Y-12 Retiree Book of Benefits

Summary Plan Descriptions

CNS | consolidated nuclear security, llc
PANTEX PLANT | Y-12 NATIONAL SECURITY COMPLEX

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Introduction

About This Summary Plan Description

Consolidated Nuclear Security, LLC ("CNS" or "Company") offers eligible Y-12 retirees and their eligible spouses and dependents valuable benefits through the CNS Benefits Program ("Benefits Program" or "Program").

> It is your responsibility to understand your coverage and benefits; therefore, you will want to review all of the sections of this SPD. If you have questions about your coverage and benefits after you review this SPD, contact the appropriate source listed in the Contacts section.

The CNS Benefits Program and certain benefit plans, as described in this Summary Plan Description (SPD), commonly referred to as the Book of Benefits, are intended to conform to all applicable legal requirements including, but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code of 1986 (the "Code"), and all regulations issued thereunder.

Enclosed is your updated Y-12 Retiree and Vested Terminated Participant's Book of Benefits, which is the SPD for the Company's group retiree benefit plans. You should replace this book with any prior Book of Benefits and keep it handy for reference.

Note: Neither receipt of this SPD nor use of the term "you" means that you are an eligible retiree or vested terminated participant or Eligible Dependent under the Program (in aggregate or any combination of the plans described in this document). You are eligible only if you satisfy the applicable eligibility requirements for each individual plan. In addition, the Company reserves the right to amend, modify, suspend, or terminate the CNS Benefits Program, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law. The Company further reserves the right to change the amount of required participant contributions for coverage at any time, with or without advance notice to participants.

Every attempt has been made to ensure the accuracy of this summary. However, its contents are not legally binding nor should it be considered as a substitute to the actual contract language or Company policies. In the event the SPD and the Plan Document for the benefit in which you are reviewing differ, the Plan Document is the prevailing document.

About Your Benefits

When You Retire and are Eligible for Pension and Post-Retirement Benefits

If you retired under the pension plan, you and your Eligible Dependents who are under age 65 may continue the coverage under the medical (includes prescription drugs), dental and vision plans you had prior to retirement. You must be covered in the plan in order for an eligible spouse or child to be covered as your dependent.

If you retired under the pension plan, and you and your eligible spouse are age 65 or over, you may be eligible to enroll in the Aon Retiree Health Exchange, and the Company's Post-65 Dental and Vision plans. You must be covered in the plans in order for a spouse to be covered. Upon reaching age 65, your spouse may also be eligible to participate in these post-65 retiree plans.

Retirees who waive coverage upon retirement because they are opting for another active employer's plan, either because of their own new employer or becoming a dependent of an actively working spouse, and who subsequently wish to return to the Company plans, must submit proof of creditable coverage from the former employer or other insurance carrier **within 31 days** of termination of the other coverage.

There is no Annual Open Enrollment. You must enroll when initially eligible. Retirees who cancel the Company's medical, dental, vision or retiree HRA plan cannot enroll at a later date. Likewise, if a retiree waives coverage upon retirement, the retiree will not be allowed to enroll at a later date **unless he or she maintained participation in another active employee group plan.**

For You – Under Age 65 Retiree

Medical (Including Prescription Drugs), Dental, and Vision

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, your spouse and Eligible Dependents under the medical (includes prescription drugs), dental and vision plans. You must be enrolled in the Company plans in order for your spouse and Eligible Dependents to continue their coverage in the plans. You must pay any cost required by the Company for the continued coverage.

If a retiree marries after his/her retirement effective date, any newly acquired dependents are not eligible for medical, dental or vision coverage. Likewise, a surviving spouse cannot add dependents after the Retiree's death.

When you or your spouse reach age 65, medical coverage ends at the end of the month prior to the 65th birthday and you may be eligible for the Retiree Health Reimbursement Arrangement (RHRA) and you may elect to purchase an individual policy through the Aon Retiree Health Exchange. You must elect to enroll in the RHRA and purchase an individual medical policy through the Aon Retiree Health Exchange in order for an enrolled younger Spouse and other enrolled Eligible Dependents to continue coverage under the Company plans until your Spouse reaches age 65.

If your spouse reaches age 65 before you, the spouse's medical coverage will end and your Spouse may be eligible for the Aon Retiree Health Exchange.

For dental and vision, if your spouse reaches age 65 before you, you may keep coverage on your spouse under your pre-65 dental/vision plan until you reach age 65.

Dependent Child(ren) coverage ends when both you and your Spouse are no longer eligible for the pre-65 retiree plans. They may be eligible to continue coverage under COBRA.

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 medical, dental and vision coverage for yourself and your Eligible Dependents. However, you must pay 100% of the cost for the continued coverage.

