under your basic Group Life benefit.

Seat Belt Benefit

An extra benefit is payable if you or an eligible dependent on a Business Trip dies as a result of injuries sustained while driving or riding in a private passenger car equipped with seat belts. If the eligible person was wearing a seat belt (or protected by a child restraint as defined by state law) certified in the official report of the accident, or by the investigating officer at the time of the accident, that person's benefit will be increased 10%, up to an additional \$10,000.

If it is unclear whether the eligible person was wearing the required protection, the plan will pay \$1,000 to the beneficiary.

Total and Permanent Disability Benefits

If within 365 days of a covered accident you become Totally and Permanently Disabled as a result of an injury sustained in the accident, you will receive a lump-sum payment after you have been Totally and

Permanently Disabled for 12 consecutive months. The amount of this payment will be your full benefit amount, less any other amount payable from this plan as a dismemberment benefit for the same accident.

You must have been under age 70 at the time of the covered accident to receive Total and Permanent Disability benefits under this plan.

Exclusions

Business travel accident benefits are not payable for losses or death caused by:

- illness or disease
- bacterial infections; this exclusion does not apply to infection in an accidental cut or wound, or due to food poisoning
- commission of a common law felony by the covered individual
- intentionally self-inflicted injury or suicide
- flying in a rocket-propelled aircraft
- flying in any private aircraft being used on Company business
- crop dusting
- war or any act of war in the United States or any nation of which you permanently reside (there is war risk coverage outside the United States); this exclusion does not apply to the hijacking or air piracy of any conveyance used during a covered trip or acts of terrorism while traveling on a covered trip, or on any premises of the Company
- service in the armed forces of any country
- a motor vehicle accident, if driving is a primary duty of your occupation (e.g., truck driver, courier, etc.)
- commuting to and from work
- flying in any aircraft other than a properly licensed and piloted commercial, chartered, corporate, or other Company-approved aircraft.

Travel Assistance Services – Business Travel

Travel assistance services are available 24 hours a day, 365 days a year while traveling on Company business at least 100 miles from your place of residence. Services range from pre-departure information to replacing lost passports to coordinating emergency medical evacuations. Please call 1-888-226-4567 within the United States and Canada or call collect 1-202-331-7635 from any other location. Travel assistance services are provided by Worldwide Assistance Services, Inc. (WA). WA ID cards are available from the travel office.

Emergency Medical Evacuation

When necessary, WA will arrange and pay for your transportation to the nearest adequate medical facility that can properly treat your condition.

Repatriation Benefit

If you die while traveling, WA will arrange and pay for all necessary government authorization, and pay for the return of your remains to your place of residence for burial.

Special Accident Insurance

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

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

Special accident insurance benefits are paid in addition to any other life and accident insurance benefits you are eligible to receive.

Benefit Amount

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 dependants at the time of loss:	Your spouse's benefit will be:	Each child's benefit will be:
Spouse & children	90%	20%
Spouse only	100%	n/a
Children only	n/a	30%

You can elect special accident insurance coverage for yourself from \$20,000 to \$500,000 in \$10,000 increments. You may elect coverage greater than \$250,000, only if the amount you choose does not exceed ten times your annual Pay. Hourly employees receive a Total and Permanent Disability feature. Note: additional coverage above \$250,000 will not increase the coverage for the Total and Permanent Disability benefit.

In any case, your total coverage may not exceed \$500,000. (Regardless of the coverage you elect, if you die or suffer a covered loss while serving as a licensed pilot or crew member of an aircraft, your maximum benefit will be \$100,000.)

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

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

Your contributions for special accident insurance will not be reduced when your benefit is reduced.

Payment of Benefits

Death Benefits

If you or a covered eligible dependent should die as a result of and within one year after an accident, the full benefit amount is payable to you or your beneficiary, as applicable, in a lump sum. If you and your covered spouse should both die in the same accident or separate accidents that occur within a 24-hour period, your spouse's benefit will increase to 100% of your benefit. However, the combined benefit will not be more than \$1,000,000.

Seat Belt Benefit

An extra benefit is payable if you or a covered eligible dependent dies as a result of injuries sustained while driving or riding in a private passenger car equipped with seat belts. If the covered person was wearing a seat belt (or protected by a child restraint as defined by state law) at the time of the accident, that person's benefit will be increased 10%, up to an additional \$10,000.

If it is unclear whether the covered person was wearing the required protection, the plan will pay \$1,000 to the beneficiary.

Child Care Center Benefit

If you elect family coverage and you or your spouse dies as a result of an accident, an additional annual benefit of up to 3% of your special accident insurance benefit (to a maximum of \$5,000 per year for each child) will be payable for a licensed child care center to care for your surviving child.

To be eligible for this payment, your child must have been enrolled in a legally licensed child care center prior to your death (or your spouse's death) or within 365 days thereafter. This benefit will be paid once a year for up to four years, or until your child reaches age 13, whichever comes first.

After the child has been in child care for 12 months following the accident, the claim for child care should be submitted to the Benefit Plans Office for reimbursement. If the surviving spouse has custody of the child, benefits will be paid to the surviving spouse. If there is no surviving spouse or the child does not live with the spouse, benefits will be paid to the child's legally appointed guardian.

If you had family coverage at the time of the accident, but no children are eligible for the child care benefit, a one time \$1,500 payment will be made to your beneficiary.

Education Benefit

If you elect family coverage and then lose your life as the result of an accident, an annual education benefit of an additional 5% of your benefit amount, up to \$15,000 a year, is payable on behalf of any dependent child who, on the accident date, is:

- enrolled as a full-time student in any institution of higher learning beyond the 12th grade
- or*
- enrolled in the 12th grade and, within 365 days after the accident, enrolls as a full-time student in an institution of higher learning beyond the 12th grade.

Benefits are payable for four years provided your child remains a full-time student.

If you have family coverage at the time of the accident but no dependent children who qualify for the education benefit, your beneficiary will receive an additional \$5,000 lump-sum benefit.

Spouse Retraining Benefit

If you elect family coverage and then lose your life as the result of an accident, a “spouse retraining benefit” is payable to your surviving spouse who enrolls in any professional or trade school or training program in order to obtain an independent source of income and support. The plan will pay up to \$5,000 toward the cost of training received within 30 months after the date of your death.

Surviving Spouse Benefit

If you choose family coverage and you or your covered spouse dies as a result of an accident, an additional 1/2% of your special accident insurance amount will be payable to the surviving spouse each month for 12 months.

Continuation of Special Accident Coverage After Employee’s Death

If you choose family coverage and you die as a result of an accident, coverage for your eligible spouse and children will continue, at no cost, for 36 months.

Dismemberment Benefits

If you or a covered eligible dependent should suffer a loss as a result of and within one year after an accident, you or your family member will receive the following benefits in a lump sum:

For loss of:	The plan pays:
Any combination of one hand, one foot, or sight of one eye	100% of the benefit amount
Both hands, both feet, or sight of both eyes	100% of the benefit amount
Both speech and hearing (both ears)	100% of the benefit amount
Total paralysis of both upper and lower limbs (Quadriplegia)	100% of the benefit amount
One hand, one foot, sight of one eye	50% of benefit amount
Speech, or hearing (both ears)	50% of benefit amount
Total paralysis of both lower limbs (Paraplegia)	50% of benefit amount
Total paralysis of upper and lower limbs on one side of body (Hemiplegia)	50% of benefit amount
Thumb and index finger of same hand	25% of benefit amount

If two or more of these losses are sustained in the same accident, your benefit amount will be for the loss with the largest percentage amount payable. If your covered dependent child suffers a dismemberment loss as described above, the plan will pay double the benefit amount indicated up to a maximum of \$200,000.

“Loss,” “Paralysis,” and “Limb” are defined in the Glossary.

Total and Permanent Disability Benefit Feature – Available to Hourly Employees Only

If within 365 days of a covered accident you become Totally and Permanently Disabled as a result of an accident, you will receive a monthly benefit after you have been Totally and Permanently Disabled for 12 consecutive months. The amount of this monthly benefit is 2% of your benefit amount, up to \$5,000 a month with a maximum of \$250,000. Benefits are payable for up to 50 months or until you recover, whichever comes first.

If you should die before receiving the maximum benefit – 100% of your benefit amount – your beneficiary will receive the remaining benefit.

You must have been under age 70 at the time of the covered accident to receive Total and Permanent Disability benefits under this plan.

There are no Total and Permanent Disability benefits for dependents or salaried employees.

Rehabilitation Benefit

If you or an eligible dependent are injured as a result of an accident, an additional benefit of up to \$50,000 will be payable for approved rehabilitation expenses incurred within two years of the accident.

Covered expenses include physical therapy, home reconstruction, and outfitting of special vehicles. This benefit will be reduced by any other rehabilitation benefits that are payable, such as health or accidental insurance, workers' compensation, occupational disease, or similar law.

You must notify the Benefit Plans Office in writing of your injury before any rehabilitation benefits are payable.

Exclusions

Special accident insurance benefits are not payable for losses or death caused by:

- illness or disease
- bacterial infection (except an infection resulting from an accidental cut, wound, or ingestion of a poisonous food or substance)
- intentionally self-inflicted injury or suicide
- commission of a common law felony by a covered individual
- war or any act of war in the United States; this exclusion does not apply to acts of terrorism in the United States
- service of more than 30 days in the armed forces, other than Reserve or National Guard active duty for training
- traveling or flying in any aircraft or device, other than hang gliders or parachutes, if the aircraft or device does not have a valid certificate of air worthiness, or is being used:
 - for travel, or is designed for travel beyond the earth's atmosphere
 - crop dusting; spraying or seeding; firefighting; skywriting; pipeline or powerline inspection; aerial photography or exploration, except for plant site selection or inspections, inventory inspections, and quarry site selection; racing, endurance tests, stunt or acrobatic flying; or any operation which

requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on)

- test or experimental purposes
- any military authority [aircraft flown by the U.S. Military Airlift Command (MAC) or similar service, or another country are not excluded].

If the Company requests participation in any activity listed in paragraphs 2 or 3 above, the aircraft exclusions will be modified. However, a \$100,000 maximum benefit limitation will apply.

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 may change your beneficiary designation at any time by completing the appropriate form available from the Benefit Plans Office. Forms are also available on the Forms web page. The beneficiary you name for basic life insurance benefits will automatically be your beneficiary for supplemental life and business travel accident insurance, unless you elect otherwise in writing. You may also name anyone as your beneficiary for special accident insurance.

If you do not designate a beneficiary, basic and supplemental life insurance benefits will be paid to your estate. Business travel accident and special accident insurance benefits will be paid to the first survivor among the following beneficiaries:

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

If you do not have any living beneficiaries, your business travel accident and special accident insurance benefits will be paid to your estate.

If you elect dependent life coverage or family coverage under the special accident insurance plan, you will automatically be the beneficiary in case of the death of a family member, unless you elect otherwise in writing.

Costs for Coverage

As described in the "About Your Benefits" section, you and the Company share the cost of basic life insurance coverage. You pay the full cost of all supplemental life insurance and special accident insurance coverage. The Company pays the cost of business travel accident coverage.

Tax Consequences

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

Claiming Benefits

You or your beneficiary must file a claim with the Benefit Plans Office in order to receive any life and accident insurance benefits. By contacting the Benefit Plans Office, you or your beneficiary will receive the necessary forms, as well as instructions and assistance in filing forms.

When Coverage Ends

Basic life insurance ends on the date your employment terminates for any reason other than retirement, after you become eligible for an immediate pension benefit, or Total and Permanent Disability.

Supplemental life insurance ends on the date your employment terminates unless you are approved for Total and Permanent Disability. Dependent coverage ends on the date your employment terminates. Business travel accident insurance and special accident insurance coverages end on the date your employment terminates for any reason.

If you are on temporary suspension of work or an approved leave of absence, you may continue your basic life insurance and supplemental life insurance coverage until the end of the third month following the month in which your absence began. In addition, you may elect to continue your special accident insurance coverage for up to 12 months if you are on an approved leave of absence or long-term disability, provided you pay the 12 months' premium in advance.

Basic life insurance, supplemental life insurance, business travel accident insurance, and special accident insurance coverages may end before termination of employment. However, these coverages will end on the earliest of the following dates:

- the date you are no longer considered eligible because of a change in your employment status and (if eligible) you elect not to continue coverage
- the last day of the period for which your last contribution was made
- the date the plan is terminated.

If you should die (in a circumstance or event otherwise covered by the life insurance benefits provided under this plan) within the 30-day period after your coverage terminates, basic life insurance and supplemental life insurance benefits will be paid.

Special accident insurance coverage for a dependent child will end the earlier of 120 days after your child stops being a full-time student or if your child turns age 28, marries, or begins full-time employment.

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 18.

Conversion Privileges

Within 30 days after your basic life insurance, supplemental life insurance, spouse and dependent life insurance and special accident insurance coverages terminate, you may convert all or part of these coverages to individual insurance policies without taking a medical examination. The cost for individual coverage will be based on the insurance company's regular premium rates for the type and amount of insurance available to you through the conversion privilege. The conversion privilege under the special accident insurance plan ends at age 70.

If your basic life coverage is reduced, you will also have an opportunity to convert the amount of discontinued insurance to an individual policy within 30 days after the reduction without taking a medical examination.

If your life and/or accident insurance coverages terminate, you may contact the insurance company to request a conversion form. For a special accident conversion form, contact the Benefit Plans Office.

Business travel accident insurance may not be converted.

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 (ABO).

Within 30 days after your supplemental life insurance coverage terminates due to voluntary termination, retirement, or dismissal, you may port all of the coverage 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.

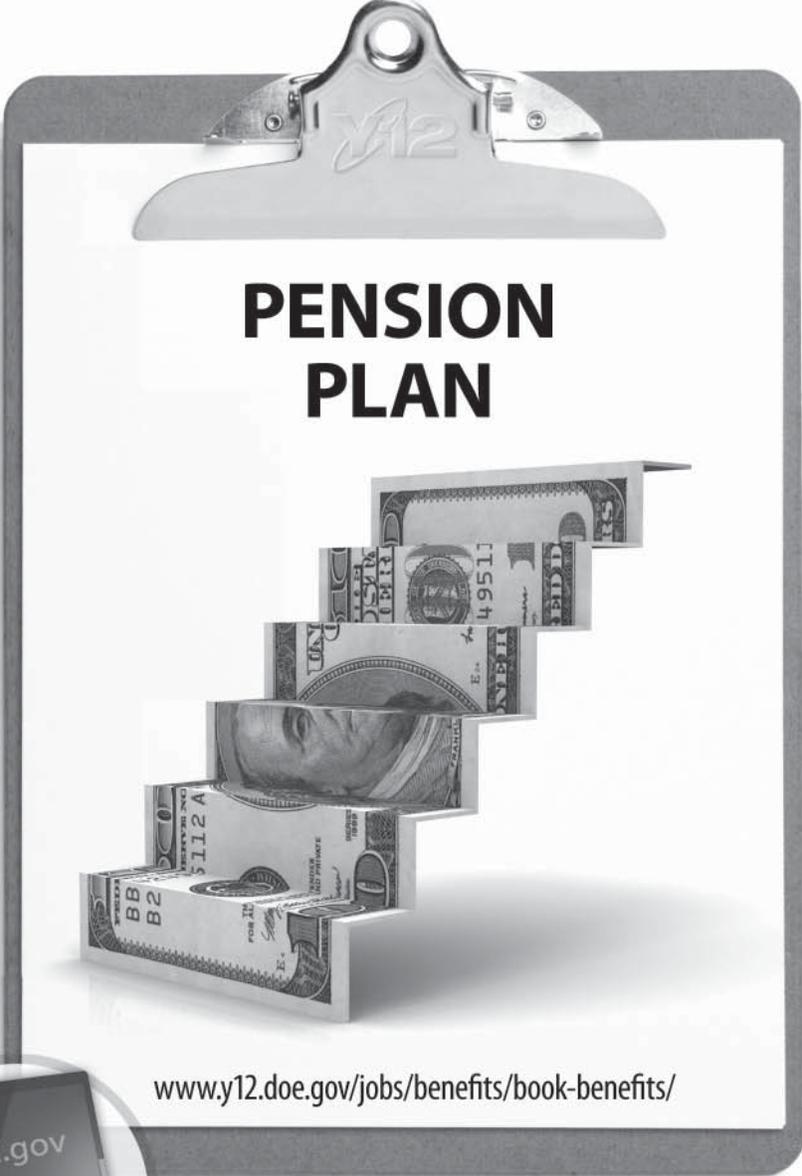
The portable coverage reduces at age 70 and terminates at age 80. (You may convert the ported coverage when the benefit reduces at age 70 and when it terminates at age 80.)

The minimum amount of coverage that you can port is \$20,000 and the maximum amount is the amount of supplemental life coverage you had at the time your group supplemental life benefits ended. 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 may contact the insurance company to request an Election of Portable Coverage Form.

You may not continue group coverage under portability AND convert the coverage to an individual policy. If you elect portable coverage and it is reduced or ends due to age, new conversion rights may be triggered.

Y-12 BOOK OF BENEFITS



PENSION PLAN



www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

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.

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 85 or more. You can receive a reduced benefit as early as age 50 if you have at least 10 years of Company Service.

- Lets you choose from a variety of payment forms

There are several payment forms to choose from, including life annuity and survivor benefit options. If you are married, you will be paid in a joint and 50% survivor benefit, unless you have your spouse's written consent to elect another payment form.

- Offers financial security to your family in case of your death

If you should die while you are still working, the pension plan will pay a survivor benefit if you have at least five years of Company Service.

Plan Eligibility

Company employees automatically become pension plan participants unless they are in one of the following excluded categories:

- covered by a collective bargaining agreement unless the collective bargaining agreement provides for plan participation;
- leased employees;
- independent contractors;
- non-resident aliens who do not have earnings from the Company from sources within the United States; and
- employees who have entered into a written agreement with the Company waiving the right to participate in the plan.

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
- at age 62 or later, with at least 10 years of Company Service
- when your age and years of Company Service total 85 or more.

You can retire with a reduced pension:

- at age 50, with at least 10 years of Company Service.

"Company Service" is defined in the Glossary.

