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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.