If you are in one of the following groups at retirement, you will have access only to enroll in the pre-65 retiree medical plans and will be responsible for 100% of the cost:

1. ATLC retirees, who hired on or after January 1, 2016
2. IGUA Security Police Officers retirees, who hired on or after August 15, 2016
3. IGUA CAS and Beta-9 Operators, CTF Instructors retirees, who hired on or after January 1, 2016

Your Life Insurance Coverage

As a pension-eligible retiree, you may continue your Basic Life coverage benefit **if you had coverage for one year immediately preceding your retirement.** Basic Life coverage pays benefits to your beneficiary in the event of your death from any cause while you are insured. Please refer to the MetLife Plans section in this SPD for further details.

Group Universal Life (GUL) – During Retirement

Supplemental Group Universal Life

Employees enrolled in GUL coverage may continue on a direct bill basis.
Dependents enrolled in GUL coverage may continue on a direct bill basis.

Long-Term Care (Closed Plan)

Retirees participating in the Long-Term Care Plan may contact the Long-Term Care vendor, MetLife at 1-800-438-6388.

Savings Program

At retirement you are entitled to receive the vested value of your Savings Plan account. You may refer to the 401(k) Savings section in this SPD for further details.

For You – Age 65 or Older Retiree

If you are age 65 or older and are retired under the Company's pension plan, you are eligible for the following benefits.

Aon Retiree Health Exchange

The Aon Retiree Health Exchange is provided by Aon. Please contact them directly at 1-844-695-8293 for information about the program. They can also provide information on dental and vision providers if you are interested in these coverages outside the Company. The Aon Retiree Health Exchange is not an employee benefit plan provided by the Company. However, for your convenience we have included information about the Aon Retiree Exchange. For further details on this benefit, please refer to the Aon Retiree Health Exchange section in this SPD.

Retiree Health Reimbursement Arrangement (RHRA)

The Retiree Health Reimbursement Arrangement is administered by Aon. For further details on this benefit, please refer to the Retiree Health Reimbursement Arrangement section in this SPD.

Post-65 Dental Plan

Post-65 dental insurance may be continued for retirees and spouses at age 65 or over, if you are participating in the Company pre-65 dental plan. The retiree is responsible for 100% of the cost. Dental coverage is provided by Delta Dental – the same provider of active employee and pre-65 retiree/spouse dental benefits. See the Post-65 Retiree Dental Plan section of this SPD for more information.

Post-65 Vision Plan

Post-65 vision insurance may be continued for retirees and spouses at age 65 or over, if participating in the pre-65 vision plan. The retiree is responsible for 100% of the cost. Vision coverage is provided by the Vision Service Plan (VSP) – the same provider of active employee and pre-65 retiree/spouse vision benefits. See the Post-65 Retiree Vision Plan section of this SPD for more information.

Please note that these Post-65 Dental and Post-65 Vision Plans provide coverage for post-65 retirees and spouses only and a retiree must elect to participate in the particular Plan in order to cover his/her spouse. Dependent children are ineligible to participate in either the Post-65 Dental or Vision plans.

Long-Term Care (Closed Plan)

Retirees participating in the Long-Term Care plan may contact the Long-Term Care vendor, MetLife at 1-800-438-6388.

Savings Program

At retirement you are entitled to receive the vested value of your Savings Plan account. You may refer to the 401(k) Savings section in this SPD for further details.

Eligible Dependents

If a Retiree marries after his/her retirement effective date, any newly acquired dependents are not eligible for medical or dental coverage. Likewise, a surviving spouse cannot add dependents after the Retiree's death.

Disabled Child(ren)

Prior to a retiree and a retiree spouse reaching age 65, medical (including prescription drugs), dental, and vision 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. You must submit proof of the Child's disability to the claims administrator within 31 days after attaining the maximum age. 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.

You are under age 65 and your spouse is age 65 or older

The retiree must be enrolled in the plan in order for an eligible spouse or child to be covered as a dependent in the medical, vision or dental plans (this includes pre-65 and post-65 plans).

Medical coverage for your spouse will end on the last day of the prior month prior in which the spouse turns age 65 and becomes Medicare-eligible. If Company coverage was maintained under age 65, your spouse may be eligible to participate in the RHRA and may purchase an individual policy through the Aon Retiree Health Exchange.

Dental and Vision Coverage: You, your spouse who is age 65 or older, and other Eligible Dependents may continue in the vision and dental plans until you reach age 65.

You age 65 or older and your spouse is under age 65

Your eligible spouse and other eligible dependents may continue in the medical plan (including prescription drugs) and vision and dental plan until your spouse reaches age 65.

You must be enrolled in the RHRA and you must have purchased an individual medical policy through the Aon Retiree Exchange in order for a spouse or child to be covered as your dependent in the medical, vision, or dental plan.

Both you and your spouse are age 65 or older

- Your age 65 or over spouse will be eligible to enroll in the RHRA and may purchase an individual policy through the Aon Retiree Exchange if you are enrolled and receiving RHRA benefits.
- Spouse must be enrolled in Medicare Part A and Part B.
- You and your spouse must have had continuous coverage under the Company's or another employer's medical plan since retirement. Proof of continuous coverage is required.
- If you cancel your individual medical policy purchased through the Aon Retiree Health Exchange, both you and your spouse will no longer be eligible for the RHRA benefit. The RHRA benefits will be terminated as of the effective date of your cancellation and you cannot re-enroll at a later date.
- A covered spouse can continue his or her participation in the RHRA at the Retiree's death.