If you choose not 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 70-1/2, unless you decide to defer commencement of your benefit until you actually retire.

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.

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 eight years of Company Service or if your years of Company Service and age total 83 or more
- a reduced pension benefit if you are at least age 48 with at least eight 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 three years during the last 10 years just before you retire (for a discussion of how these earnings are calculated, continue reading)
- 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:

- 1.4% of your average straight-time monthly earnings times your years and months of Company Service.

Alternate Formula

The Alternate formula provides a monthly benefit of:

- 1.767% of your average straight-time monthly earnings times your years and months of Company Service minus 50% of your monthly Primary Social Security Benefit, with the resulting amount prorated for years of Company Service less than 30.

Under this formula, 50% of your Primary Social Security Benefit will be used to offset your earnings. If you provide the Company with complete Social Security Administration records of your covered earnings within six months of your retirement date, the Company will use a Social Security benefit based on actual earnings rather than an estimated earnings history if it provides a higher benefit. Otherwise, the Company will use your estimated earnings history.

When you retire, your Primary Social Security Benefit for purposes of this formula is the benefit you would be eligible to receive at your retirement age or age 62, if later. This benefit is based on the Social Security laws in effect on the date you retire.

Minimum Formula

The Minimum formula provides a monthly benefit of:

- \$5 for each of your first 10 years of Company Service plus \$7 for each of the 11th through 20th years of service, plus \$9 for each year in excess of 20 years of service, plus 10% of your average straight-time monthly earnings (if you have less than eight years of Company Service, this will be reduced 1% a year for each year less than eight), plus \$18.

Pension Benefit Formulas

Formula	Provides monthly benefit of...
<i>Regular</i>	1.4% of your average straight-time monthly earnings times your years and months of Company Service.
<i>Alternate</i>	1.767% of your average straight-time monthly earnings times your years and months of Company Service minus 50% of your monthly Primary Social Security Benefit, with the resulting amount prorated for years of Company Service less than 30.
<i>Minimum</i>	\$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 eight years of Company Service, this will be reduced 1% a year for each year less than eight) 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 27 years of service, you will receive 85% of your full benefit.

For a table of the reduction factors, see Table 1 at the end of this section.

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.

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 27 years of service but postpone starting your pension until age 58, you will receive a full pension because your 27 years of service and your age will then total 85. You can add years to your age after you terminate employment only if you were eligible for early reduced 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 section for survivor reduction factors.

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	\$560	\$700	\$840	\$980	\$1,120
\$3,000	840	1,050	1,260	1,470	1,680
\$4,000	1,120	1,400	1,680	1,960	2,240
\$5,000	1,400	1,750	2,100	2,450	2,800
\$6,000	1,680	2,100	2,520	2,940	3,360

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, since the highest benefit produced by any of the three formulas is the one used.

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 COLA) and your regularly scheduled hours during:

- the three calendar years in which these earnings were highest, during the ten calendar years just before you retire

or, if greater

- the final three years (36 months) just before you retire.

The average straight-time monthly earnings during the final three years are calculated by using:

- scheduled straight-time monthly earnings in the completed months of the calendar year in which you retire
- scheduled straight-time earnings in the two preceding calendar years
- 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 do not 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 entitled "Service and Earnings During Military Service Leave" within the "Credited Service and Severance from Service" section in this tab.

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	$.014 \times 30 \times \$4,500 = \$1,890$	Per month = \$1,890
Alternate formula	$.01767 \times 30 \times \$4,500 = \$2,385$ minus $50\% \times \$1,724^* = \862	Per month = \$1,523
Minimum formula	$\$5 \times 10 \text{ years} = \50 $\$7 \times 10 \text{ years} = \70 $\$9 \times 10 \text{ years} = \90 $10\% \times \$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 \$1,890 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 section for survivor reduction factors.

*This is a typical Primary Social Security Benefit

Normal Forms of Payment

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

For Married Employees

If you are married when you retire, the normal form of payment is a joint and 50% survivor benefit. Under this form of payment, your pension is reduced and, after your death, 50% of that benefit is continued to your surviving spouse for the rest of his or her life. This reduction reflects the fact that benefits are payable during both of your lifetimes. If your spouse dies before you but after your payments start, this form of payment will "pop-up" to the amount that would be paid to a single employee, as discussed under the section "For Single Employees."

For a table of reduction factors, see Table 3 at the end of this section.

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

For Single Employees

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

Optional Forms of Payment

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, in order to elect a form of payment other than the joint and 50% survivor benefit.

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

Life Annuity Option for Married Employees

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

50% Survivor Benefit Option

You can elect a reduced pension in order to provide continuing income to 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(ren) 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 marries or 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 section. If there are multiple dependents receiving a survivor benefit and a dependent dies or is no longer eligible for the dependent survivor benefits, the remaining recipients shall continue to draw only their respective shares.

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

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

Your election of a 50% survivor benefit cannot be changed after your pension begins. If your named survivor should die before you, this payment form will "pop-up" to the amount paid to a single

employee. You must provide a certified copy of your elected survivor's death certificate to Benefit Plans to initiate the "pop-up."

75% Surviving Spouse Option

Under this form of payment, your pension is reduced and, after your death, 75% of that benefit is continued to your surviving spouse for the rest of his or her life. If your spouse dies before you, this form of payment does not "pop-up" to the amount that would be paid to a single employee.

For a table of 75% Surviving Spouse reduction factors, see Table 6 at the end of this section.

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 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 age and average straight-time monthly earnings for the calendar year immediately preceding your retirement date.

If you elect the level income option, the 50% survivor's benefit will be based on the pension amount before adjustment for this option.

The Level Income Option is not available with the 75% surviving spouse coverage.

Social Security

Social Security retirement benefits are entirely in addition to benefits paid from the pension plan.

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

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

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

Participate While You Are Disabled

Continuation of Plan Participation

If you become totally disabled and qualify for benefits under the Company's long-term disability plan, you will continue to accrue Company Service just as if you had continued working. While you continue to be totally disabled, your earnings will be assumed to remain the same as at the time you became disabled. For purposes of determining your benefit, your average straight-time monthly earnings will be based on:

- the three calendar years in which your earnings were highest, during the ten calendar years just prior to your last day worked

or

- the final three years just prior to your last day worked.

For information on how your average straight-time monthly earnings during the final three 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 you have completed at least five years of Company Service, the plan will pay a benefit to your surviving spouse or "dependent child" or "dependent parent." The timing and amount of this benefit will depend on your years of Company Service at the time of death.

If you die after completing 10 years of Company Service, the survivor benefit is payable immediately. (The age 50 requirement for early retirement does not apply in determining eligibility for the survivor benefit.) The benefit is a monthly income equal to 50% of the pension you would have received if you had retired on the day of your death. If your survivor is a younger spouse, the benefit will be reduced 1/2% for each full year more than five years that your spouse is younger than you. However, in no event will the survivor benefit be reduced to less than 25% of your full pension, calculated using your average earnings and service at your death.

If you die before completing 10 years of Company Service (but after five 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 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 6-2/3% for each year before age 65, for up to three 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 unmarried or totally and permanently disabled).

If you have no dependent children, then 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 benefit is payable.

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

Any benefit being paid to a dependent child or dependent parent cannot be transferred to someone else when the child or parent no longer qualifies for it. However, if a spouse dies while receiving the survivor benefit, the spouse's benefit will continue in equal shares to any of your unmarried 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 five years of Credited Service, you are "vested." Being vested means you have a nonforfeitable right to receive plan benefits.

Credited Service (as defined in the Glossary) generally means the time you work at the Company, from your first hour of service until you sever from service.

Further discussion follows on Credited Service and Severance from Service.

Benefit Amount

The amount of your vested pension payable at age 65 depends on your average straight-time 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 pension payments to begin. The three formulas described previously are used to calculate your pension, but with these differences:

- The flat amount of \$18 per month under the Minimum formula 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 ten years of Company Service, that part of the formula using 10% of your average straight-time earnings will be reduced by 1% for each full year less than ten.

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, and 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 6-2/3% for each year before age 65 for up to three 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 (6-2/3% x 3) plus 10% for the years between 60 and 62 (5% x 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 section. If your benefit is paid in the 75% surviving spouse form, it will be reduced according to Table 6 at the end of this section (based on applicable mortality and interest rates as specified by the IRC).

Pre-Retirement Spouse's Benefit

If you leave the Company with vested benefits and you die before plan payments begin, your spouse may be eligible to receive a pre-retirement 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 one 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 five years of Credited Service, you will forfeit your right to any plan benefits.

Credited Service and Severance from Service

"Credited Service" (as defined in the Glossary) is used to determine whether you are eligible for a vested pension.

"Company Service," which is used to determine the amount of your pension benefit, is defined in the Glossary.

Credited Service begins with your first hour of service and ends when you have a severance from service.

A severance from service occurs:

- the day you quit, retire, are discharged, or die

- one 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
- one 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
- two 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.

If you are reemployed within one 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 one 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 one year after the period of severance and the length of your severance is less than five years.

In any event, you will not earn Credited Service during a period of severance lasting one 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 eight 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 considering returning to active service after you retire, you should contact the Benefit Plans 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 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 only include 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 Benefit Plans Office. You may also contact the U.S. 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 Benefit Plans 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 Benefit Plans 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 Benefit Plans Office is not provided, benefits will be delayed.

Transfer of Assets and Benefit Liabilities for ORNL Participants

On September 2, 2010, accrued benefits liabilities were transferred from the 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 September 2, 2010 if either (i) you were employed (or on leave) at ORNL by UT-Battelle, LLC on September 1, 2010, or (ii) you terminated employment or retired prior to September 1, 2010 and your last employer was UT-Battelle or a previous prime contractor at ORNL. If you satisfy one of these conditions, your benefit will be paid by the ORNL Plan rather than this plan for benefits owed on or after October 1, 2010.

If you have a question on whether your benefit will be paid from this plan or the ORNL plan, contact the Benefit Plans Office.

Other Important Information

Other Retirement Income

Any benefits due you (or your survivor, if you die before retirement) from the pension plan will be reduced by the amount (or the actuarial equivalent, if appropriate) of any retirement benefit payable from any of the following sources, provided the benefit is related to service recognized under this pension plan, and is attributable to contributions made by a Department of Energy contractor:

- any other private plan
- any retirement or separation benefit payable under the law of any foreign government

- 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 Benefit Plans Office for more information about tax withholding.

Direct Deposit of Payments

Your pension payments will be directly deposited 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.

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																	
	10 to 18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35 & over
50	40	45	50	50	50	50	50	50	55	60	65	70	75	80	85	90	95	100
51	45	45	50	55	55	55	55	55	60	65	70	75	80	85	90	95	100	100
52	50	50	50	55	60	60	60	60	65	70	75	80	85	90	95	100	100	100
53	55	55	55	55	60	65	65	65	70	75	80	85	90	95	100	100	100	100
54	60	60	60	60	60	65	70	70	75	80	85	90	95	100	100	100	100	100
55	65	65	65	65	65	65	70	75	80	85	90	95	100	100	100	100	100	100
56	70	70	70	70	70	70	75	80	85	90	95	100	100	100	100	100	100	100
57	75	75	75	75	75	75	80	85	90	95	100	100	100	100	100	100	100	100
58	80	80	80	80	80	80	85	90	95	100	100	100	100	100	100	100	100	100
59	85	85	85	85	85	85	90	95	100	100	100	100	100	100	100	100	100	100
60	90	90	90	90	90	90	95	100	100	100	100	100	100	100	100	100	100	100
61	95	95	95	95	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	100	100	100	100
65	100	100	100	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 Benefit Plans 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.

Age	Years of service																		
	8-9	10-18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35 & over
48	40	40	45	50	50	50	50	50	50	55	60	65	70	75	80	85	90	95	100
49	40	40	45	50	50	50	50	50	50	55	60	65	70	75	80	85	90	100	100
50	40	40	45	50	50	50	50	50	50	55	60	65	70	75	80	85	100	100	100
51	45	45	45	50	55	55	55	55	55	60	65	70	75	80	85	100	100	100	100
52	50	50	50	50	55	60	60	60	60	65	70	75	80	85	100	100	100	100	100
53	55	55	55	55	55	60	65	65	65	70	75	80	85	100	100	100	100	100	100
54	60	60	60	60	60	60	65	70	70	75	80	85	100	100	100	100	100	100	100
55	65	65	65	65	65	65	65	70	75	80	85	100	100	100	100	100	100	100	100
56	70	70	70	70	70	70	70	75	80	85	100	100	100	100	100	100	100	100	100
57	75	75	75	75	75	75	75	80	85	100	100	100	100	100	100	100	100	100	100
58	80	80	80	80	80	80	80	85	100	100	100	100	100	100	100	100	100	100	100
59	85	85	85	85	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	100	100	100	100
61	100	100	100	100	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	100	100	100	100

Factors for intermediate ages and service are available from the Benefit Plans Office.

Table 3 – 50% Surviving Spouse Reduction Factors

If you terminate employment on or after June 30, 2004 a factor of .98 will be applied to your life amount to determine your joint and 50% survivor benefit.

If you terminated employment prior to June 30, 2004, the following table is used to determine the percentage of your life amount that is payable as a joint and 50% survivor benefit.

Spouse's Age	Pensioner's age																									
	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
40	.955	.951	.947	.943	.939	.935	.930	.926	.921	.915	.910	.904	.893	.891	.885	.878	.870	.862	.854	.843	.836	.827	.817	.808	.798	.786
41	.956	.952	.949	.945	.941	.936	.932	.927	.922	.917	.911	.906	.900	.893	.886	.879	.872	.864	.856	.847	.838	.829	.819	.810	.800	.789
42	.957	.954	.950	.946	.942	.938	.933	.929	.924	.919	.913	.908	.901	.895	.888	.881	.874	.866	.858	.849	.840	.831	.821	.812	.802	.792
43	.958	.955	.951	.948	.944	.939	.935	.930	.925	.920	.915	.909	.903	.897	.890	.883	.876	.868	.860	.851	.842	.833	.823	.814	.804	.794
44	.960	.956	.953	.949	.945	.941	.937	.932	.927	.922	.917	.911	.905	.899	.892	.885	.878	.870	.862	.853	.844	.835	.826	.816	.806	.796
45	.961	.958	.954	.950	.947	.943	.938	.934	.929	.924	.919	.913	.907	.901	.894	.887	.880	.872	.864	.856	.847	.838	.828	.818	.808	.798
46	.962	.959	.956	.952	.948	.944	.940	.935	.931	.926	.921	.915	.909	.903	.897	.890	.882	.875	.867	.858	.849	.840	.830	.821	.811	.801
47	.963	.960	.957	.953	.950	.946	.942	.937	.933	.928	.923	.917	.911	.905	.899	.892	.885	.877	.869	.861	.852	.842	.833	.823	.813	.803
48	.965	.962	.958	.955	.951	.948	.943	.939	.935	.930	.925	.919	.914	.908	.901	.894	.887	.879	.872	.863	.854	.845	.836	.826	.816	.806
49	.966	.963	.960	.957	.953	.949	.945	.941	.937	.932	.927	.921	.916	.910	.903	.897	.890	.882	.874	.866	.857	.848	.838	.829	.819	.809
50	.967	.964	.961	.958	.955	.951	.947	.943	.938	.934	.929	.924	.918	.912	.906	.899	.892	.885	.877	.868	.860	.851	.841	.832	.822	.812
51	.969	.966	.963	.960	.956	.953	.949	.945	.940	.936	.931	.926	.920	.915	.908	.902	.895	.887	.880	.871	.863	.854	.844	.835	.825	.815
52	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.928	.923	.917	.911	.904	.897	.890	.882	.874	.866	.857	.847	.838	.828	.818
53	.971	.969	.966	.963	.960	.956	.953	.949	.945	.940	.935	.931	.925	.920	.913	.907	.900	.893	.885	.877	.869	.860	.851	.841	.831	.821
54	.973	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.928	.922	.916	.910	.903	.896	.888	.880	.872	.863	.854	.844	.835	.825
55	.974	.971	.969	.966	.963	.960	.956	.952	.949	.944	.940	.935	.930	.925	.919	.913	.906	.899	.891	.883	.875	.866	.857	.848	.838	.828
56	.975	.973	.970	.967	.964	.961	.958	.954	.951	.947	.942	.938	.933	.927	.921	.915	.909	.902	.894	.887	.878	.870	.861	.851	.842	.832
57	.976	.974	.972	.969	.966	.963	.960	.956	.953	.949	.944	.940	.935	.930	.924	.918	.912	.905	.898	.890	.882	.873	.864	.855	.845	.836
58	.978	.975	.973	.970	.968	.965	.962	.958	.955	.951	.947	.942	.938	.932	.927	.921	.915	.908	.901	.893	.885	.877	.868	.859	.849	.840
59	.979	.977	.974	.972	.969	.966	.963	.960	.957	.953	.949	.945	.940	.935	.930	.924	.918	.911	.904	.897	.889	.880	.871	.862	.853	.844
60	.980	.978	.976	.973	.971	.968	.965	.962	.959	.955	.951	.947	.943	.938	.933	.927	.921	.914	.907	.900	.892	.884	.875	.866	.857	.848
61	.981	.979	.977	.975	.972	.970	.967	.964	.961	.957	.954	.950	.945	.940	.935	.930	.924	.918	.911	.904	.896	.888	.879	.870	.861	.852
62	.982	.980	.978	.976	.974	.971	.969	.966	.963	.959	.956	.952	.948	.943	.938	.933	.927	.921	.914	.907	.900	.892	.883	.874	.865	.856
63	.983	.981	.979	.977	.975	.973	.970	.968	.965	.961	.958	.954	.950	.946	.941	.936	.930	.924	.918	.911	.903	.895	.887	.879	.870	.861
64	.984	.982	.981	.979	.977	.974	.972	.969	.967	.963	.960	.957	.953	.948	.944	.939	.933	.927	.921	.914	.907	.899	.891	.883	.874	.865
65	.985	.984	.982	.980	.978	.976	.974	.971	.968	.965	.962	.959	.955	.951	.947	.942	.936	.931	.925	.918	.911	.903	.896	.887	.879	.870
66	.986	.985	.983	.981	.979	.977	.975	.973	.970	.967	.964	.961	.958	.954	.949	.945	.940	.934	.928	.922	.915	.908	.900	.892	.883	.875
67	.987	.986	.984	.982	.981	.979	.977	.974	.972	.969	.967	.963	.960	.956	.952	.948	.943	.937	.932	.925	.919	.912	.904	.896	.888	.879
68	.988	.987	.985	.984	.982	.980	.978	.976	.974	.971	.969	.966	.962	.959	.955	.951	.946	.941	.935	.929	.923	.916	.908	.901	.893	.884
69	.989	.987	.986	.985	.983	.981	.980	.978	.975	.973	.971	.968	.965	.961	.957	.953	.949	.944	.939	.933	.927	.920	.913	.905	.897	.889
70	.990	.988	.987	.986	.984	.983	.981	.979	.977	.975	.972	.970	.967	.964	.960	.956	.952	.947	.942	.937	.930	.924	.917	.910	.902	.894

Table 4 – Surviving Child Reduction Factors

If you elect to provide your dependent child with a survivor pension, use this table instead of Table 3.