Medicare Eligibility and Retirement

It is you and/or your Eligible Dependents' obligation to determine the earliest date any coverage under Medicare could become effective for yourself/your dependent(s). Medicare eligibility may be due to age, disability, or certain medical conditions as specified under Medicare regulations.

Company plans will pay secondary to Medicare as permitted by law, whether or not you are enrolled in Medicare.

Contact your Social Security Office and Medicare for assistance and additional information.

When You May Change Your Elections

There are limited circumstances under which you may change your benefit elections. You can drop your retiree medical, dental, vision, or group life coverage at any time by filling out a cancellation form. If you drop a retiree benefit plan, you may not later re-enroll. Cancellation forms are available from the Benefit Plans Office.

There may be times when an individual may make a mid-year election change when it is because of and consistent with a qualifying life event. Examples of a qualifying life event may include, but are not limited to:

- Legal separation, annulment, or divorce
- The death of your Spouse or Child
- The loss of benefit eligibility of your Child
- A change in health coverage due to your Spouse's or Child's employment
- A "special enrollment period" under the group health plan as required by law
- You, your Spouse, or Child becomes eligible for Medicare or Medicaid

Steps to Take If You Get Married…

- Notify the Benefit Plans Office to update your retirement records if your name changes. In addition, make sure the Benefit Plans Office knows of any address or telephone changes.
- Consider updating your beneficiary records to your life insurance.
- Consider updating your 401(k) Savings Plan beneficiary records. Contact the 401(k) Savings Plan Recordkeeper for more information.

Steps to Take If You Get Divorced or Legally Separated…

- Notify the Benefit Plans Office to update your retirement records. If your name changes, make sure the Benefit Plans Office knows of any address or telephone changes.
- Change your benefit elections within 31 days after the date your divorce or legal separation is final. You must submit a copy of the final divorce or legal separation decree in order to drop coverage for your ex-spouse. Your ex-spouse may be eligible to continue the medical, dental, and vision coverages that were in effect immediately prior to the divorce or separation 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.
- Evaluate life insurance coverage.
- Consider updating your life insurance Beneficiary records. Beneficiary forms are available from the Benefit Plans Office.
- Contact the 401(k) Savings Plan Recordkeeper for more information about updating your Beneficiary if you wish to make a change.

What Happens to Your Benefits If You Die?

In the Case of Your Death…

- A family member should notify the Benefit Plans Office of your death.
- The Benefit Plans Office will provide guidance to your appropriate family member(s) on the applicable documents for initiating benefits that may be available as a result of the death.
- Your designated Beneficiary should complete a life insurance claim form. The completed forms with a certified death certificate and other supporting information should be sent to the Benefit Plans Office.
- Your designated family member should contact the insurance company for information on filing a Group Universal Life claim, if applicable.

If Your Spouse or Dependent Dies…

- Notify the Benefit Plans Office.
- Contact the insurance company for information on filing a Group Universal Life claim, if applicable.

Medical (Including Prescription Drugs), Dental, and Vision

- If your spouse is under age 65, he or she may continue medical, dental, and/or vision coverage by paying the appropriate premiums.
- When your Spouse reaches age 65, coverage ends and your Spouse may purchase an individual policy through the Aon Retiree Health Exchange.
- Dependent Child(ren) coverage ends when the surviving spouse is no longer eligible for the pre-65 retiree plans. They may be eligible to continue coverage under COBRA.
- If you or your spouse participate in the Retiree Health Reimbursement Arrangement benefit, please refer to that section in this SPD.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

In accordance with plan provisions, your Beneficiary(ies) may receive benefits based upon the coverage you elected.

Pension Plan

If you participated in the Pension Plan, your Beneficiary should contact the Benefit Plans Office regarding any benefits that may be payable.

401(k) Savings Plan

Your designated Beneficiary should contact the 401(k) Savings Plan record keeper for additional information.

Keep in mind that if you have been married for at least one year, your Spouse is your Beneficiary unless you have designated otherwise with your Spouse's written and notarized consent.

Rights and Responsibilities

The Company may, but is not required to share in the cost of the benefits offered to you. You must enroll in a timely manner and pay your share of any cost.

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 reasonably necessary to support the administrative processes and features of the benefit plans.

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.

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Long-Term Care

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Long-Term Care Plan (Closed Plan)

Retirees who continue to participate in the closed Y-12 Long-Term Care plan may contact their Long-Term Care vendor:

MetLife: 1-800-438-6388

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Pension Plan

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Pension Plan

The Pension Plan provides vested participants with a source of income throughout their retirement years.

The pension plan maintained by the Company for Employees at the Y-12 is:

- The Retirement Program Plan for Employees of Consolidated Nuclear Security, LLC at the U.S. Department of Energy (DOE) Facilities at Oak Ridge, Tennessee (the "Y-12 Plan")

The pension plan may be referred to as the "Pension Plan" or the "Plan" and is a tax-qualified defined benefit plan and is offered to some bargaining unit and non-bargaining eligible employees at the Y-12 location.

Receiving Benefit Payments

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

- **If Your Benefit Has Not Started**
  - If your pension benefit has not started, contact the Benefit Plans Office to discuss your benefits.

If you are eligible for benefits and have terminated employment, your pension benefit must begin no later than April 1 of the following year in which you reach age 70 ½ if you turned age 70 ½ before January 1, 2020. Otherwise, you must begin benefits no later than April 1 of the following year in which you reach age 72.

Applying For Benefits

Upon 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.

Withholding Taxes

Under tax law, any applicable federal or state 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 financial institution of your choice. You may change the designated institution by notifying the Benefits Plans Office.

Change of Address

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

Administrative Information

Information about the administration of your retirement benefits can be found in the section entitled Administrative Information.

Qualified Domestic Relations Orders

As a general rule, your accrued benefit may not be assigned to another individual. This means that your accrued benefit cannot be sold, used as collateral for a loan, given away, or otherwise transferred. In addition, your creditors may not attach, garnish, or otherwise interfere with your accrued benefit. If you become divorced or separated, a court order could require that part of your benefit be paid to someone else, your Child(ren) or former Spouse for example. Payments cannot be made to anyone other than you unless the court order meets the legal requirements of a qualified domestic relations order. The Plan Administrator will review the court order and has the sole discretion to determine if the order meets these legal requirements. You may request the Plan Administrator to review a draft order prior to submission to the court. You may obtain a copy of the Plan's qualified domestic relations order guidelines, free of charge, by contacting the Plan Administrator.

Pension Benefit Amount

The amount of your pension benefit is determined when you retire based on the plan's formula (and your eligible earnings and service) in effect at that time, and the payment form you elect. If you have a question about how your benefit amount was determined, contact the Benefit Plans Office.

Employee Contributions

Any mandatory participant contributions will be reflected as a non-taxable portion of your monthly benefit when it is commenced. Also, if you die before benefits commence and do not have a spouse who is eligible to receive a survivor annuity, your beneficiary will receive a lump sum payment equal to the total of your contributions plus earnings credited to the contributions under the terms of the Plan. If you die after benefits commence and your benefit form of payment does not include a survivor benefit, if the total payments you received are less than the total of your contributions plus interest, the difference will be paid in a lump sum to your beneficiary. If you die after benefits commence and the benefit form includes a survivor benefit, if the total payments to you and your survivor are less than the total of your contributions plus interest, the difference will be paid in a lump sum to your beneficiary.

Pre-Retirement Spouse's Benefit (If you die as a terminated vested participant)

If you leave the Company with vested benefits and you die before plan payments begin, your Spouse is eligible to receive a pre-retirement pension benefit equal to 50% of the benefit you would have received under the joint and 50% survivor benefit. Your Spouse will be eligible only if married to you at least one year at the time of your death. If you have no Spouse or you have not been married at least one year at the time of your death, no survivor benefit is payable. However, if you made participant contributions to the Y-12 Plan, the contributions plus interest credited to the contribution as provided in the Y-12 Plan will be paid to your beneficiary.

If you die after age 50, payments may begin the month following your death. If you die before age 50, payments may begin the month following the date you would have reached age 50.

Level Income Option

If you retired before age 62 you were given the opportunity to elect the level income option. If you chose this option, your pension benefit is increased until age 62 and is decreased after age 62 so that your combined income from the Plan and Social Security is approximately level throughout your retirement.

Note: If you are receiving Social Security due to disability prior to age 62, you may still elect the level income option at time of retirement. However, your pension benefit will reduce at age 62 resulting in an actual decrease in overall income. Regardless of whether you apply for Social Security at age 62, your pension will be decreased to the reduced pension amount payable after age 62 if you elected the level income option form of payment.

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

Regarding Social Security

You should consult with the Social Security Administration to determine the age at which you may receive full benefits.

Please remember that Social Security 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.

Returning to Work after Terminating with a Vested Benefit (Before Starting Benefit Payments)

If you terminate employment with the Company (or prior Management and Operating Contractor) with a vested pension benefit and have not started your benefits and subsequently return to work with the Company as an Employee, you will reenter the Y-12 Plan and begin accruing additional benefits. However, if you received a lump sum payment of your vested accrued benefit before returning to employment you will not reenter the Y-12 Plan. Should you return to work and reenter the Y-12 Plan, your Pension Service Credit will be adjusted to include both prior and current service.

Returning to Work after Retirement (After Starting Benefits Payments)

If you have been receiving pension payments and return to work for the Company as an Employee, your benefit will be suspended during your period of reemployment, or until your work schedule is such that you are not subject to a benefit suspension.