Child's age	Your age															
	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
1	.961	.957	.952	.948	.943	.938	.932	.926	.918	.910	.902	.892	.882	.871	.859	.847
2	.964	.960	.956	.952	.947	.943	.937	.931	.924	.917	.908	.899	.890	.879	.868	.855
3	.967	.963	.960	.956	.951	.946	.942	.936	.930	.923	.915	.906	.897	.887	.876	.864
4	.970	.967	.963	.959	.955	.951	.946	.942	.936	.928	.921	.913	.905	.895	.884	.873
5	.973	.970	.967	.963	.960	.955	.951	.946	.941	.935	.928	.920	.912	.903	.893	.882
6	.976	.973	.971	.967	.964	.960	.956	.951	.946	.941	.935	.927	.920	.911	.902	.891
7	.979	.976	.974	.971	.968	.965	.961	.957	.952	.947	.942	.935	.928	.919	.910	.901
8	.981	.979	.977	.976	.972	.969	.966	.962	.958	.953	.948	.943	.936	.928	.920	.911
9	.984	.982	.980	.978	.976	.973	.970	.967	.963	.959	.954	.949	.944	.937	.930	.921
10	.986	.985	.983	.981	.979	.977	.974	.971	.968	.965	.961	.956	.951	.945	.939	.931
11	.988	.987	.985	.984	.982	.980	.978	.976	.973	.970	.966	.962	.958	.952	.947	.941
12	.990	.989	.988	.986	.985	.983	.982	.980	.977	.975	.972	.968	.964	.960	.955	.949
13	.992	.991	.990	.989	.988	.986	.985	.983	.981	.979	.977	.974	.970	.967	.962	.958
14	.993	.993	.992	.991	.990	.989	.988	.986	.985	.983	.981	.979	.976	.973	.969	.965
15	.995	.994	.994	.993	.992	.991	.990	.989	.988	.987	.985	.983	.981	.979	.976	.973
16	.996	.996	.995	.995	.994	.993	.993	.992	.991	.990	.989	.987	.986	.984	.981	.979
17	.997	.997	.996	.996	.996	.995	.995	.994	.993	.993	.992	.991	.989	.988	.986	.984
18	.998	.998	.998	.997	.997	.997	.996	.996	.995	.995	.994	.994	.993	.992	.991	.989
19	.999	.999	.998	.998	.998	.998	.998	.997	.997	.997	.996	.996	.995	.995	.994	.993
20	.999	.999	.999	.999	.999	.999	.999	.999	.998	.998	.998	.998	.997	.997	.997	.996
21	—	—	—	—	—	—	.999	.999	.999	.999	.999	.999	.999	.999	.999	.998
22	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

Factors for intermediate ages are available from the Benefit Plans Office

Table 5 – Surviving Dependent Parent Reduction Factors

If you elect to provide your dependent parent with a survivor pension, use this table instead of Table 3.

Parent's age	Your age		
	55	60	65
70	.950	--	--
75	.985	.949	--
80	.991	.985	.972
85	.995	.992	.985

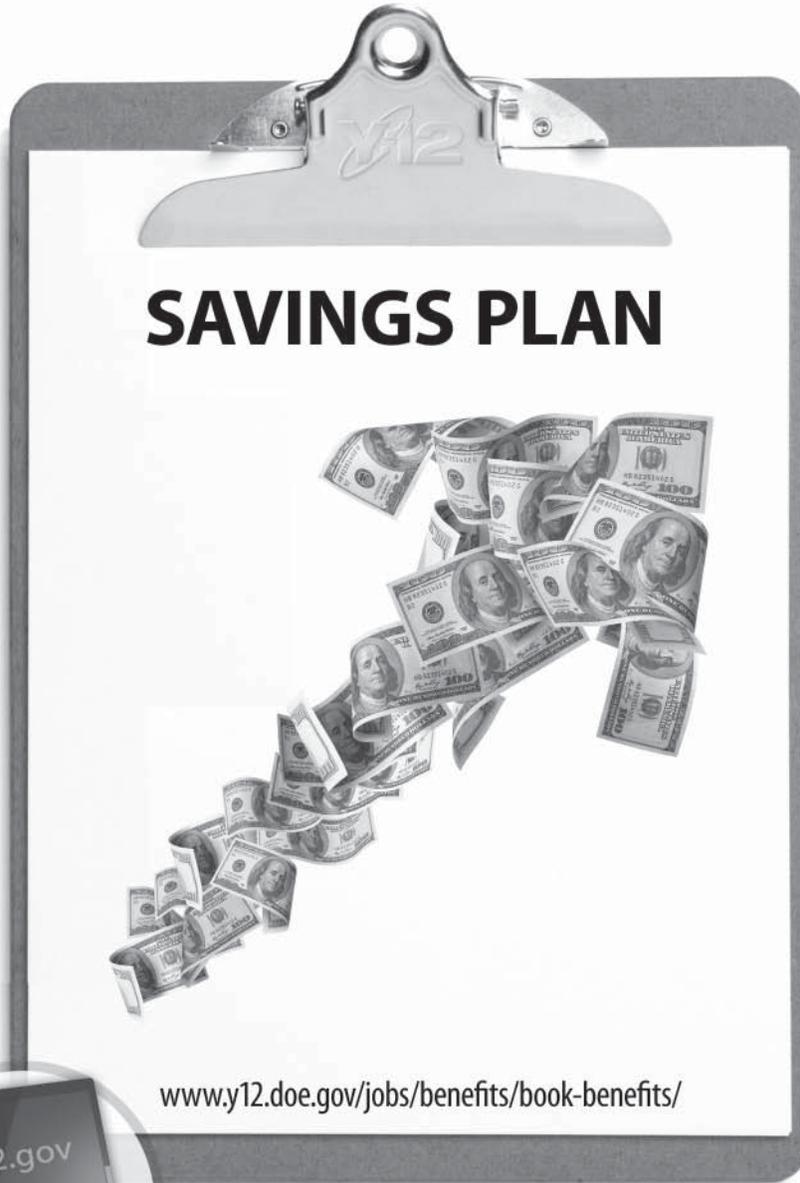
Table 6 – 75% Surviving Spouse Reduction Factors

If you terminate employment during 2010, the following table is used to determine the percentage of your life amount that is payable as a 75% joint and survivor benefit.

Spouse's 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	71	72	73	74	75
41	.909	.901	.893	.885	.876	.866	.856	.845	.834	.822	.810	.797	.784	.771	.757	.742	.728	.713	.697	.682	.666	.649	.633	.615	.597	.579	.561	.542
42	.913	.905	.897	.889	.880	.870	.860	.850	.839	.827	.815	.802	.789	.776	.762	.747	.733	.717	.702	.687	.671	.654	.637	.620	.602	.584	.565	.546
43	.916	.909	.901	.893	.884	.875	.865	.854	.843	.832	.820	.807	.794	.781	.767	.752	.738	.723	.707	.692	.676	.659	.642	.625	.607	.589	.570	.551
44	.920	.913	.905	.897	.888	.879	.869	.859	.848	.837	.825	.812	.799	.786	.772	.758	.743	.728	.713	.697	.681	.664	.648	.630	.612	.594	.575	.555
45	.923	.916	.909	.901	.892	.883	.874	.864	.853	.842	.830	.817	.805	.791	.777	.763	.748	.733	.718	.702	.686	.670	.653	.635	.617	.599	.580	.561
46	.927	.920	.913	.905	.897	.888	.878	.868	.858	.847	.835	.823	.810	.797	.783	.769	.754	.739	.724	.708	.692	.676	.659	.641	.623	.604	.585	.566
47	.930	.924	.917	.909	.901	.892	.883	.873	.863	.852	.840	.828	.816	.802	.789	.775	.760	.745	.730	.714	.698	.682	.665	.647	.629	.610	.591	.571
48	.934	.928	.921	.913	.905	.897	.888	.878	.868	.857	.846	.834	.821	.808	.795	.781	.766	.751	.736	.720	.704	.688	.671	.653	.635	.616	.597	.577
49	.937	.931	.925	.917	.910	.901	.893	.883	.873	.862	.851	.839	.827	.814	.801	.787	.772	.758	.742	.727	.711	.694	.677	.660	.641	.622	.603	.583
50	.941	.935	.928	.922	.914	.906	.897	.888	.878	.868	.857	.845	.833	.820	.807	.793	.779	.764	.749	.734	.718	.701	.684	.666	.648	.629	.610	.590
51	.944	.938	.932	.926	.918	.910	.902	.893	.883	.873	.862	.851	.839	.826	.813	.800	.785	.771	.756	.740	.724	.708	.691	.673	.655	.636	.617	.597
52	.947	.942	.936	.929	.922	.915	.907	.898	.889	.879	.868	.857	.845	.833	.820	.806	.792	.778	.763	.747	.732	.715	.698	.680	.662	.643	.624	.604
53	.950	.945	.940	.933	.927	.919	.911	.903	.894	.884	.874	.863	.851	.839	.826	.813	.799	.785	.770	.755	.739	.723	.706	.688	.670	.651	.631	.611
54	.954	.949	.943	.937	.931	.924	.916	.908	.899	.890	.879	.869	.857	.845	.833	.820	.806	.792	.777	.762	.747	.730	.713	.696	.677	.658	.639	.619
55	.956	.952	.947	.941	.935	.928	.921	.913	.904	.895	.885	.875	.864	.852	.840	.827	.813	.799	.785	.770	.754	.738	.721	.704	.685	.666	.647	.627
56	.959	.955	.950	.945	.939	.932	.925	.917	.909	.900	.891	.881	.870	.858	.846	.834	.821	.807	.793	.778	.762	.746	.730	.712	.694	.675	.655	.635
57	.962	.958	.953	.948	.942	.936	.929	.922	.914	.906	.896	.887	.876	.865	.853	.841	.828	.814	.800	.786	.770	.755	.738	.720	.702	.683	.664	.644
58	.965	.961	.956	.951	.946	.940	.934	.927	.919	.911	.902	.892	.882	.871	.860	.848	.835	.822	.808	.794	.779	.763	.747	.729	.711	.692	.673	.652
59	.967	.963	.959	.955	.950	.944	.938	.931	.924	.916	.907	.898	.888	.878	.867	.855	.843	.830	.816	.802	.787	.772	.755	.738	.720	.701	.682	.662
60	.970	.966	.962	.958	.953	.948	.942	.936	.929	.921	.913	.904	.894	.884	.874	.862	.850	.837	.824	.810	.796	.780	.764	.747	.729	.711	.691	.671
61	.972	.969	.965	.961	.956	.951	.946	.940	.933	.926	.918	.910	.900	.891	.880	.869	.857	.845	.832	.819	.804	.789	.773	.757	.739	.720	.701	.681
62	.974	.971	.968	.964	.959	.955	.950	.944	.937	.931	.923	.915	.906	.897	.887	.876	.865	.853	.840	.827	.813	.798	.783	.766	.749	.730	.711	.691
63	.976	.973	.970	.966	.962	.958	.953	.948	.942	.935	.928	.920	.912	.903	.893	.883	.872	.860	.848	.835	.822	.807	.792	.776	.758	.740	.721	.701
64	.978	.975	.972	.969	.965	.961	.957	.951	.946	.940	.933	.925	.918	.909	.900	.890	.879	.868	.856	.844	.831	.816	.801	.785	.768	.750	.732	.712
65	.980	.977	.975	.971	.968	.964	.960	.955	.950	.944	.937	.930	.923	.915	.906	.896	.886	.876	.864	.852	.839	.825	.811	.795	.778	.761	.742	.723
66	.982	.979	.977	.974	.971	.967	.963	.958	.953	.948	.942	.935	.928	.920	.912	.903	.893	.883	.872	.860	.848	.835	.820	.805	.789	.771	.753	.734
67	.983	.981	.979	.976	.973	.970	.966	.962	.957	.952	.946	.940	.933	.926	.918	.909	.900	.890	.879	.868	.856	.843	.830	.815	.799	.782	.764	.745
68	.985	.983	.980	.978	.975	.972	.969	.965	.960	.955	.950	.944	.938	.931	.923	.915	.906	.897	.887	.876	.865	.852	.839	.824	.809	.792	.775	.756
69	.986	.984	.982	.980	.977	.974	.971	.968	.963	.959	.954	.949	.943	.936	.929	.921	.913	.904	.894	.884	.873	.861	.848	.834	.819	.803	.786	.767
70	.987	.986	.984	.982	.979	.977	.974	.970	.967	.962	.958	.953	.947	.941	.934	.927	.919	.911	.901	.892	.881	.870	.858	.844	.829	.814	.797	.779
71	.988	.987	.985	.983	.981	.979	.976	.973	.969	.966	.961	.956	.951	.945	.939	.932	.925	.917	.908	.899	.889	.878	.867	.854	.840	.824	.808	.791
72	.990	.988	.987	.985	.983	.981	.978	.975	.972	.969	.965	.960	.955	.950	.944	.938	.931	.923	.915	.907	.897	.887	.876	.863	.850	.835	.819	.802
73	.991	.989	.988	.986	.985	.983	.980	.978	.975	.971	.968	.964	.959	.954	.949	.943	.936	.929	.922	.914	.905	.895	.884	.873	.860	.846	.831	.814
74	.992	.990	.989	.988	.986	.984	.982	.980	.977	.974	.971	.967	.963	.958	.953	.948	.942	.935	.928	.920	.912	.903	.893	.882	.870	.856	.842	.826
75	.992	.991	.990	.989	.988	.986	.984	.982	.979	.977	.973	.970	.966	.962	.957	.952	.947	.941	.934	.927	.919	.911	.901	.891	.879	.866	.853	.837

75% factors are updated each year to reflect the preceding November 30-year treasury rate.

Y-12 BOOK OF BENEFITS



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Y-12 BOOK OF BENEFITS

The Savings Plan offers a convenient, tax-effective way to save and invest for the future. At retirement, Savings Plan benefits are designed to work together with the Pension Plan and Social Security benefits to provide retirement income.

The Savings Program:

- Makes saving easy

You may save from 2.5% up to 75% of your eligible earnings on a before-tax, Roth, or after-tax basis each year through convenient payroll deductions subject to certain other limits. Persons above a certain compensation amount are called “highly compensated employees” and can only contribute up to 16% of eligible earnings, subject to certain other limits.

- Offers matching contributions to increase your savings

When you contribute to the Savings Plan, the Company makes a matching contribution based upon every dollar you save up to 6% of your eligible earnings.

- Lets you save tax-deferred

Your before-tax contributions, Company matching contributions and investment earnings are tax-deferred, which means you will not pay federal income taxes on these amounts until you take the money out of the Savings Plan.

- Gives you the opportunity to invest in your future

You can invest your savings and Company matching contributions in the investment funds made available under the Savings Plan.

- Provides 24-hour access to account information

The Savings Plan information line offers up-to-date information about your account 24 hours a day, 7 days a week and our Internet access provides the same convenience.

- Allows you flexibility today

Although the objective of the Savings Plan is to help you save for the future, you have the flexibility to meet short-term needs through loan and withdrawal provisions.

Enrolling in the Savings Plan

The Savings Plan is completely voluntary. When you begin work, you will receive a Savings Plan enrollment kit, which includes this summary plan description, investment fund prospectuses and fact sheets, as well as beneficiary designation and rollover contribution forms. You will also receive a separate mailing containing your web password and personal identification number (PIN).

You can start participating in the Savings Plan on your first day of employment by logging on to the website at www.401kaccess.com and entering your account number which is your Social Security Number or by calling the Participant Services information line at 1-800-777-4015 to elect:

- the percentage you wish to save
- how you want to save – on a before-tax basis, an after-tax basis, a Roth basis, or a combination of all three

and

- your investment choices.

Your payroll deductions will begin as soon as administratively possible, generally within two pay periods.

Once you have enrolled, your contribution amount and investment choices will remain in effect until you make a change.

A few days after you enroll, a confirmation statement will be sent to your home. You should review the statement carefully to make sure your participation and election information is correct.

Naming Your Beneficiary

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

Be sure to keep your beneficiary designation up to date. If you do not make a valid beneficiary designation and you have been married for at least one year at the time of your death, your spouse will receive the value of your vested Savings Plan account. If you are single and do not name a beneficiary, your vested Savings Plan account will be paid to your personal representative if one is appointed within 12 months of your death or if none is appointed to your heirs-at-law.

You may change your beneficiary at any time. Simply call the Participant Services information line or use the Internet to complete the form online or to print the form. Your beneficiary election will be effective when Participant Services receives your completed form.

The Savings Plan Information Sources

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

- enroll in the Savings Plan
- check your account balance and investment performance
- make investment elections
- transfer between investment funds
- change contribution percentages
- change investment elections
- request a loan or withdrawal
- update or change beneficiary information.

To reach Participant Services

In the United States:
1-800-777-4015

International:
1-512-344-3000

Telecommunications Device for the Deaf:
1-877-852-4289

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

Participant Services Representatives:
8 am – 10 pm Eastern time, Monday through Friday (except on days when the New York Stock Exchange is closed)

Internet Access:
To access the Savings Plan via the Internet, please use the following URL:
<http://www.401kaccess.com>

When you call Participant Services, you will need your PIN and a touch-tone telephone to use the voice response unit. If you do not have a touch-tone telephone, call Participant Services and speak to a customer service representative.