Note: This does not apply to Ad Hoc Employees that work all or part of seven shifts or less in a month, or if you are over age 70 ½.

Your benefits will be suspended for any month in which you receive payment from the Company for one or more hours of service performed on each of eight or more days (or separate work shifts). When pension payments begin again, they will be adjusted to reflect your additional service and earnings after returning to work following the retirement.

If you expect to return to work after you retire or there is any understanding that you will come back to work for the Company in any capacity, your retirement will not be considered a bona fide retirement that allows you to commence a retirement benefit under IRS requirements. Thus, the Company will request information when you apply for benefits to ensure you have a bona fide retirement.

If you have had a bona fide retirement and commenced benefits then consider returning to active service, you should contact the Benefit Plans Office to make a determination concerning whether your return to work may cause your benefit to be suspended.

Savings Plan

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Savings Plan

At retirement or other termination of employment, you are entitled to receive the vested value of your 401(k) Savings Plan account.

ⓘ Voya Participant Services Contact Information

Internet Access: To access the 401(k) Plan via the Internet, please use the following URL: https://cns.voya.com

In the United States: 1-877-267-8692

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

Participant Services Representatives: 7:00 am – 7:00 pm central time; 8:00 am – 8:00 pm eastern time, Monday through Friday (except on days when the New York Stock Exchange is closed)

When you call, 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 the number and ask to speak to a customer service representative.

Accessing the System

To log on to your account, go to https://cns.voya.com and select the Participant log-in screen, enter your user name and your password, and press log in.

Request a Payout

To apply for a 401(k) Plan payout, call1-877-267-8692.

If you elect a lump sum payout, you will be mailed the payout generally within three business days from the date Participant Services processes 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 possible after Participant Services processes your properly completed forms.

Mandatory Distributions

At the time of your termination from service, you can elect to defer receiving payments. However, under IRS required minimum distribution rules, you may not defer payment beyond April 1 of the year following the year in which you reach age $70^1/_2$ or the date you retire if you work for the Company beyond age $70^1/_2$. Your Roth contributions and earnings are also subject to this rule unless you roll over the Roth account into a Roth IRA. If you were not age 70 ½ prior to January 1, 2020, age 72 applies rather than age 70 ½.

Distributions before Age 59 ½

If you make a withdrawal or receive a 401(k) Plan distribution before age 59 $^1/_2$, and do not roll it over, you may have to pay a 10% penalty in addition to ordinary income tax on the taxable portion of the payment, unless you qualify for one of the exceptions to this penalty, as listed in the “Special Tax Information Notice” section of the distribution paperwork. You can avoid the income and additional taxes if you roll over the taxable portion of your payment into an IRA or other eligible retirement plan within the time period permitted by law.

Your Beneficiary(ies) are never subject to the 10% tax penalty, regardless of your age at death.

Distributions or Withdrawals at Age 59 1/2 or Later

If you make a withdrawal or receive a 401(k) Plan distribution after age 59 1/2, you will not have to pay the 10% penalty; however, you will be responsible for the payment of any income taxes due.

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 because the contributions were made on an after-tax basis. Earnings on your Roth contributions will be subject to federal income tax unless the distribution occurs at least five years after you made your first Roth contribution or roll over Roth contributions from a former employer and the distribution is made after you turn 59 ½, upon your death, or upon your disability. Employer match contributions (and earnings on match contributions) which were made based on your Roth contributions are taxable upon distribution.

Rollovers and Withholding

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

If you want to roll over your eligible distribution 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 ensure you are using your benefits to their full advantage, check with a tax advisor regarding the specific requirements for using these and other forms of favorable tax treatments that may apply to your distribution. Neither the Benefit Plans Office nor the Recordkeeper can provide tax advice.

Quarterly Statement

After the end of each calendar quarter, the Recordkeeper will generate a statement you can elect to receive via mail or online, that reports your account activity, total fund balances, and investment elections.

You also have access to your account statement at any time by visiting https://cns.voya.com. You can create an online statement for any period of time within the last 24 months.

Naming Your Beneficiary

Your Beneficiary is the person you name to receive benefits from the 401(k) Plan if you die with a vested balance remaining in your 401(k) 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.

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 401(k) Plan account. If you are single (or have been married for less than one year at the time of your death) and do not name a Beneficiary, your vested 401(k) Plan account will be paid to your heirs at law or estate.

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Medical Plan

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Medical Plan Pre-65 Retirees

If eligible, you may continue enrollment at upon retirement until age 65 for medical coverage under one of the following Cigna Plans:

- Cigna Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA) Plan
- Cigna Open Access Plus (OAP) Preferred Provider Option (PPO) Core Plan
- Cigna Open Access Plus (OAP) Preferred Provider Option (PPO) Select Plan

The medical plans have different plan designs. Cigna administers these plans and manages the network of health care providers. You are automatically enrolled in prescription drug benefits if enrolled in a Cigna medical plan.