You will receive your web password and PIN separate from your enrollment kit. You may change your password and PIN to personalize it at any time you wish. Your password and PIN are confidential and should be kept in a safe place. If you lose your password or PIN, call Participant Services and a copy of

the number will be sent to your home. You may also request a password reminder from the Internet site to be mailed or e-mailed to you provided you have set up your e-mail preference. For security reasons, you can never get your PIN over the telephone.

Accessing the System

To log on to your account, simply go to the log-in screen, press log-in, enter your account number and your password, and press submit. Every participant in the plan will be able to gain access to the plan, even if you do not have an account balance.

Working With the Plan

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

Your Quarterly Statement

After the end of each calendar quarter, you will receive a Savings Plan statement that reports your account activity, total fund balances, and investment elections.

You can use these statements to track the value of your savings under the Savings Plan.

You also have access to your account statement at any time by visiting the Internet at www.401kaccess.com. You can create an online statement for any period of time within the last 24 months.

Your Contributions

You can contribute to the Savings Plan in the following ways:

- before-tax contributions from your eligible earnings
- after-tax contributions from your eligible earnings
- Roth contributions from your eligible earnings

and

- rollover contributions.

Your eligible earnings are:

Straight-time earnings/Straight-time hours X scheduled hours = eligible earnings

Straight-time earnings include shift premiums and hourly COLA, but do not include overtime.

Before-Tax Contributions

Your before-tax contributions are deducted from your eligible earnings before federal and, in most cases, state and local taxes are determined. (Social Security taxes are not affected.) By saving with before-tax dollars, you reduce your current taxable income and, therefore, your current annual tax liability. The government allows this reduction in taxable income to encourage you to save for retirement. For this reason, withdrawals during your active career with the Company are restricted.

Roth Contributions

Your Roth contributions are deducted from your eligible earnings on an after tax basis. Roth contributions and earnings grow tax free. Upon retirement Roth contributions are distributed free from federal and most state income tax. Earnings on Roth contributions are also tax free if they are withdrawn after age 59-1/2 and your account has been open at least 5 years.

Limitations

There is a limit on the amount of before-tax and Roth contributions that you can make to all employer plans during any year. This combined annual limit is \$16,500 for 2011. The before-tax/Roth contribution limit, which is announced annually, will be adjusted for changes in the cost of living increases as determined by the federal government. If you are employed during one year by another employer and make before-tax or Roth contributions to another employer's plan, these contributions also count in the annual contribution limit and you are responsible to notify the Company that you have reached your limit or if you have exceeded the limit you are responsible to request a distribution of the excess amount.

There is also a limit on the total amount of contributions including before-tax, Roth, after-tax, and matching contributions that can be made to your account each year. This annual limit is \$49,000 for 2011 (\$54,500 if you are eligible to make catch-up contributions) and will be adjusted for changes in the cost of living increases as determined by the federal government.

Additional limits may apply to highly compensated employees. You will be notified if these additional limits apply to you.

Once you reach the annual before-tax/Roth limit (adjusted if you are age 50 or older and eligible to make additional catch-up contributions), you may elect to stop making contributions. If you elect to stop your contributions, the employer match will also stop. If you do not stop making contributions when you reach this limit, they will automatically be changed to after-tax contributions for the remainder of the year unless you take action to stop making contributions or you reach your overall annual contribution limit. Your contributions will revert back to your original election of before-tax or Roth contributions at the beginning of the new calendar year without filing a new election. However, if you are a highly compensated employee and have made a flat dollar catch-up election, you must make a new catch-up election at the beginning of the year. Company matching contributions will continue to be made as usual after the change to after-tax contributions.

Catch-up Contributions

Those participants age 50 and older may be able to contribute additional amounts of before-tax or Roth contributions called "catch up contributions." Call the toll-free number 1-800-777-4015 for assistance in determining whether you qualify to make an additional contribution and the maximum amount of such contribution.

After-Tax Contributions

Your after-tax contributions are deducted from your eligible earnings after income taxes are withheld and do not provide the advantages of deferring your taxes that are available through before-tax contributions. Investment earnings on after-tax contributions, however, are tax-deferred until withdrawn from the Savings Plan.

Also, after-tax contributions are subject to less stringent government withdrawal restrictions, as described later in this section.

Contributions During and After Military Leave

If you receive differential pay while you are on military leave, you may continue to make contributions to the Plan from your differential pay.

When you return to work after you have been on military leave, you may be able to make contributions to the Savings Plan to make up for contributions you missed while you were on leave and may receive Company matching contributions on your make-up contributions.

Contact Participant Services for more information if you think this may apply to you. You may also contact the U.S. 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 the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Before-Tax Savings vs. After-Tax Savings

Here is an example comparing before-tax contributions to after-tax contributions.

Assume you are married, earn \$50,000 a year, claim two exemptions on your joint return, and elect to save 6% of your eligible earnings.

Assume also that your marginal tax rate is 15%, which means that for each dollar you save on a before-tax basis, you save \$.15 in taxes. Here is how it works:

	Before-tax savings	After-tax savings
Eligible earnings	\$50,000	\$50,000
Before-tax contributions (6%)	-\$3,000	-\$0
Adjusted gross income	\$47,000	\$50,000
Federal income tax*	\$2,660	\$3,110
After-tax contributions	-\$0	-\$3,000
Take home pay	\$44,340	\$43,890
Differences: \$450		

*Taxes are estimated federal income taxes. Note that this example only takes federal tax savings into account. Depending on where you live, you may also save on state and local taxes.

As you can see, by saving with before-tax contributions, you can reduce your income taxes by \$450 (15% x \$3,000) in this example. Therefore, you can invest the same \$3,000 a year, but your take-home pay will be higher by \$450.

Rollovers to the Savings Plan

As a general rule, you may rollover taxable and Roth amounts you receive from a tax-qualified plan of a former employer to your Savings Plan account if the amounts you received qualify to be rolled over. When you request a withdrawal or receive a distribution from a tax-qualified plan of a former employer you will receive information telling you that the amount qualifies or does not qualify to be rolled over. You will continue to defer current federal income taxes on the amount you rollover. If you come to work for the Company after working for another employer that has a tax-qualified retirement plan, and you receive a distribution from that plan that qualifies to be rolled-over, you may transfer the taxable and Roth portion of your payout directly to the Savings Plan or following an interim transfer to a conduit Individual Retirement Account (IRA).

Any rollover must be made within 60 days of the date you receive a distribution from the other qualified plan (or conduit IRA). If you miss the deadline, you cannot roll your distribution into the Savings Plan and you will have to pay taxes on the taxable portion of your distribution.

To make a rollover of a qualified distribution, you must submit a certified check or a check from your prior plan's trustee or custodian payable to the Plan, the distribution statement you receive with your rollover check and a completed rollover contribution form, to Participant Services.

Call Participant Services to obtain the instructions and form for a rollover or print the form from the Internet site.

How Much You Can Save

You may contribute from 2.5% to 75% (or 16% for a highly compensated employee) of your eligible earnings each pay period, subject to the annual contribution limits. You may save in 0.5% increments.

These percentages may be reduced for highly compensated employees to satisfy certain Internal Revenue Code tests. You will be notified of the restrictions for each year if they apply to you.

Your contributions up to 6% of eligible earnings are eligible for Company matching contributions, as discussed later in this section. Any additional contributions are not eligible for Company matching contributions.

Changing Your Contributions

You can increase, decrease or stop your before-tax, after-tax, or Roth contributions at any time by calling Participant Services or through your Internet account. The last election you make before the payroll system computes your contribution will override any previous elections. Changes will be sent to payroll on a weekly basis and will be effective as soon as administratively possible, generally within two pay periods.

You can suspend or resume contributions at any time. When you resume your contributions, cash deposits to make up for the period of suspension will not be permitted. All contributions must be made by payroll deduction.

Company Matching Contributions

Each pay period, the Company will match a percentage of each dollar you save.

i The Company Match

The Company will match your contributions up to...

- 100% of first 2% of eligible earnings
- 50% of next 4% of eligible earnings.

Suppose an employee with \$50,000 of eligible earnings contributes 6% of eligible earnings for a total savings of \$3,000 per year. The Company matching contribution would be:

100% of first 2% of eligible earnings	$\$1,000 \times 100\% = \$1,000$
50% of next 4% of eligible earnings	$\$2,000 \times 50\% = \$1,000$
The company match would be: \$2,000	

Vesting

You are always 100% vested in your own contributions, as adjusted for investment earnings and losses on your contributions. Company matching contributions become 100% vested after you complete three years of Credited Service (as defined in the Glossary).

You will also become immediately 100% vested in all Company matching contributions, adjusted for investment earnings and losses, when you:

- reach age 65 while a Company employee
- retire and are eligible to receive an immediate pension

or

- leave the Company because you are Totally and Permanently Disabled, die or are involuntarily terminated for reasons other than cause.

Your Investment Options

You may choose to have your contributions and Company matching contributions invested in any one or a combination of the Savings Plan's investment funds – in increments of 1%. The funds are valued at market daily. The Retirement and Savings Plan Committee may freeze or change the funds at any time.

Any investment involves some degree of financial risk. Actual investment results for your Savings Plan contributions will vary depending on the fund or funds in which they are invested. Investment information can be found online at www.401kaccess.com.

Detailed information about each of the funds currently available under the Savings Plan is provided in the chart on the following pages. This data is provided for informational purposes only. Before making any investment decision, you should also review the fund prospectuses and fact sheets.

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

Investment Earnings

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

Savings Plan Investment Options

Fund name	Investment objectives	Investment strategy
Stable Value Fund (Commingled Fund) (most conservative)	Maximum safety of principal, stable income and liquidity	To invest in investment contracts and high quality intermediate duration fixed income securities and money market instruments
Intermediate Term Investment Grade Bond Fund (MBFIX) (more conservative)	Conservation of capital with attractive total returns	To invest in undervalued investment grade securities in the fixed income market, with an average portfolio maturity ranging from 3–7 years.
American Balanced Fund (RLBFX) (conservative to moderate)	Appreciation of capital, current income and long-term capital growth	To invest in a diversified portfolio of assets including stocks, bonds, and other fixed income securities, responding to market changes by shifting its asset allocation

Fund name	Fund holdings	Factors affecting performance	Fund manager
Stable Value Fund (Commingled Fund) (most conservative)	High quality investment contracts issued by insurance companies, banks, or other financial institutions High quality short-term money market instruments to provide additional diversification and liquidity.	Lower risk of principal; however, higher inflation risk, because its expected rate of return is usually lower than the other options and may not outpace inflation.	Invesco Advisers, Inc.
Intermediate Term Investment Grade Bond Fund (MBFIX) (more conservative)	U.S. Treasury bonds U.S. Agency bonds Mortgage-backed bonds Corporate bonds	Inflation expectations and interest rate changes affect performance. Long-term decisions made by the fund manager and the nature of the fund's investments should be expected to provide higher returns and higher risks as compared to the Stable Value Fund.	Wells Fargo Funds Management
American Balanced Fund (RLBFX) (conservative to moderate)	Stocks in key sectors of the U.S. economy Small amount of non-U.S. securities High quality corporate and government bonds.	Subject to stock market risk and volatility. Bond values tend to vary inversely with interest rates. Long-term decisions made by the fund manager and the nature of the fund's investments may provide higher returns and higher risks as compared to a long-term bond portfolio.	Capital Research and Management Company (CRMC)

Fund name	Investment objectives	Investment strategy
Indexed Equity Fund (moderate)	Replication of the Standard & Poor's 500 Index investment performance.	To fully replicate the Standard & Poor's 500 Index portfolio through passive management, trading only when there is a change to the index. Offers exposure to approximately 70% of the U.S. equity market.
The Investment Company of America (RICFX) (moderate to aggressive)	Long-term growth of capital and income, with an emphasis on future dividends and capital appreciation.	To invest in "blue-chip" companies with proven track records of rising earnings and dividends.
Allianz NFJ Dividend Value Instl. (NFJEX) (aggressive)	The Fund seeks long-term growth of capital and income.	To invest in stocks of companies whose securities have low valuations and that pay or are expected to pay dividends.
The Growth Fund of America (RGAFX) (aggressive)	Long-term capital growth.	To invest in a wide range of companies that appear to offer superior opportunities for long-term growth.
New Perspective Fund (RNPFX) (more aggressive)	Long-term capital growth.	To invest in large established companies in world markets, focusing on changing global trade patterns and related growth opportunities.

Fund name	Fund holdings	Factors affecting performance	Fund manager
Indexed Equity Fund (moderate)	Primarily large U.S. stocks in identical proportions to the Index. Small amount of money market securities to maintain liquidity.	As a fund investing primarily in common stocks, the fund is subject to market risk – the possibility that common stock prices will decline over short or even extended periods.	State Street Bank and Trust Company
The Investment Company of America (RICFX) (moderate to aggressive)	Primarily stocks and a small percentage of bonds issued by large, well-known U.S. companies May include non-U.S. securities.	Stocks are subject to market risk. Bond values tend to vary inversely with interest rates. Long-term decisions made by the fund manager and the nature of the fund's investments may provide higher returns and higher risks as compared to a balanced portfolio.	Capital Research and Management Company (CRMC)
Allianz NF J Dividend Value Instl. (NFJEX) (aggressive)	U.S. common stocks Some fixed income securities and other equities such as convertible preferred stocks.	Stocks are subject to market risk. Long-term decisions made by the fund manager and the nature of the fund's investments may provide higher returns and higher risks as compared to a balanced portfolio. Due to the contrarian approach, there is the potential that the common stock prices will decline over short or even extended periods.	Allianz Global Investors Fund Management, LLC
The Growth Fund of America (RGAFX) (aggressive)	Primarily U.S. securities May include foreign securities May invest up to 10% in debt securities rated below investment grade.	Subject to stock market risk and volatility; there is the potential that the common stock prices will decline over short or even extended periods.	Capital Research and Management Company (CRMC)
New Perspective Fund (RNPFX) (more aggressive)	Stocks of companies in major world markets, including the U.S.	Subject to global market risks, such as exchange rates, currency fluctuations, and political and social instability.	Capital Research and Management Company (CRMC)

Fund name	Investment objectives	Investment strategy
Small Cap Value Fund (GSSIX) (more aggressive)	Long-term growth of capital	The fund will invest at least 80% of its assets in securities of small companies which the managers feel are undervalued.
Small Cap Growth Fund (WFSIX) (more aggressive)	Seeks to achieve long-term capital appreciation through a diversified portfolio of equity securities of small capitalization companies.	Under normal market conditions, the fund invests at least 80% of its total assets in equity securities of U.S. companies, such as common and preferred stock. The fund generally invests in small companies with capitalization of \$2.0 billion or less. The fund may retain securities that it already has purchased even if the company outgrows the fund's capitalization limitations.
International Growth Fund (RERFX) (more aggressive)	Seeks to provide long-term growth of capital by investing in companies based outside the U.S.	Invests in securities of strong, growing companies based chiefly in Europe and the Pacific Basin, ranging from small firms to large corporations. The fund can only own securities of issuers domiciled outside the United States, except a nominal portion that, for liquidity purposes, may be held in U.S. dollars and/or equivalents.

Fund name	Fund holdings	Factors affecting performance	Fund manager
Small Cap Value Fund (GSSIX) (more aggressive)	Common stock issued by small capitalization companies	The securities of small capitalization companies generally involve greater risks than those associated with larger, more established companies, and may be subject to erratic price movements. Securities of such companies may lack sufficient liquidity to enable the fund managers to effect sales at an advantageous time or without a substantial drop in price.	Goldman Sachs Asset Management
Small Cap Growth Fund (WFSIX) (more aggressive)	U.S. common and preferred stock issued by small capitalization companies.	In addition to risk factors associated with investing in the stock market in general, small companies trade less frequently and in lower volume than the shares of larger companies. This could result in significantly higher volatility in their share price over short and extended periods of time. Small companies may also have more business risk due to limited product lines and less access to financial capital.	Wells Fargo Funds Management
International Growth Fund (RERFX) (more aggressive)	Stocks of large and medium-sized international companies.	Subject to global market risks, such as exchange rates, currency fluctuations, and political and social instability.	Capital Research and Management Company (CRMC)

Changing Your Investments

You may change your investment choice for future contributions – in 1% increments – at any time by calling Participant Services or through your Internet account. The last change you make before 4 pm Eastern time, or before the market closes if earlier, will override any previous changes made that day. Your changes will be effective with the next deposit of your contributions.

You can transfer existing balances – in 1% increments – among the investment options up to 12 times a calendar year, and in any event at least once per quarter. Transfers completed before 4 pm Eastern time will be effective that day, assuming it is a business day and the New York Stock Exchange is open; otherwise, changes will be effective the next business and market trading day. Confirmation of your transaction will be mailed within three business days.

Transaction Processing

The transactions you request through Participant Services will ordinarily be processed within the times specified in this handbook. However, in certain circumstances, such as technical problems with the internet site or telephone service, you may experience difficulty in making your request or your transaction may be delayed.

Telephone service can be interrupted from time to time and, further, a high volume of telephone calls can overload the system and prevent calls from being answered. Transactions may also be delayed. For example, if market conditions require a daily volume limit on trades in an asset, there is suspension in trading of an asset or in the event of a major market or systems disruption. You will be informed if a transaction is not completed on the day requested, and the transaction will be completed as soon as administratively possible thereafter, based on the unit prices in effect when the transaction is completed.

Reward vs. Risk

One way to think of the gain or loss potential of an investment is to think of the potential for reward or the level of risk it offers. Generally, investments with more risk to principal have the potential to yield higher returns over a longer period of time than investments with less risk.

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

When will you need the money in your accounts?

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

What are your investment goals?

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

What is your financial situation?

Figure out how much money you can afford to save. It may be more than you think. If you save a little, with the tax savings you receive from before-tax contributions, your take-home pay may not be reduced as much as you expect.

Are your investments sufficiently diversified?

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

Loans from Your Account

Although the Savings Plan is meant to help you save for the future, you have some access to your funds today through loans and withdrawals.

You may borrow money from a portion of your vested account balance and pay back the loan through payroll deduction. You will repay loan amounts, plus interest, back to your Savings Plan account. You will not be taxed on the money you borrow from your account, provided you timely repay the loan as required, and any interest that you pay is credited to your account. Loan payments are made on an after-tax basis.

There are two types of loans available to employees: general and residential. General loans are available for any reason. Residential loans are for the purchase or building of your primary residence. You may only have one general loan and one residential loan outstanding at any one time. You must wait at least 30 days after a loan is repaid before taking another loan of the same type.

Loan Amounts

The maximum amount available for loans at one time is the lesser of:

- 50% of your vested account balance at the time of the loan

or

- \$50,000 minus your highest outstanding loan balance during the previous 12 months

Your account balance is based on the market value of the funds at the time the loan is requested. The minimum loan amount is \$1,000.

Loans are in the form of cash only. For information about the maximum loan amount available to you, check your account on the Internet or call Participant Services.

Loan Fee

There is a one-time, nonrefundable application fee of \$50 for each loan. This fee will be deducted from your account balance after the loan has been granted, and will be taken from your most conservative investment fund (as determined by The Recordkeeper).

Interest Rate

The loan interest rate used for the entire term of the loan is the Treasury Rate plus 4%, as published in The Wall Street Journal on the first business day of the month preceding the month in which the loan is requested. The rate in effect when you take a loan is the rate you will pay for the term of your loan. Under current federal income tax law, none of the interest on a loan from the Savings Plan is tax deductible.

Loan Funding

If a loan is approved, a loan account is set up in your name. The loan amount is taken proportionally from the investment funds in which you have elected to invest your different types of savings in this order:

- first from your before-tax accounts, starting with vested Company matching contributions
- second from your after-tax accounts, starting with vested Company matching contributions
- third from any pre-tax or after-tax rollover contributions.
- fourth from your Roth contributions and then your Roth rollover contributions

Repaying Your Loan

Repayment on loans will be automatically deducted from your paychecks. General loans must be repaid within 4.5 years and residential loans must be repaid within 15 years. The minimum loan repayment period is 6 months.

As you repay your loan, your savings will be restored in the reverse order from which your loan was taken, starting with Roth rollover contributions and rollover contributions, followed by after-tax contributions and the Company matching contributions on those funds, then before-tax and Company matching contributions on those funds. Your repayments will be invested proportionally in the Savings Plan funds you have chosen for your current contributions at the time each payment is made.

You may pay off your outstanding loan at any time prior to maturity by sending a certified check to The Recordkeeper for the payoff amount. Loans must be paid off in full – no partial payments are allowed. You must call Participant Services to find out payoff amounts.

If you take a long-term leave of absence or are on long-term disability, you must continue to make repayments directly to The Recordkeeper. You will receive a monthly invoice with which to continue your monthly payments.

Any payments missed because of a short-term absence will be automatically deducted from your paycheck when you return to work.

Loan Default

A portion of your account balance equal to the amount of your original loan serves as collateral for the loan. If you default on your loan, The Recordkeeper will satisfy your unpaid loan balance by using the collateral in your account. Your loan will default if you:

- leave the Company and do not pay the outstanding balance within six months
- fail to make a scheduled loan repayment by the end of the quarter following your last payment
- do not repay your loan by the end of the term of the loan

or

- are on long-term leave of absence or long-term disability and stop making payments, on the maturity date or the last day of the 12th month of missed payments, whichever occurs first.

If your loan defaults, the outstanding balance of your loan will be treated as a taxable distribution when the default occurs. Your defaulted loan will be subject to tax law distribution rules such as the 10% penalty if you are under age 59-1/2. You will remain obligated for any unpaid balance on a loan that is in default.

If you do not repay your loan by the time you become entitled to a distribution from the Savings Plan (except for in service withdrawals) your loan becomes due and payable in full immediately. You may repay the entire balance of the loan (including any accrued interest). If you do not repay the entire outstanding loan balance, the amount payable to you from the Savings Plan will be reduced by the outstanding balance on the loan.

You may not take out a new loan while you have a loan which is in default.

Change in Payroll Frequency

If your pay period changes from weekly to monthly or vice versa, the repayment of the remaining principle loan balance will be adjusted for the new payroll frequency. You will receive notice of the new payroll deduction amount.

Taking a Loan

For a general loan:

- Log on to your account or call Participant Services to find out the maximum loan amount available to you and current interest rates.
- Select the loan amount and terms that best suit your needs.
- You will be mailed a check and loan disclosure statement to your address on record with payroll, generally within three business days. The check and loan disclosure statement constitute your legal notification of your loan responsibilities. Your endorsement indicates your acceptance of those responsibilities and your promise to repay the loan within the agreed-upon period.

For a residential loan:

- Log on to your account or call Participant Services to request a residential loan package, which will include a promissory note.
- Sign and return the application along with any other paperwork to The Recordkeeper within 60 days of the date on the note.
- You will be mailed a check and loan disclosure statement, generally within three business days after your loan is approved. The check and the loan disclosure statement constitute your legal notification of your loan responsibilities and your promise to repay the loan within the agreed-upon period.

Withdrawals While You are Employed

The Savings Plan also allows you to take a withdrawal from your account while you are still employed by the Company within certain limits and rules which are described in this section. A withdrawal must be at least \$200 (or your vested account balance if less) and only one withdrawal may be made on any day.

You will be mailed a check generally within three business days after your withdrawal is approved.

Withdrawal of After-Tax Contributions

Within the limits described below, you may withdraw your after-tax contributions limited to once every six months by logging on to your account or by calling Participant Services.

Contributions and Related Company Matching Contributions

You may withdraw any amount of after-tax contributions, adjusted for investment earnings and losses, limited to once every six months and may continue afterwards to make after-tax contributions. You may also withdraw the vested portion of related Company matching contributions that have been in your account at least 24 months, but not the earnings on the Company matching contributions.

Taxation of After-Tax Withdrawals

Your after-tax contributions to the Savings Plan made before January 1, 1987 can be withdrawn without any tax if you do not withdraw any earnings on these contributions. The earnings on the pre-January 1987 contributions are kept separate but are available for withdrawal on a taxable basis. When you request a withdrawal, the first money paid out will be these pre-January 1, 1987 contributions.

Withdrawals of after-tax contributions made on or after January 1, 1987 are subject to partial taxation, since a withdrawal of post-1986 after-tax contributions will be assumed to be made up of both contributions and earnings. To avoid this taxation, you can rollover the taxable portion of your withdrawal to an IRA or other eligible retirement plan. You may also rollover the non-taxable portion of the distribution.

Withdrawal of Before-Tax Contributions

It is important to remember that withdrawals of your before-tax contributions are restricted by the Internal Revenue Code while you are working. Roth contributions are generally treated like before-tax contributions for withdrawal limitations. You must include withdrawals of before-tax contributions in your income in the year of withdrawal. In some cases, distributions of before-tax and Roth contributions may also be subject to a 10% premature withdrawal tax penalty, so you should consider these tax implications before making a withdrawal of your before-tax or Roth contributions.

Withdrawals Before Age 59-1/2

Because the emphasis is on long-term savings, the government limits withdrawals before age 59-1/2 to your before-tax and Roth contributions upon proof of financial hardship

To qualify for a hardship withdrawal, you must have a documented "immediate and heavy financial need" which cannot be met by "other reasonably available resources." Immediate and heavy financial need means:

- purchase of your primary residence (but not mortgage payments)
- tuition payments for a year of post-secondary education for you, your spouse or dependent children; the amount may also include room and board expenses for the year
- expenses not covered by insurance for you, your spouse, or dependent children that would qualify as deductible medical expenses (not taking into account income limitations)
- expenses to prevent eviction from or foreclosure on your primary residence
- funeral expenses of your deceased parent, spouse, children, or dependents
- expenses for repair of damage to your principal residence that would qualify as deductible casualty expenses (not taking into account income limitations).

"Other reasonably available resources" include after-tax contributions and Savings Plan loans. You must request a maximum withdrawal of after-tax savings and the maximum loan amount available to you before you request a hardship withdrawal. The amount of your hardship withdrawal from your before-tax and Roth contributions is limited to your own contributions (regardless of when they were made) and Company matching contributions on your before-tax and Roth contributions in which you are vested that have been in your account at least 24 months – up to the amount needed to satisfy your financial need.

If you take a hardship withdrawal, your Savings Plan participation will be suspended for 6 months. In addition, the maximum before-tax and Roth contribution you can make during the calendar year in which the suspension ends will be reduced by the amount of your before-tax and Roth contributions in the year of the hardship withdrawal. Hardship withdrawals are not eligible to be rolled over to another qualified plan or IRA.

You may log on to your account or call Participant Services for a hardship withdrawal request form. Hardship withdrawals must be approved by The Recordkeeper.

Withdrawals After Age 59-1/2

When you reach age 59-1/2, you may withdraw your before-tax contributions, vested Company matching contributions, and any investment earnings at any time for any reason.

Withdrawal During Military Leave

You may be able to withdraw your before-tax or Roth contributions if you go on a military leave for more than 30 days. If you think this might apply to you, contact Participant Services. If you take a withdrawal of before-tax or Roth contributions while you are on military leave, you may not make contributions to the Savings Plan for six months after the withdrawal.

To request a withdrawal, log on to your account or call Participant Services.

Withdrawal of Rollover Contributions

You may withdraw your rollover contributions, as adjusted for investment earnings and losses, at any time for any reason without causing a suspension of Company contributions under the Savings Plan. To request a withdrawal, log on to your account or call Participant Services.

Plan Payouts

You are eligible to receive the full value of your Savings Plan account when you leave the Company:

- after you are eligible to retire with an immediate pension
- because you are Totally and Permanently Disabled
- after completing three years of Credited Service

or

- before completing three years of Credited Service for any reason other than your voluntary resignation or your discharge by the Company for cause.

If you voluntarily resign or are discharged for cause before completing three years of Credited Service, you will forfeit any Company matching contributions, adjusted for investment gains and losses.

Forfeitures will be used for corrective allocations contributions and restorations if permitted by law or administrative guidance, to reduce matching contributions due from the participating employers for such Plan Year, and for such purposes in succeeding Plan years.

If you die before your entire vested account balance is paid to you, that balance will be paid to your beneficiary. For information about who will be paid your account balance if you do not name a beneficiary, please see the section "Naming Your Beneficiary" earlier in this summary plan description.

Timing of Payouts

When you leave the Company, you may request an immediate payout or choose to defer payment. You may not defer payment, however, beyond December 31st of the year in which you reach age

70-1/2 or the date you retire if you work for the Company beyond age 70-1/2. If you choose to defer payment, your savings will be invested in the Savings Plan funds as you direct. Your Roth contributions and earnings are also subject to the required minimum distribution rules unless you rollover the Roth account into a Roth IRA.

Mandatory Distributions

If your vested account balance (not including rollovers to the Savings Plan) is less than \$1,000 when you leave the Company and you do not request a payout method or rollover, your vested account balance will be distributed to you in a single lump sum payment.

Payout Methods

If you leave the Company before you are eligible for an immediate pension or Total and Permanent Disability benefits, and decide to receive your Savings Plan account, you will receive a lump sum payment.

If you die, your beneficiary may receive the full amount of your Savings Plan account balance in a lump sum. If you die and were eligible to retire at the time of your death, your spousal beneficiary may elect a lump sum payment or monthly installment payments over a five-year period. If your spouse is your beneficiary your spouse may also choose to defer payment or may request a rollover to an IRA. If your beneficiary is not your spouse, your beneficiary will receive a lump sum payment or may request a rollover to an IRA account.

If you are eligible for an immediate pension or Total and Permanent Disability benefits when you leave employment, you may elect to receive:

- a single lump sum payment of your total account value
- a partial payment, provided you have a remaining balance of at least \$10,000
- monthly installment payments of your fixed period of 10, 15, or 20 years (as long as this method meets the IRS minimum distributions requirements), with monthly recalculations based on market value and the remaining payment period
- monthly installment payments over a period equal to your life expectancy, or the joint life expectancy of you and your spouse
- monthly installments using the uniform life expectancy table with monthly recalculations based on market value and the remaining payment period. Life expectancies are recalculated each year.

or

- a fixed dollar installment amount that you choose. The fixed amount may be changed by you while installment payments are still ongoing.

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

Electing a Payout Method

If you leave the Company, The Recordkeeper will send a letter to you describing your payout options.

If you are eligible for installment payments, you will also receive the applicable forms. You may make your payout election over the telephone by calling Participant Services.

Request a Payout

To apply for a Savings Plan payout, you should call Participant Services at 1-800-777-4015. If you die with a remaining balance in the Plan, your beneficiaries should contact The Recordkeeper for information on obtaining a distribution.

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

Taxation of Withdrawals and Final Payouts

In general, your before-tax contributions, Company matching contributions, and investment earnings on all types of contributions other than Roth contributions are taxable when you receive them. The actual tax treatment will depend on your age at the time of receipt. You can find more information about tax treatment of Savings Plan distributions in the "Special Tax Information Notice," which is included with your quarterly statement and is also available online or by calling Participant Services.

Before Age 59-1/2

If you make a withdrawal or receive a Savings Plan distribution before age 59-1/2, you will pay a 10% additional tax in addition to ordinary income tax on the taxable portion of the payment, including on a hardship withdrawal unless you qualify for one of the exceptions to this 10% penalty listed in the "Special Tax Information Notice." You can avoid the income tax and additional tax if you rollover the taxable portion of your payment into an IRA or other eligible retirement plan within the time period permitted by law.

Your beneficiaries are never subject to the 10% tax penalty, regardless of your age at death.

At Age 59-1/2 or Later

If you make a withdrawal or receive a Savings Plan distribution after age 59-1/2, you will not have to pay the 10% penalty.

If you were at least age 50 on January 1, 1986, the law generally makes 10-year forward averaging (based on 1986 tax rates) available as an alternative, as well as special capital gains treatment, provided you were a participant before 1974.

Roth Contributions

Special rules apply to payments of Roth contributions and earnings on those contributions. Payments of the Roth contributions are not subject to federal income tax. Earnings on your Roth contributions will be subject to federal income tax unless the distribution occurs at least five years after you make your first Roth contribution or rollover Roth contributions from a former employer and the distribution is made after you turn 59-1/2, upon your death, or upon your disability.

Rollovers and Withholding

Withdrawals and lump sum distributions of your before-tax contributions and Company matching contributions, your after-tax contributions, or your Roth contributions as adjusted for investment earnings and losses, can be rolled over to an IRA, a Roth IRA or other eligible retirement plan. Required minimum distributions to employees who have terminated and reached age 70-1/2 or retired from the Company after age 70-1/2, and distributions paid out in installments are not eligible for such a rollover.

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

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

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

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

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

Severance from Service and Reemployment

Severance from service is important because it determines when your Credited Service ends for purposes of Savings Plan vesting. Severance from service occurs:

- the day you quit, retire, are discharged, or die
- one 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
- one year after your first day of leave of absence, or, if earlier, the first day after the final day of leave if you fail to return to work
- two 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.

If you are reemployed within one 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 one year after your date of severance and you were vested as of that date, your prior Credited Service will automatically be restored 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 one year after your date of severance, provided you have one year of service after the period of severance, and the length of your severance is less than five years.

In any event, you will not earn Credited Service during a period of severance lasting one year or more.

Other Important Information

Change of Address

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

Voting Your Shares

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

Investment Fees and Expenses

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

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

Call Participant Services or use the Internet for...

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

Responsibility for Investment Decisions

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

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

Confidentiality of Investment Directions

Your investment directions for all Savings Plan funds are administered by the Recordkeeper. The trustee handles all purchases and sales in the name of the Savings Plan without identifying individuals, so your transactions remain confidential.

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

Attn: Savings Plan Administrator
602 Scarboro Road, MS-8258
Oak Ridge, TN 37830-8258

Your Other Benefits

Before-tax savings under the Savings Plan reduce your taxable income – that is, they are not reported as taxable income on your W-2 earnings statement. However, they are included in determining your Social Security taxes and benefits.

Savings with before-tax dollars has no effect on your other pay-related benefits – such as life insurance, disability coverage, and retirement income. These benefits provide financial protection and security based on your full basic rate of pay.

Plan Funding and Expenses

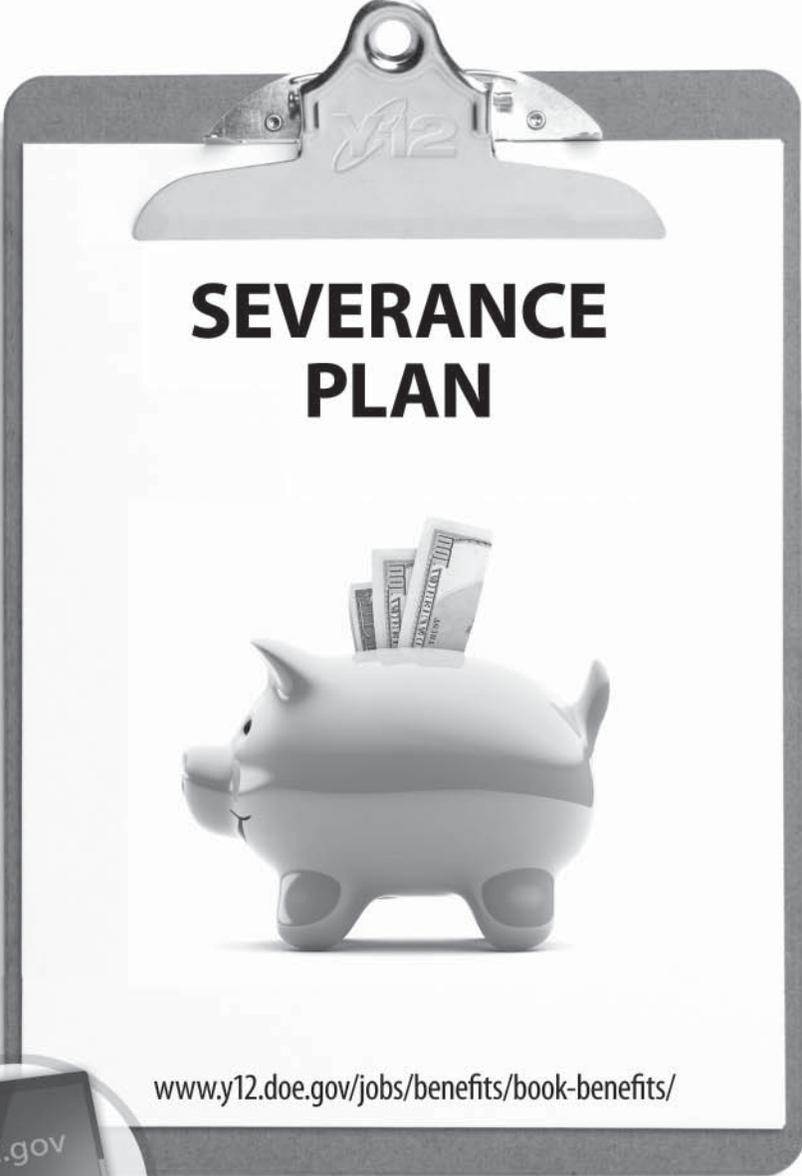
The Savings Plan is funded by participants who designate a part of their eligible earnings to be contributed on their behalf and by the Company through Company matching contributions. The assets of the Savings Plan are held in a trust fund maintained by the trustee. All Savings Plan administrative and investment management fees are paid from the investment funds and will be deducted from the participant's account.