If you temporarily reside outside of Tennessee, and Cigna has a local open access network available, you may be provided use of that network and receive in-network benefits. If you reside in an area where a Cigna network is not available, then your coverage can be provided under the Cigna Indemnity Plan. Cigna has discretion to determine network availability.

Your Cigna plan will also provide protection and coverage for your enrolled Eligible Dependents under the same plan in which you are enrolled.

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

How the Open Access Plus Plans (OAP) Work

The PPO Core, PPO Select, and Choice Fund HSA center around a network of physicians, hospitals, and other health care providers who have agreed to provide care to patients at pre-negotiated rates.

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction, and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing Participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

When you select a participating provider, these Plans pay a greater share of the costs than if you select a non-participating provider. Participating providers contract with Cigna to provide their services and charge only the contracted fee amount. Consult the Cigna website for a list of participating providers in your area. Participating providers are committed to providing you and your dependents appropriate care while lowering medical costs. A Primary Care Physician (PCP) is generally responsible for coordinating all health care. In-network PCPs and specialists also handle all inpatient and outpatient pre-certification.

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. A PCP will provide a full range of preventive care based on recognized medical guidelines for your age, gender, and personal and family health histories. This care includes the following:

- immunizations
- annual well-woman/man exam

- well-child care
- cholesterol screenings
- prostate exams
- mammograms
- routine physical exams

With an OAP Plan, you have a choice each time you need health care to use only in-network providers, or to use providers outside the network and receive reduced benefits.

Under the OAP Plans

- You do not need a referral to receive covered services from any participating specialist, but you may want your PCP's advice and assistance in arranging care with a specialist in the network. If you choose to see an out-of-network specialist, the health care services you receive will be covered at the out-of-network level.
- You do not need prior authorization from the Plan or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals.

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 is your share of the costs of a covered service, calculated as a percent of the allowed amount of the service. For example, if the medical plan's allowed amount for an overnight hospital stay is $1,000, your Coinsurance payment of 20% would be $200. This may change if you have not met your Deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- Copayments (Copays) are fixed dollar amounts you pay for covered health care, usually when you receive the service. Deductibles are expenses to be paid by you or your Eligible Dependents. Deductibles are in addition to any Coinsurance. Once the Deductible for your Plan has been reached, you and your family need not satisfy any further medical deductible for the remainder of that year.
- Copayments and Deductibles are expenses to be paid by you or your Eligible Dependents for services received.
- Deductible amounts are separate from, and not reduced by copayments.
- Copayments and Deductibles are in addition to any Coinsurance.
- The Plans encourage you to use in-network providers by charging you lower Deductibles, Copayments, and Coinsurance amounts.

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.

If you need care while traveling outside your network area

Contact Cigna for more information about your coverage while traveling.

The Network Credentialing Process

All network doctors (i.e., PCPs and specialists) must meet certain educational and professional requirements before they are admitted into the network. Cigna has a regular credentialing process to ensure the doctors in the network meet certain standards, such as the following:

- 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 without advance notice.

Case Management

Coordinated by Cigna HealthCare, this is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or on a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. In some cases, a Medicare-based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply, or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used

Note 1: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and Coinsurance.

Note 2: Some providers forgive or waive the cost-share obligation (e.g., your Copayment, Deductible and/or Coinsurance) that this Plan requires you to pay. Waiver of your required cost-share obligation can jeopardize your coverage under this Plan. For more details, see the Exclusions section.

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 Maximum Reimbursable Charge, subject to any requirement that you pay coinsurance, for most kinds of medically necessary services until the annual Out-of-Pocket Maximum has been reached.

The Out-of-Pocket Maximum protects you 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 Maximum Reimbursable Charge for the remainder of that year.

You must file paper claims to be reimbursed for out-of-network expenses. Claim forms are available from Cigna member services. If your physician recommends any non-emergency hospitalization or surgery, you are responsible for calling Cigna member services for hospital pre-certification at least seven days, or as soon as reasonably possible, before you are admitted to the hospital. If you do not call for pre-certification, your benefit will be reduced by 50%.

Pre-Certification Requirements

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

If services are provided in-network, you do not have to worry about pre-certification. Your in-network PCP or specialist will handle it for you. But, if you go out-of-network for care, you are responsible for calling Cigna member services no later than seven days before you are admitted to the hospital or receive outpatient diagnostic testing or procedures. If you do not call, your benefit will be reduced.

When you call Cigna member services for pre-certification, 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 the Indemnity plan, you are responsible for requesting certification, even if you receive services from an in-network provider. If you do not obtain approval through certification, penalties will apply.

Pre-admission Certification (PAC)/ Continued Stay Review (CSR) for Hospital Confinement

Pre-admission 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, except for 48/96 hours maternity stays;
- for Mental Health or Substance abuse Use Disorder Residential Treatment Services.

PAC should be requested prior to any non-emergency 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 by 20% 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 be reduced by 20%:

- 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; and
- 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.