Tax Treatment

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

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

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SEVERANCE PLAN



www.y12.doe.gov/jobs/benefits/book-benefits/



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Severance Pay is money paid by the Company to some workers whose employment ends involuntarily. It is paid in recognition of their years of service and the effort these employees put into the Company.

The Severance Plan:

- Can help sustain you financially until you find a new job

Severance pay isn't a benefit that companies are required to offer employees. But it certainly can help to provide a financial cushion, making the transition between jobs easier and less stressful.

- Recognizes your years of company service

Employees with a longer history with the Company receive a larger amount of severance pay. The severance pay you may receive is directly linked to your length of service with the Company.

- Is paid in addition to other benefits

In addition to severance pay, there are other benefits that may help your financial situation while you are between jobs. When you leave the Company, you may be paid for your earned but unused vacation time. You may be eligible for unemployment benefits as well.

Who Can Receive Severance Pay

If you are a regular, salaried employee and your employment ends involuntarily, you may be eligible for the severance pay benefits provided through the Severance Plan. In other words, the Company must initiate the termination, and it should be reflected as such in the Company's records.

You will not be eligible for severance benefits if you voluntarily terminate employment for any reason unless you voluntarily terminate employment after receiving a Notification Letter (as defined in the following paragraphs).

The reason for your termination must not be due to "cause." The Company defines "cause" as termination due to poor performance, misconduct, or a violation of the Company's rules or policies.

You also will be eligible for severance pay benefits if your employment is terminated because you are Disabled (as noted in the Glossary) and after one of the following events occur:

- you receive benefits for 24 consecutive months under the Company's long-term Disability Plan and are approved for the second phase of long-term disability benefits

or

- you are no longer considered to be Totally Disabled (during the initial 24-month period of receiving long-term disability benefits under the Company's plan), but the Company does not have a position available for you to return to work at that time.

To qualify for severance pay benefits, you also must receive a Notification Letter from an authorized Company official stating that your employment is being terminated and that you are eligible for severance pay benefits. This letter will be sent to you immediately before or at the time of your termination of employment. In the case of disability, you will be notified as soon as possible after the Company determines you are eligible for severance pay because of disability.

The letter will indicate your Termination Date. If you do not receive a Notification Letter, you will not receive and are not eligible for severance pay benefits.

Your Termination Date

The date designated by the Company as your last day of active employment is called your "Termination Date." The Company reserves the right to change your Termination Date if business circumstances require it.

Who is Not Eligible for Severance Pay

If you do not meet the eligibility criteria, you will not be entitled to any severance pay or similar benefits when you leave the Company. You are not eligible for severance pay benefits if you are:

- employed in a temporary position or an independent contractor position
- categorized by the Company as a collective bargaining unit (union) employee, an hourly employee or a leased employee
- an employee with less than three months of Company Service (as defined in the Glossary)

- ending your employment with the Company due to your death
- leaving the Company voluntarily (unless you resign after receiving your notification letter)
- terminated for cause, which may include poor performance, misconduct, or violation of the Company's rules or policies
- terminated due to a temporary suspension of work
- offered employment with a U.S. government contractor or subcontractor within the Department of Energy Oak Ridge Operations after your job is eliminated, and if the contract with the third party required them to offer you employment in connection with the transfer of work, and you are not required to relocate
- employed by or receive an offer of employment with a replacement contractor unless the Department of Energy authorizes the Company to pay severance benefits under the plan, and agrees to reimburse the Company in full for the payment of severance pay

or

- an employee who has signed a waiver of benefits whether or not the waiver was executed before or in connection with the end of your employment with the Company.

The Company has the sole discretion to determine your eligibility for severance pay and the amount of severance pay you may receive if you are eligible.

How Severance Pay is Determined

The amount of severance pay you will receive is based on your Company Service and your base pay as of the date immediately before your Termination Date.

Company Service	Severance pay at base rate
Under 3 months	No pay
3 months and under 1 year	Proportion of 1/2 month's pay equal to completed months of service in relation to 12 months of service*
1 year and under 3 years	1/2 month's pay
3 years and under 5 years	3/4 month's pay
5 years and under 7 years	1 month's pay
7 years and under 10 years	1-1/2 month's pay
10 years	2 month's pay
11 years or more	2 month's pay plus 1/4 month for each additional full year of service
* For example, if you have 8 months of Company Service, that is equal to 2/3 of a year of service, so your benefit would be equal to 2/3 of 1/2 month's pay.	

Your "Company Service" will be determined as of your Termination Date. If you are rehired, you will not receive any Company Service under the severance plan for any period of service for which a severance benefit or layoff allowance previously has been paid to you.

Your "Base Rate" is defined as your regular, straight-time pay for your normal work schedule. It does not include overtime pay, bonuses, commissions, fees, incentive allowances, or Company-provided benefits.

How Your Severance Pay is Paid Out

Severance benefits will be paid to you in the form of a lump-sum payment as soon as administratively possible after your Termination Date. Deductions will be made for taxes and all other required or authorized deductions.

If you owe the Company any unpaid debts, the Company may withhold this amount from your severance pay.

If the Company rehires you before the end of the period covered by the severance benefits, you must return the difference to the Company before you begin work again. For example, if you received 20 weeks of severance benefits and are re-employed after 15 weeks, you must return the difference (in this case, five weeks' worth of pay) to the Company.

Conditions for Severance Pay

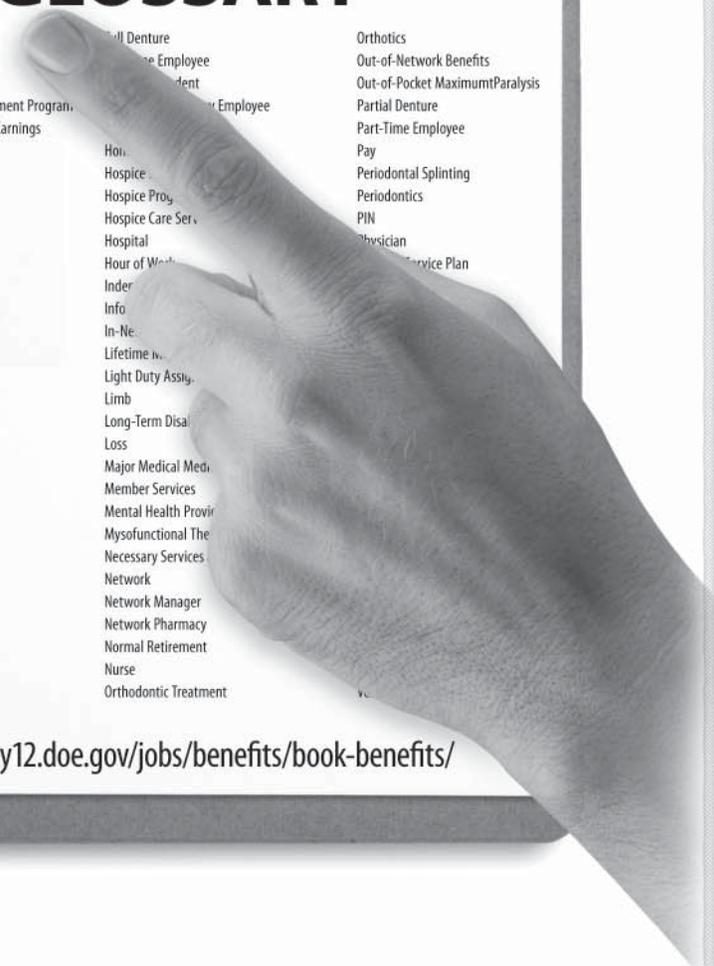
To be eligible to receive severance pay, you will be required to turn in all Company property, including, but not limited to:

- materials, documents, plans, records or papers, or any copies of documents that in any way relate to the Company's affairs
- tools
- vehicles
- manuals
- credit cards and any money due to the Company
- computer equipment
- cellular phones and pagers
- security badges.

You also must sign a termination statement provided by the Company.

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YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

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Glossary

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

Acts of Terrorism

For business travel accident coverage

Premeditated, politically motivated violence perpetrated against a non-combatant by:

- persons not acting on behalf of a sovereign state; or
- clandestine state agents.

Ad Hoc Employee

A non-exempt employee who works on an on-call, as-needed basis.

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
- maximizing your medical improvement.

Approved Rehabilitative Employment Program

During disability, a program of physical, mental or vocational rehabilitation which:

- is expected to result in your return to your own occupation or to a reasonable occupation on a full-time basis
- is approved, in writing, by the Company and the claims administrator.

A rehabilitative employment program will no longer be considered approved on the earliest of these dates:

- the date you are able to perform the material duties of your own occupation
- the date you return to work for the Company on a reduced-hour basis
- the date the claims administrator or the Company withdraws, in writing, its approval of the program.

Average Straight-Time Monthly Earnings

The average of your highest earnings for three years during the last ten years just before you retire. Refer to the "Pension Plan" section for information on how average straight-time monthly earnings are calculated.

Beneficiary

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

Birthing Center

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

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

Bomb Scare/Search/Explosion

For business travel accident coverage

"Bomb" means any real or dummy explosive device placed with intent to damage, scare, or cause injury. "Scare" means any real or false report of the presence of a bomb on the premises of the Company. "Search" means any organized search of a reported bomb. "Explosion" means any artificially induced explosion of a bomb on the Company's premises where it appears that the explosion was intended to cause injury or unlawful property damage, whether or not the presence of the bomb was reported before the explosion occurs.

Business Trip

Travel authorized by the Company (including trips outside the United States), including relocation trips, home leaves and rest and relaxation leaves, as well as any side trips or vacations taken in conjunction with a business trip.

Cause

When used in the context of a termination from employment, cause means a termination of employment due to poor performance, misconduct, or a violation of the Company's rules or policies.

Child

For medical, prescription drugs, dental, vision, and health care spending account, a child is defined as:

- (1) Your natural child,
- (2) Your legally adopted child (or a child who is lawfully placed with you for legal adoption),
- (3) Your stepchild,
- (4) A 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),
- (5) A child where you have legal guardianship, custody, or conservatorship by court order or an agreement with a state or other governmental agency,

(6) A child who is recognized as an alternate recipient in a "Qualified Medical Child Support Order ("OMCSO") enforceable with respect to the plan.

In the case of a child described in items 1 through 4 and item 6 above, the child is under age 26, except for dental, which is under the age of 24.

In the case of foster children, you must expect to raise the child to adulthood. A child who is living with you temporarily or for whom you have temporary custody does not qualify as a foster child. A child who has been placed in your home by a welfare or social service agency under an agreement where the agency retains control of the child or pays for support or maintenance of the child does not qualify as a foster child. Further, you and the foster child must have a "parent-child" relationship (as described below).

A child must meet the requirements below in the case of a child described in item 5 above. Or as in the case for the employee assistance plan, a child described in items 1 through 6 above must meet these requirements:

- The child is not married.
- The child is under age 24 (26 in New Hampshire, 25 in Montana and 25 in Washington).
- You must be able to claim the child as a dependent on your federal income tax return (without regard to any gross income limitations on a dependent).
- You provide over 50% of the child's support during the calendar year.
- The child lives with you in a "parent-child relationship" for the entire calendar year. The child is considered to have lived with you during periods of time when one of you, or both, are absent due to handicap, disability, illness or education. A "parent-child relationship" means that you are exercising parental authority, responsibility and control over the child by caring for, supporting, disciplining and guarding the child, including making decisions about the child's education and health care. If you are not the child's biological parent, the "parent-child relationship" must be with you, not the child's biological parent.

A child who is permanently and totally disabled before reaching the maximum coverage age above may continue to be covered regardless of age provided that he or she remains permanently disabled and is primarily dependent on you for support.

For business travel and special accident insurance coverage

Your natural child, stepchild, foster child, legally adopted child, or child of adopting parents, pending adoption, who relies chiefly on you for support and maintenance.

Child Care Center

For special accident insurance

A facility which is run according to law, including laws and regulations applicable to child care facilities and provides for care and supervision for children in a group setting on a regular daily basis. A child care center does not include a hospital, a child's home or care provided during normal school hours (attending grades 1–12).

COBRA

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

Coinsurance

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

Company

Babcock & Wilcox Technical Services Y-12, LLC.

Company Service

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

Conduit IRA

A temporary Individual Retirement Account that you use to hold rollovers between two employers' qualified plans.

Conversion Privilege

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

Copayment

The amount you and your enrolled dependents are required to pay for the services received – in addition to any Coinsurance or Deductible. Deductibles are not reduced by Copayments.

Credited Service

All the time you work for the Company, from your first hour of service until you sever from service. Credited Service is used for vesting purposes. Refer to the Pension Plan section for more information on credited service.

Crown

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

Deductible

The Deductible is the amount you and your enrolled dependents are required to pay each year for covered expenses before the plan pays, and is in addition to any Coinsurance or Copayments.

Dependent Child

For the pension plan

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

Dependent Parent

For the pension plan

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

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.

Durable Medical Equipment

Any equipment which can withstand repeated use and is medically essential to treat an injury or sickness.

Early Retirement

Retirement prior to reaching age 65.

Elective Surgery

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

Eligible Dependents

For medical, dental, health care spending account and employee assistance program coverage

Your eligible dependents are:

- the person who is recognized under applicable law as your spouse
- a Child described above in this Glossary.

For business travel accident insurance and special accident insurance coverage

Your Eligible Dependents are your spouse under age 70 and your unmarried children from birth through 18 years of age. An unmarried child under age 28 is also considered your Eligible Dependent if he or she is enrolled as a Full-Time Student.

Coverage will continue for any child who reaches the age limit and is totally incapable of self-sustaining employment due to a physical or mental handicap and is chiefly dependent upon you for support and maintenance.

For Spouse and Dependent Life Insurance

Your Eligible Dependents are your spouse under age 70 and your unmarried children from age 6 months to 19 years (up to age 24, if a Full-Time Student).

Eligible Earnings

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

Eligible Employee

With respect to a benefit plan, an employee who has satisfied the eligibility and waiting period requirements, if any, for such benefit plan.

Emergency

A serious accident or sudden illness that is life-threatening or could result in a long-term medical problem, such as uncontrolled bleeding, seizure or chest pain.

Emergency Admission

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

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

ERISA

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

Fixed Bridgework

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

Full Denture

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

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.

Full-Time Student

For business travel accident insurance, special accident insurance, and spouse and dependent life insurance coverage.

A person who is enrolled full-time in any accredited school, including a trade or vocational training program.

Full-Time Temporary Employee

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

Home Health Aide

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

Home Health Services

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

Hospice Facility

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

Hospice Program

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

Hospice Care Services

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

Hospital

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

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

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

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.

Imputed Income

The IRS requires you to be taxed on the value of employer-provided group life insurance over \$50,000. The taxable value of this life insurance is called "imputed income". Even though you don't receive cash, you are taxed as if you received cash in an amount equal to the value of this coverage. IRS issues rate tables for purposes of imputing income under group term life insurance.

Indemnity Plan

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

In-Network Benefits

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

Lifetime Maximum

The maximum amount of eligible benefits a plan will pay for an individual during his or her lifetime. Beginning with the 2011 plan year, a lifetime maximum does not apply to essential health benefits under the medical plan (including prescription drug, dental and vision) for active employees. A lifetime maximum continues to apply to non-essential health benefits under the medical plan for active employees and continues to apply to all benefits under the retiree medical plan.

Light Duty Assignments

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

Limb

An arm or a leg.

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 six months.

Loss

For purposes of business travel accident and special accident insurance coverage, loss of hand or foot means complete severance through or above the wrist or ankle joint. Loss of eyesight means the complete or irrecoverable loss of entire sight of either eye. Loss of speech means complete inability to communicate audibly in any degree. Loss of hearing means irrecoverable loss of hearing which cannot be corrected by any hearing aid or device. Loss of thumb and index finger means actual severance through or above the joint closest to the wrist. A Loss must result directly from bodily injuries caused by an accident.

Major Medical Medicare Supplement Plan

A medical plan available to retirees who are age 65 or over and enrolled in Medicare Part A and Part B. The plan is designed to supplement your Medicare Part A coverage and to provide coverage for certain expenses for which no Medicare benefits or limited Medicare benefits are payable.

Member Services

The customer service unit of the plan's third party vendor or claims administrator with responsibility for administering or insuring the plan of benefits.

Mental Health Provider

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

Myofunctional Therapy

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

Necessary Services and Supplies

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

Network

A group of health care providers who have agreed to provide care for pre-negotiated rates, as well as to comply with quality assurance procedures, patient service standards, and compliance with all applicable laws and regulations.

Network Manager

The health plan that sets up and manages a network of providers and administers out-of-network benefits.

Network Pharmacy

A pharmacy that has contracted with the pharmacy benefit management company to provide prescription drugs under a contractual arrangement for discounted costs.

Normal Retirement

Retirement at age 65.

Nurse

A Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse. A nurse is a professional who has the right to use the respective title and the respective abbreviation R.N., L.P.N. or L.V.N.

Orthodontic Treatment

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

Orthotics

A custom-molded rigid insert that, when placed in the shoe, distributes the patient's weight equally throughout the foot and leg and relieves the stress from any one particular area.

Out-of-Network Benefits

Care that does not qualify as in-network.

Out-of-Pocket Maximum

The maximum you have to pay for eligible medical expenses in one plan year. Once you reach this amount, the medical plan pays 100% of eligible expenses for the rest of that plan year.

All eligible medical expenses count toward the Out-of-Pocket Maximum, except for expenses for prescription drugs, mental health/alcohol and drug abuse treatment, amounts above reasonable and customary charges and any penalties for failing to pre-certify services.

Beginning with the 2014 plan year, an Out-of-Pocket Maximum does not apply to essential health benefits under the medical plan (including prescription drug, dental and vision) for active employees. An Out-of-Pocket Maximum for essential health benefits under the medical plan for active employees is limited to \$750,000 for the 2011 plan year, \$1,250,000 for the 2012 plan year and \$2,000,000 for the 2013 plan year. An out-of pocket maximum continues to apply for non-essential health benefits.

Paralysis

The loss of all practical use of a limb as it relates to the ability to perform the normal functions and activities of everyday life without the use of a prosthesis or any other mechanical device(s).

Partial Denture

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

Part-Time Employee

An employee who is scheduled to work more than 20% and less than 80% of the regular work schedule on a regular or temporary basis.

Pay*For short-term disability and long-term disability*

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

For life and accident insurance benefits

Your annual basic rate of pay, determined as described in the Life & Accident Insurance section, before any before-tax salary reductions. Pay does not include overtime, bonuses or any other form of extra compensation.

For Retirees

If you are a retiree, your pay is your annual pension benefit.

Periodontal Splinting

Stabilizing or immobilization of periodontically involved teeth. Splinting may be accomplished with acrylic resin bit guards, orthodontic band splints, wire ligation, provisional splints and fixed prosthesis.

Periodontics

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

Personal Identification Number (PIN)

The number that allows you to access Savings Program account information through the information line.

Physician

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

Point-of-Service Plan

A medical plan through which you may receive care in-network (at the highest level of benefits) or out-of-network (at a lower level of benefits).

Precertification

The process used to certify the clinical treatment, the medical necessity and length of a hospital confinement.

Prescription Drugs

Medication prescribed by a physician for the treatment of an illness or injury. There are two types of Prescription Drugs: brand-name and generic.

Primary Care Physician

A physician – generally an internist, general/family practitioner or pediatrician – whom you select to coordinate all your medical care within the Point-of-Service network.

Prosthodontic Services

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

Qualifying Life Event

An event described in the “About Your Benefits” section which permits a change in coverage or election on a pre-tax basis.

Reasonable and Customary Charge*For medical coverage*

A rate that the claims administrator determines is the normal charge made by providers in your geographic area for a similar service or supply. The nature and severity of the injury or sickness will be considered. If the claims administrator considers your medical expenses more than Reasonable and Customary, you will be responsible for paying the additional amount. Charges in excess of the Reasonable and Customary charge do not count toward your Deductible or Out-of-Pocket Maximum.

For dental coverage

A rate for dental services that is determined by the claims administrator by taking into account:

- the usual fees charged by dentists with similar training and experience in your geographic area
- any unusual circumstances or complications that require special skill, experience or additional time.

If the claims administrator considers your dental expenses more than Reasonable and Customary, you will be responsible for paying the additional amount. These charges do not count toward your Deductible.

Rollover Contributions

Distributions from another employer’s qualified plan that you deposit into your Savings Program account.

Room and Board

All charges commonly made by a hospital for rooms and meals and all general services and activities needed for the care of registered bed patients.

Routine

A situation that does not require immediate attention, such as immunizations or annual exams.

Service Credit

Refer to the “Company Service” definition in the Glossary.

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.

Skilled Nursing Facility

A licensed institution, other than a Hospital, which specializes in physical rehabilitation or provides skilled nursing and medical care on an inpatient basis. The institution must maintain on the premises all facilities necessary for medical treatment. Such treatment is provided for compensation and must be under the supervision of physicians and provide Nurses' services.

Space Maintainers

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

Straight-Time Earnings

Your basic rate of pay, including executive incentive compensation, shift premiums and hourly COLA, but not including overtime.

Terminally Ill

A medical prognosis of six months or less to live.

Total Disability or Totally Disabled

For basic and supplemental life insurance.

You are considered Totally Disabled if, because of an illness or injury:

- you cannot do your job, and
- you cannot do any other job for which you are qualified by your education, your training or your experience.

For long-term disability

During the first 24 months you are absent from work under the long-term disability plan, you are considered Totally Disabled if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the regular care of a licensed practicing physician. After you have been absent from work for 24 months, you are considered Totally Disabled if you remain under the regular care of a licensed practicing physician and you are unable to work at any job for which you might be qualified based on your education, training and experience. For purposes of any collective bargaining agreement, the preceding sentence will constitute the definition of "totally and permanently disabled."

Totally and Permanently Disabled

For business travel accident and special accident insurance coverage

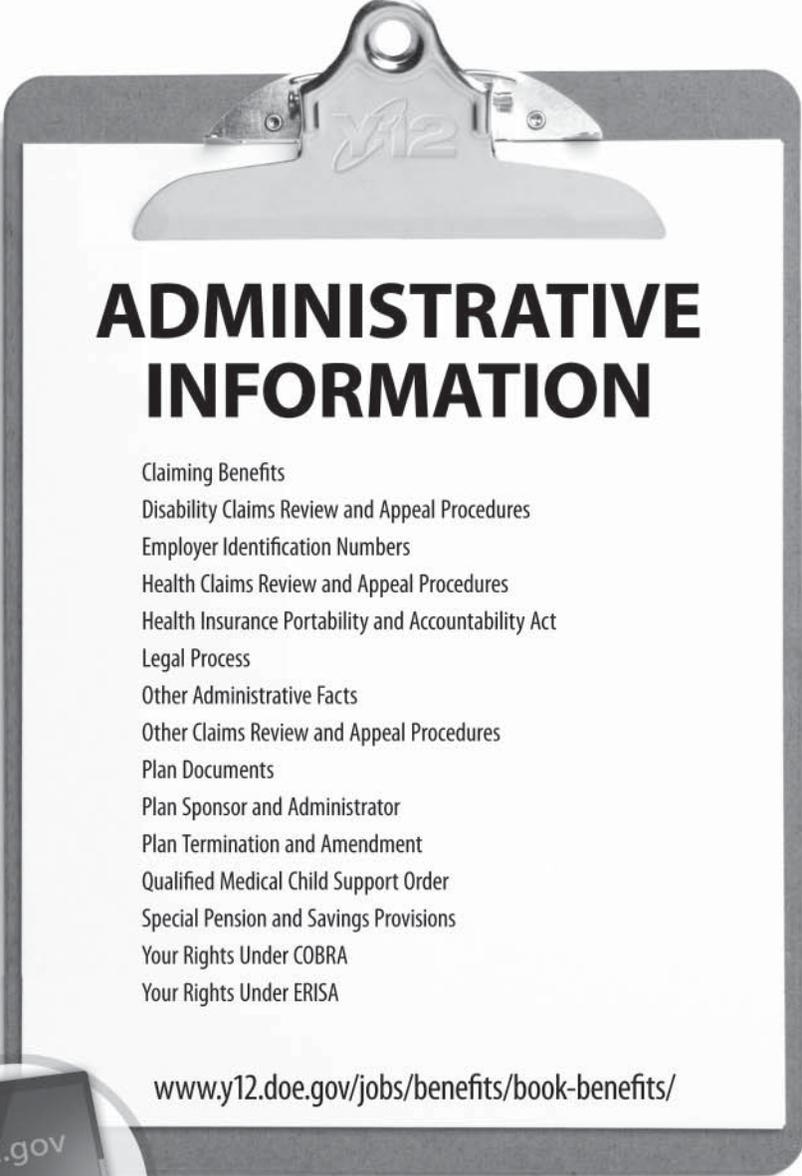
You are considered Totally and Permanently Disabled if, as the result of a qualifying accident, you cannot do any work for which you are or can become qualified by reason of your education, experience or training, and you are not expected to be able to do so for the remainder of your life.

Urgent Care

Services for a situation that requires prompt medical attention, but is not life threatening.

Vesting

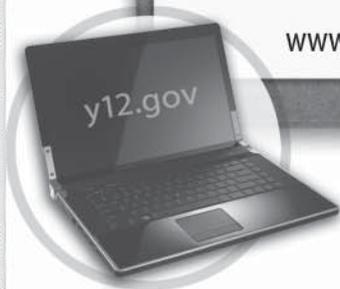
Ownership interest in your pension plan benefits and Company matching contributions under the Savings Program. You have an irrevocable right to a benefit when you are fully vested.



ADMINISTRATIVE INFORMATION

Claiming Benefits
Disability Claims Review and Appeal Procedures
Employer Identification Numbers
Health Claims Review and Appeal Procedures
Health Insurance Portability and Accountability Act
Legal Process
Other Administrative Facts
Other Claims Review and Appeal Procedures
Plan Documents
Plan Sponsor and Administrator
Plan Termination and Amendment
Qualified Medical Child Support Order
Special Pension and Savings Provisions
Your Rights Under COBRA
Your Rights Under ERISA

www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS — ACTIVE EMPLOYEES

This section contains information on the administration and funding of all 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

Babcock and Wilcox Technical Services Y-12, LLC (B&W Y-12) (formerly known as BWXT Y-12, LLC) is the sponsor and the plan administrator of the employee benefit plans described in this book. You can reach the plan administrator at:

Babcock & Wilcox Technical Services Y-12, LLC
c/o Benefits Plan Administrator
P.O. Box 2009
Oak Ridge, TN 37831-8267
865-574-1500

In carrying out its responsibilities under the plans, the plan administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the plan administrator are final, conclusive, and binding on all persons. The plan administrator may delegate some or all of these duties. A person to whom these duties have been delegated acts with the discretionary authority granted to the plan administrator.

The term "Company" means Babcock & Wilcox Technical Services Y-12, LLC, also known as B&W Y-12.

The term "Benefit Plans Office" refers to the Company's benefits department.

Employer Identification Numbers

The employer identification number assigned by the Internal Revenue Service to B&W Y-12 is 54-1987297.

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 that they have been negotiated and accepted by the duly certified representatives of participating units. Complete details of each of the plans can be found in the official plan documents, insurance contracts, and trust agreements (as applicable) that legally govern the operation of the plans. **All statements made in this book are subject to the provisions and terms of those documents.** Copies of those documents, as well as the latest annual reports of plan operations and plan descriptions as filed with the Internal Revenue Service 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 the summary annual reports of the plans' financial activities, which will be made available to you at no charge. In the event of a conflict between the official plan documents and the summaries in this book, the plan documents are controlling.

Depending on where you live, there may be state law requirements or mandated coverages for health and welfare plans. If the Company-sponsored plans have to comply with those requirements or mandated coverages, your benefits may vary from the benefits described in this summary plan description. Requirements under the law and the terms of benefits are set forth in the insurance company's certificate of coverage for the insured coverage and in a third party or claims administrator's benefit summary for self-funded coverage. In the event of any conflict between this summary plan description and such certificate of coverage or benefits summary the provisions of such certificate of coverage or benefits summary shall control. You may request a copy of such certificate of coverage or benefit summary by following the steps outlined in the "Administrative Section" of this book.

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. Claiming benefits and appealing the denial may differ for different types of plans and different types of benefits under each plan. The following section describes claims and appeals procedures based on the type of claim and the type of plan. Claiming benefits and appealing the denial may differ for different types of plans and different types of benefits under each plan. The following section describes claims and appeals procedures based on the type of claim and the type of plan. All forms required to take any action under the plans are available through the Benefit Plans Office. All completed forms must be submitted to the appropriate office, as described throughout this book.

If your claim is denied, you cannot bring a lawsuit to recover benefits under the plan unless you have exercised, in a timely manner, all appeal rights available to you under the plan's administrative claims procedures for a denied claim and your appeal(s) seeking benefits have been denied by the plan. Any such lawsuit may not be filed after one year (180 days for the Savings Plan or the Pension Plan), from the date the final decision on appeals is issued. If you do not file suit within this period, the final determination of your appeal will be binding and cannot be challenged by you in court.

Health Claims Review & Appeal Procedures

You may file claims for health plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An “authorized representative” means a person you authorize, in writing, to act on your behalf with respect to a claim or appeal for benefits. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a medical claim involving urgent care, a health care professional with knowledge of your condition may act as your authorized representative, unless you have designated a different authorized representative. References to “you” in this section are intended to include references to your authorized representative.

If your claim for benefits is denied, you cannot bring a lawsuit to recover benefits under the plan unless you have timely exercised all appeal rights available to you under the plan’s administrative claims procedures for a denied claim and your appeal(s) seeking benefits have been denied by the plan. Any such lawsuit may not be filed after one year from the date the final decision on appeals is issued. If you do not file suit within this period, the final determination of your appeal will be binding and cannot be challenged by you in court.

Urgent Health Care Claims

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

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

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

Other Health Claims (Pre-Service and Post-Service)

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

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

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period.

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

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

Ongoing Course of Health Treatment

If you are receiving an ongoing course of treatment, you will be notified in advance if the plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, you must request an extension of the course of treatment at least 24 hours before its expiration. You will be notified of the decision within 24 hours after receipt of the request.

Notification of Health 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:

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

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request.

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit when applying the terms of the plan to the participant's medical circumstances, an explanation of

the scientific or clinical judgment for the denial will be provided, or the denial will state that such an explanation is available upon request at no cost to you.

In the case of an Urgent Care Claim, the above information may be provided orally within the timeframes described in the Urgent Care Claims section, provided that a written or electronic notification as described is furnished to you no later than 3 days after the oral notification.

Information Pertaining to the Filing of an Appeal of an Adverse Benefit Determination for a Health Claim

You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial claim determination will be final. You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. 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 may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

For claim appeals, the Claim Administrator has been delegated exclusive rights to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. The appeal must be submitted in writing, except for Urgent Care Claims. An expedited appeal for Urgent Care Claims may be initiated by a telephone call to Member Services. You or your authorized representative may appeal the claim. All necessary information, including the appeal decision, will be communicated to you or your authorized representative by telephone, facsimile, or other similar method. You will be notified of the decision on an appeal of an Urgent Care Claim no later than 72 hours after the appeal is received.

In reconsidering any denial that is based in whole or in part on a medical judgment, (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate) the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the plan relies on their advice in making any benefit determinations.

Notification of Health Claim 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:

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

A lawsuit may not be filed more than one year after the date of the final decision on appeal.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to your medical circumstances, or a statement that such an explanation is available will be provided to you free of charge upon request.

The plan's claims review procedures do not generally include any voluntary levels of appeal (such as voluntary arbitration).

Finally, you and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Disability Claims Review and Appeal Procedures

Disability Claims Appeal

You may file claims for disability plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

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 time 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 time period may be extended up to an additional 30-day extension period, 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:

- the specific reasons for the denial with reference to the specific plan provisions on which the denial was based
- a description of any additional information needed to complete the claim and an explanation of why such information is necessary
- a description of the plan's claim review procedures and applicable time limits
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review or, if you are an hourly employee, your right to medical arbitration regarding your claim that you are totally and permanently disabled.

A lawsuit may not be filed more than one year after the date of a final decision on appeal.

Information Pertaining To The Filing of an Adverse Benefit Determination for a Disability Claim Appeal

You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial claim determination will be final. You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. 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 may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

For claim appeals, the Claim Administrator has been delegated exclusive rights to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. The appeal must be submitted in writing.

In reconsidering any denial that is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the plan relies on their advice in making any benefit

determinations. You will ordinarily be notified of the decision no later than 45 days after the appeal is received. If special circumstances require an extension of time 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 again denied in whole or in part, you will receive written or electronic notification that will include:

- the reasons for the decision, again with reference to the specific plan provisions on which that decision is based
- that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits
- your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review or, if you are an hourly employee, your right to medical arbitration regarding your claim that you are totally and permanently disabled.

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

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

Notice of Adverse Benefit Determination for Other Claims

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

Notification on Other Claim Decisions

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

- the specific reasons for the denial with reference to the specific plan provisions on which the denial was based
- a description of any additional information needed to complete the claim and an explanation of why such information is necessary
- a description of the plan's claim review procedures and applicable time limits

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

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 decision to appeal the decision. You will ordinarily be notified of the decision no later than 60 days after the appeal is received. If special circumstances require an extension of time of up to an additional 60 days, you will be notified of such extension during the 60 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also 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:

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

For claims under the Savings Plan and the Pension Plan, you may not file a lawsuit disputing a claim determination more than 180 days after the plan administrator makes a final decision on appeal.

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 may also be served upon the plan trustee (where applicable) or the plan administrator.

Agent for Service of Legal Process:

Babcock & Wilcox Technical Services Y-12, LLC
CT Corporation System
800 S. Gay Street, Suite 2021
Knoxville, TN 37929

Plan Termination and Amendment

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

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

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may result in the transfer of plan assets and debts to another plan or 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 three months after termination of the plan. The amount and form of any final benefit you or your beneficiary receives will depend on any insurance contract provisions affecting the plan and the Company's decisions.

Special Pension and Savings Provisions

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

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 Benefit Plans Office.

Top-Heavy Provisions

Under current tax law, the Pension Plan and Savings Plan are required to contain provisions that apply in the event that 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 which 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 three years of Credited Service (definition in the Glossary). Even after three 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.

Benefits Restrictions

If at any point, the funding level of the Pension Plan, as determined in accordance with IRS rules, falls below 80%, restrictions on certain forms of benefit payments must be applied. A more detailed explanation of the provisions will be provided if and when these restrictions apply.