You or your Dependent should call the toll-free number on the back of your ID card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures.

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

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or outpatient 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 outpatient 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.

Outpatient Diagnostic Testing and Outpatient Procedures

Diagnostic tests and outpatient procedures that require certification include, but are not limited to:

- Advanced Radiological Imaging (e.g., CT scans, MRI, MRA, or PET scans)
- Home Health Services
- Medical Pharmaceuticals
- Radiation Therapy

Prior Authorization/Pre-Authorized

The term Prior Authorization means 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 Authorization include, but are not limited to:

- inpatient hospital services, except for 48/96 hour maternity stays
- inpatient services at any participating Other Health Care Facility
- residential treatment
- outpatient facility services
- partial hospitalization
- advanced radiological imaging
- non-emergency ambulance
- certain Medical Pharmaceuticals
- home health care services
- radiation therapy
- transplant services

Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services; and
- services or supplies that are, unless otherwise noted, Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. Any applicable Copayments, Deductibles, or limits are shown in the Summary of Benefits section.

Covered Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule
- Charges made for Emergency Services and Urgent Care
- Charges made by a Physician or a Psychologist for professional services
- Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service
- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration
- Charges made for an annual prostate-specific antigen test (PSA)
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures
- Charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies)
- Charges made for the following preventive care services (detailed information is available at www.healthcare.gov):
    1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;

3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- Charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction
- Charges made for hearing aids, 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
- Cochlear implants
- Charges for nutritional formulas and enteral feedings, regardless of diagnosis
- Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, including telephones and internet, when delivered through a contracted medical telehealth provider
- Behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, clinical trials conducted by non-Participating Providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing.

Nutritional Evaluation and Counseling

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Obesity Treatment

- charges made for medical and surgical services only at approved centers for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature, and scientifically-based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
    - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
    - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
    - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
    - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
    - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Home Health Care Services

Charges made for Home Health Care Services when you:

- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

If you are a minor or an adult who is dependent upon others for nonskilled care (e.g., bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy."

Hospice Care Services

Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Bed and Board and Services and Supplies
- by a Hospice Facility for services provided on an outpatient basis
- by a Physician for professional services
- by a Psychologist, social worker, family counselor, or ordained minister for individual and family counseling
- for pain relief treatment, including drugs, medicines and medical supplies
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse
  - part-time or intermittent services of an Other Health Care Professional
- physical, occupational and speech therapy
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house
- for any period when you or your Dependent is not under the care of a Physician
- for services or supplies not listed in the Hospice Care Program
- for any curative or life-prolonging procedures
- to the extent that any other benefits are payable for those expenses under the policy
- for services or supplies that are primarily to aid you or your Dependent in daily living

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your dependent is not confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder Residential Treatment Services

Services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center

An institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your dependent is not confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders
- Counseling for activities of an educational nature
- Counseling for borderline intellectual functioning
- Counseling for occupational problems
- Counseling related to consciousness raising

- Vocational or religious counseling
- I.Q. testing
- Custodial care, including but not limited to, geriatric day care
- Psychological testing on children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline

Durable Medical Equipment

Charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by Cigna. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to, crutches, Hospital beds, wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in another section of this certificate, the following are specifically excluded:

- Hygienic or self-help items or equipment
- Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines
- Institutional equipment, such as air fluidized beds and diathermy machines
- Elastic stockings and wigs
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints
- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective
- Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars

Coverage is subject to the maximum shown in The Schedule.

External Prosthetic Appliances and Devices

Charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

Outpatient Therapy Services

Charges for the following therapy services: Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- Charges for therapy services are covered when provided as part of a program of treatment.

Cardiac Rehabilitation

Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Chiropractic Care Services

Charges for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

Coverage is provided to:

- Restore function (called "rehabilitative"):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Illness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called "habilitative"):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Illness or Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy;
- treatment of dyslexia;
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status;
- charges for Chiropractic Care not provided in an office setting; or
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.

A separate Copayment applies to the services provided by each provider for each therapy type per day.

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in the manner chosen by the insured and Physician. Services and benefits include:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- postoperative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

Cosmetic Surgery

Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by Cigna.

Transplant Services

Charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LifeSOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LifeSOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LifeSOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan include:

- Care for health conditions that are required by state or local law to be treated in a public facility
- Care required by state or federal law to be supplied by a public school system or school district
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available
- Treatment of 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. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law
- 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

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the Clinical Trials sections of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the Clinical Trials sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications: abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance 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.
- unless otherwise covered in this 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 including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, 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 is also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- 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), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services, including but not limited to, Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.

- 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. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the Home Health Services or Breast Reconstruction and Breast Prostheses sections of this plan.
- private Hospital rooms and/or private-duty nursing except as provided under the Home Health Services provision.
- 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, elastic stockings, garter belts, corsets, dentures and wigs.
- aids or devices that assist with non-verbal communications, including but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants, Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this 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.
- all nutritional supplements and formulas except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- massage therapy.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for 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.
- to the extent that you or any one of your 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.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider;

- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature, or guidelines.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Other Health Care Facility/Other Health Professional

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

Filing Claims

If you stay in-network under the Open Access Plus (OAP) plans, your network provider is responsible for filing your claims.