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, the PBGC will step in to pay pension benefits, within limits. 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:

- normal and early retirement benefits
- disability benefits if you become disabled before the plan terminates
- certain benefits for your survivors.

The PBGC guarantee generally does **not** cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- some or all of benefit increases and new benefits-based plan provisions that have been in place for fewer than 5 years at the time the plan terminates
- benefits that are not vested because you have not worked long enough for the Company
- benefits for which you have not met all of the requirements at the time the plan terminates

- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age
- 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 the PBGC depending on how much money your plan has, and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask the plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Washington, D.C. 20005-4026, or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <http://www.pbgc.gov>.

Assignment or Alienation of Benefits

Except as required by applicable law (such as a qualified domestic relations order), 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 qualified domestic relations order (QDRO) is a legal judgment, decree, or order that recognizes the rights of another individual under the Savings Plan or Pension Plan with respect to child or other dependent support, alimony or marital property rights.

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

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

Qualified Medical Child Support Order

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

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

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

Specific Plan Information

Plan name	Plan number	Plan type	Plan year
Retirement Program Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	001	Defined Benefit	Calendar
Savings Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	009	Defined Contribution and 401(k) Plan	Calendar
The Group Welfare Benefit Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee provides for the following benefits:			
Group Life Insurance	506	Welfare	Calendar
Business Travel Accident	506	Welfare	Calendar
Special Accident Insurance	506	Welfare	Calendar
Health Benefits (Medical, Dental, Vision)	506	Welfare	Calendar
Long-Term Disability Plan	\$10	Welfare	Calendar
Cafeteria Plan	\$11	Welfare	Calendar
Employee Assistance Plan	\$12	Welfare	Calendar
Education Assistance Program	\$13	Welfare	Calendar
Prescription Drug Plan	\$15	Welfare	Calendar
Severance Plan for Salaried Employees	\$17	Welfare	Calendar
Long Term Care Plan	\$18	Welfare	Calendar

Insurer, Claims Administrator, or Trustee	Source of contributions	Source of benefits
Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
State Street Bank and Trust (serves as Trustee) State Street Bank and Trust P.O. Box 1389 Boston, MA 02104-1389	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust
Metropolitan Life Insurance Company	Employee/Retiree and Company	Benefits are paid from an insurance contract
Life Insurance Company of North America	Company	Benefits are paid from an insurance contract
Life Insurance Company of North America	Employee	Benefits are paid from an insurance contract
Medical: Administered by Connecticut General Insurance Company (CIGNA) Dental: Administered by MetLife Dental: Administered by Delta Dental of Tennessee Vision: Administered by Vision Service Plan (VSSP)	Employee/Retiree and Company	Benefits are paid through claims administrator and paid from employee contributions and general assets of the Company.
Long-term Disability Plan Company and an outside claims administrator	Company	Company
Cafeteria Plan Dependent Care Spending Account Health Care Spending Account 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
Employee Assistance Plan Magellan Behavioral Health	Company	Not applicable
Education Assistance Program Company	Company	Company
Prescription Drug Plan Medco	Employee and Company	Benefits are paid (through claims administrator, Medco) from employee contributions and general assets of the Company
Severance Plan for Salaried Employees Company	Company	Company
Long term Care Plan MetLife	Employee/Retiree	Benefits are paid from an insurance contract

Your Rights Under COBRA

You and your Eligible Dependents covered under a group health plan (one of the medical plans or one of the 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 following chart 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 group plan. Covered employees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of the eligible Dependents.

If you adopt or have a Child while covered by COBRA, that Child is also 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 chart on the following page. You may only continue to participate in the health care spending account through the end of the year in which the Qualifying Event occurs.

When the Qualifying Event is the death of an employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child’s losing eligibility as an Eligible Dependent child, COBRA continuation coverage lasts for up to a total of 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 2 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 (SSA) 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 would have to 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, but 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.

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 of your Eligible Dependents who is a Qualified Beneficiary is determined to be disabled at any time during the first 60 days of COBRA coverage.	29 months	29 months	29 months
You die	n/a	36 months*	36 months*
You and your spouse legally separate or divorce	n/a	36 months	36 months
You become entitled to Medicare (Part A or B, or both)	n/a	36 months	36 months
Your Child no longer qualifies as an Eligible Dependent	n/a	n/a	36 months

*If your dependent is eligible for extended coverage under the medical plan, as described in the "Medical Plan" section, then the maximum COBRA period will be reduced by the length of that extended coverage.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to a plan sponsor, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and other Eligible Dependents will also become Qualified Beneficiaries if bankruptcy results in their loss of coverage under the group health plan.

Choosing COBRA

Here are some things to keep in mind about COBRA continuation:

You and your eligible dependents have 60 days after your COBRA notice to elect continued participation. You will have an additional 45-day period to pay any make up contributions you missed from the first day of the COBRA coverage.

- If COBRA is elected, the coverage previously in effect will generally 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" section.

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 19–29 reflect the full group cost per person, plus 2%.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, 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 new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Notification

The Benefit Plans 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 Benefit Plans Office within 60 days of the event so that COBRA can be offered and your election rights can be mailed to you. Also, to extend coverage beyond 18 months because of disability, notice of the Social Security Administration's determination must be provided within 60 days after you receive that determination and before the end of the initial 18-month period.

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 pre-existing 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
- 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, the Health Insurance Portability and Accountability Act (HIPAA), and other laws contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Social Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa>.

Your Rights Under FMLA and USERRA

Leave Taken Under the FMLA

If you are covered under a group health plan (one of the medical plans, one of the dental plans or the health care spending account) and you take leave under the Family and Medical Leave Act of 1993, as amended (FLMA), you and your Eligible Dependents' coverage will continue under the Plan to the extent required by the FMLA (that is, the Company will continue to pay its share of the contributions required and you must continue to make your contributions). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your contributions), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as required by the FMLA. Under special rules that apply if you do not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA continuation coverage even if they weren't covered under one of the group health plans during the leave. Please contact the plan administrator for more information about these special rules.

Leave Taken Under the USERRA

If you are covered under a group health plan (one of the medical plans, one of the dental plans or the health care spending account) and are going into or returning from military service, you will have certain rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. As used herein, military service means service in the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. Continuation of coverage for a military leave of absence, covered by USERRA. Coverage may be continued until the earlier of (i) twenty-four months after your absence from work begins or (ii) the day after the date on which you fail to timely apply for or return to employment as required under USERRA. If you elect to continue coverage, you must timely notify the plan administrator of your election to continue coverage.

If your military service is less than 31 days, you are required to pay only your normal share of the contribution for such coverage. If the length of your military service extends past 31 days, the plan administrator may require you to pay up to 102% of the contribution cost for coverage for similarly situated covered individuals who are not serving in a military service. Your election and payment are due within 31 days after coverage would have been terminated (if you receive prior notification of the right to continue coverage) or 31 days following notification if you receive notification of the right to continue coverage after coverage is terminated. These rights apply only to individuals covered under one of the group health plans before leaving for military service.

Plan exclusions may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If you are called to active military duty, you and your Eligible Dependents may be eligible for coverage under TRICARE, the military service's health plan. You and your Eligible Dependents may also elect to continue benefits under the Company's group health plan if you were covered by such plan at the time you were called to military duty.

If you choose not to continue coverage during your military service, you and your Eligible Dependents are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. As permitted by USERRA, your coverage will not include any Illness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of military service. Any other such illness or injury will be covered, subject to all otherwise applicable conditions and limitations of the plan.

The continuation of coverage ends at the earliest of the following:

- when you become covered under another group health plan without pre-existing condition limitation
- upon the expiration of the continued period of coverage as set forth herein
- when the required payments are not received on a timely basis
- when the plan is terminated and not replaced by the Company with another health plan.

After your USERRA continuation coverage expires, you will not thereafter receive continuation of coverage under COBRA. However, if your USERRA coverage expires prior to the expiration of the continuation of coverage under COBRA (e.g., because you do not return to employment), you may be eligible for continuation of coverage under COBRA for the remainder of the original COBRA coverage period.

The above is only a summary of the FMLA and USERRA rights and limitations. If you wish to elect FMLA or USERRA coverage or obtain more detailed information, please contact the plan administrator.

Grandfathered Plan Status

The Group Welfare Benefit Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee believes that each coverages under the plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Your Rights Under ERISA

As a participant in any of the Company's benefit plans described in this book, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- receive information about your plan and benefits
- examine, without charge, at the plan administrator's office, and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration
- obtain copies of all plan documents and other plan information, including insurance contracts and collective bargaining agreements, and copies of the latest annual report, and updated summary plan description, by writing to the plan administrator. The plan administrator may make a reasonable charge for copies
- receive a summary annual report of the plan's financial activities. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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 of charge, 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, spouse or eligible dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation of coverage, and when your COBRA continuation of coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan

participants, 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.

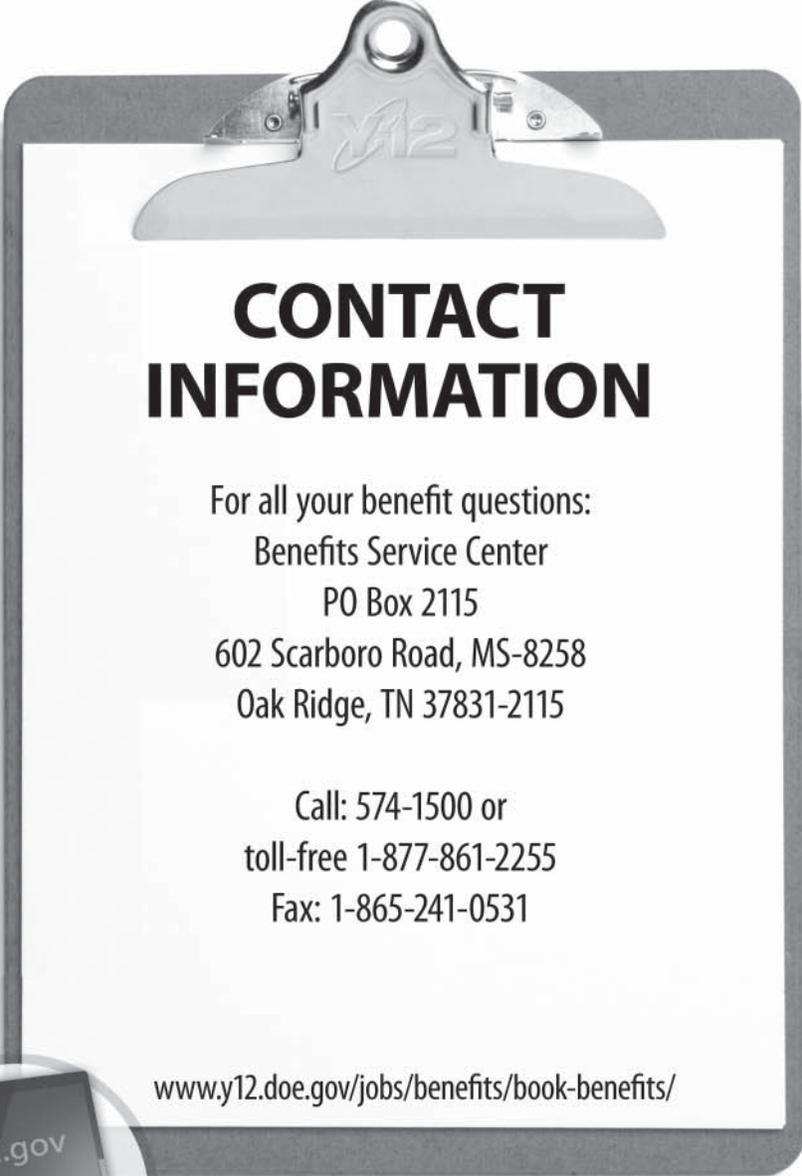
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator 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. In order to file suit in a state or federal court concerning: (i) a claim for a benefit; (ii) the qualified status of a domestic relations order or medical child support order, or (iii) your service credit, you must file the suit within one year (180 days for the Savings Plan and Pension Plan) 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 time period, the plan administrator's final determination will be binding and cannot be challenged by you in court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

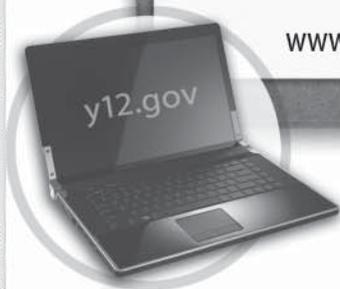


CONTACT INFORMATION

For all your benefit questions:
Benefits Service Center
PO Box 2115
602 Scarboro Road, MS-8258
Oak Ridge, TN 37831-2115

Call: 574-1500 or
toll-free 1-877-861-2255
Fax: 1-865-241-0531

www.y12.doe.gov/jobs/benefits/book-benefits/



YOUR BOOK OF BENEFITS—ACTIVE EMPLOYEES

Contact Information

For all of your benefits questions:

Benefits Service Center
P.O. Box 2115
602 Scarboro Road, MS-8258
Oak Ridge, TN 37831-2115
Call: 865-574-1500 or toll-free 1-877-861-2255
Fax: 1-865-241-0531

Contact Information

<p>Medical</p> <p>Open Access</p> <p>Point-of-Service</p> <p>Indemnity</p>	<p>CIGNA</p>	<p>Member Services: 1-800-244-6224</p> <p>To file a claim, mail your completed claim form to the address shown on your ID card</p> <p><i>Website: www.cigna.com</i></p>
<p>Mental Health/Substance Abuse (MH/SA)</p>	<p>CIGNA Behavioral Health</p>	<p>Member Services: phone number is found on your CIGNA ID card (MH/SA)</p> <p><i>Website: www.cigna.com</i></p>
<p>Prescription Drugs</p>	<p>Medco</p>	<p>Member Services: 1-800-685-8869</p> <p>To mail new prescriptions:</p> <p style="padding-left: 40px;">Medco P.O. Box 650322 Dallas, TX 75265-0322</p> <p>To order online: www.medco.com</p> <p>For the automated refill system:</p> <p style="padding-left: 40px;">1-800-473-3455</p> <p>For instructions on how to fax your prescription, have your doctor call</p> <p style="padding-left: 40px;">1-888-327-9791</p>
<p>Vision (for employees enrolled in a CIGNA Plan)</p>	<p>Vision Service Plan</p>	<p>Member Services: 1-800-877-7195</p> <p>To file a claim, mail your claim to:</p> <p style="padding-left: 40px;">Vision Service Plan Attn: Out-of-Network Provider Claims P.O. Box 997100 Sacramento, CA 95899-7100</p> <p><i>Website: www.vsp.com</i></p>
<p>Disease Management</p> <p>Clinical support for specific health conditions: asthma, cardiac arterial disease, chronic obstructive pulmonary disease, congestive heart failure, diabetes, low back pain</p>	<p>Optimal Health</p>	<p>1-866-225-2980</p>

Dental	MetLife	Member Services: 1-800-942-0854 To file a claim, mail your claim to: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 <i>Website: www.metlife.com</i>
	Delta Dental	Member Services: 1-800-223-3104 To file a claim, mail your claim to: Delta Dental Plan of Tennessee 240 Venture Circle Nashville, TN 37228 <i>Website: www.deltadentaltn.com</i>
Employee Assistance Program (EAP)	Magellan	Member Services: 1-800-888-2273 <i>Website: www.MagellanAssist.com</i>
Long-Term Disability	MetLife	Member Services: 1-800-300-4296 Mailing Address: Metropolitan Life Insurance Company P.O. Box 14590 Lexington, KY 40511-4590 Fax number: 1-800-230-9531
Long Term Care	MetLife	Member Services: 1-800-438-6388 Mailing address: Metropolitan Life Insurance Company P.O. Box 937 Westport, CT 06881-0937
Life Insurance: Basic Life, Supplemental Life	MetLife	Statement of Health Unit: 1-800-638-6420 prompt 1 For Life Insurance conversions information: 1-877-275-6387
Savings Program	Retirement Savings Plan Committee	Mailing address: Y-12 National Security Complex c/o Plan Administrator's Office 602 Scarboro Road, MS-8258 Oak Ridge, TN 37830-8258
	Schwab Retirement Plan Services Company	United States: 1-800-777-4015 TDD: 1-877-852-4289 <i>Website: http://www.401kaccess.com/oakridge</i>

<p>Flexible Spending Accounts</p>	<p>Ceridian Benefits Services</p>	<p>Member Services: 1-877-799-8820</p> <p>To file a claim for reimbursement, mail your claim to:</p> <p>Ceridian FSA Services Reimbursement Administration P.O. Box 534451 St. Petersburg, FL 33747</p> <p>Fax number: 1-877-488-6454</p> <p><i>Website: www.myceridian.com</i></p> <p>To order a comprehensive list of deductible expenses, contact the Internal Revenue Service: 1-800-829-3676 or www.irs.gov</p>
<p>COBRA</p>	<p>Ceridian Benefits Services</p>	<p>Member Services: 1-800-877-7994</p> <p>Mailing address:</p> <p>Ceridian COBRA Services COBRA Administration Center 3201 34th Street South St. Petersburg, FL 33711</p>
<p>Direct Billing for Insurance Continuation</p> <p>For Retirees under age 65, Displaced Defense Workers and Long Term Disability participants who directly pay medical, dental, and life premiums.</p>	<p>Ceridian Services</p>	<p>Member Services: 1-800-898-0217</p> <p>Billing address</p> <p>If an invoice is included with the payment, mail invoice and check to:</p> <p>Ceridian Benefits Services, Inc. 7738 Collection Center Drive Chicago, IL 60693</p> <p>If no invoice will be mailed, please be sure to include the social security number of the member on the check. Mail the check to:</p> <p>Ceridian Benefits Services Attn: Y-12 Insurance Continuation P.O. Box 7482 Princeton, NJ 08543-7482</p>
<p>Where to Get Social Security and Medicare Questions Answered</p>	<p>Social Security and Medicare</p>	<p>Social Security</p> <p>Main Telephone: 1-800-772-1213 Oak Ridge Office: 1-865-482-6908 <i>Website: www.socialsecurity.gov</i></p> <p>Medicare</p> <p>Main Telephone: 1-800-633-4227 <i>Website: www.medicare.gov</i></p>