To file a claim for out-of-network treatment under the Open Access Plus (OAP) 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 do the following:

- 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

Claim forms can be obtained from Cigna member services or Benefit Plans.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to, the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semi-private room, the difference in cost between a private and semi-private room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-certification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - then, the Plan of the parent with custody of the child;
    - then, the Plan of the spouse of the parent with custody of the child;
    - then, the Plan of the parent not having custody of the child; and
    - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the “other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you do not elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

Company Right to Reimbursement (Subrogation)

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Personal Health Team

Client-specific team of clinical specialists who provide support for healthy, at-risk, and acute-care individuals to help them stay healthy:

- Health and Wellness Coaching
- Cigna Well-Informed Program
- Preference Sensitive Care
- Behavioral Health Case Management
- 24-hour Health Information Line Outreach
- Pre-Admission Outreach
- Post-Discharge Outreach
- Inpatient Advocacy
- Case Management – Short-term and complex

Continuation of Medical Coverage (COBRA)

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

Certificate of Creditable Coverage

Upon loss of coverage under these plans, 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.

Cigna Member Services

Cigna member services is a customer service line staffed to answer your questions and provide information about your participation and benefits. Cigna member services can help you with the following:

- find out more about in-network PCP, specialists, and facilities
- get more information about plan features and procedures
- change PCP
- 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.myCigna.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. There you can do the following:

- 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 pre-certification.

ⓘ Contacting Cigna Member Services

Please call 1-855-247-0884 or log on to www.myCigna.com.

Information for All Medical Plans

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).

Open Access Plus (OAP)
Choice Fund with Health Savings Account (HSA)

Open Access Plus (OAP)
Choice Fund with Health Savings Account (HSA)

The Choice Fund with HSA is a high deductible medical plan. This plan provides access to an HSA which is a tax-advantaged bank account that allows you to save and then use tax-free dollars to pay for health care expenses.

Any money you and the Company contribute to your HSA will not be taxed as long as you are eligible to contribute to your HSA and you do not contribute more than the permitted amount. In addition, as long as you use your HSA funds to pay for eligible expenses, you will not be taxed on any reimbursement you receive. If you are eligible, you can make tax-free contributions to your account up to the annual IRS limit. If you are age 55 or older, you can make additional contributions in accordance with IRS limits.

You will not be taxed on the amounts you use to pay for eligible expenses or the interest your account earns. Qualified expenses can include expenses not covered through your medical plans such as dental, vision, and prescription drugs. Eligible expenses are listed at www.cigna.com/expenses.

To use the money in your account you will receive a debit card that you can use at the doctor's office, pharmacy, and any other provider.

Your HSA balance is yours to use even if you no longer participate in a high deductible plan. The HSA funds are "portable." When your HSA coverage ends you may still receive tax-free HSA distributions for eligible expenses (or withdraw funds on a taxable basis for ineligible expenses) but you may no longer make tax-free contributions to your HSA account.

Who is not eligible for the HSA:

You are responsible for determining whether you are eligible to contribute to an HSA. Generally, you are not eligible:

- If you are currently not enrolled in a high deductible health plan
- If you are covered under any disqualifying health coverage, such as a spouse's medical plan that is not a high deductible plan or your spouse's general health care flexible spending account
- If you are entitled to Medicare
- If you are claimed as a dependent under someone else's tax return

You may refer to IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, for additional information on HSA.

Summary of Benefits Medical Plan: Choice Fund with Health Savings Account (HSA)

Important Questions	Answers	Why this Matters
What is the overall Deductible?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual and $6,000/Family Deductible per person applies when the employee is the only person covered under the plan.	**You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services you use.**
Are there any out-of-pocket limits on my expenses?	In-network providers: $4,000/Individual and $8,000/Family Out-of-network providers: $8,000/Individual and $16,000/Family	**The out-of-pocket limit is the most you could pay during a calendar year.**
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover.	**Even though you pay these expenses, they do not count toward the out-of-pocket limit.**
Do I need a referral to see a Specialist?	No. You do not need a referral to see a **Specialist**.	**You can see the Specialist you choose.**

Plan Highlights	In-Network	Out-of-Network
Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses. Annual Employer Contribution: For **Individual Coverage:** **$250** For **Family Coverage:** **$500**		
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90%	Plan Pays 70%
Calendar Year Deductible	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for in-network covered expenses only counts toward your in-network Deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network Deductibles. • The Deductible must be met first before any Copay or Coinsurance will apply. • This plan includes a combined medical/pharmacy plan Deductible. • All eligible family members contribute towards the family plan Deductible. Once the family Deductible has been met, the plan will pay each eligible family member's expenses based on the Coinsurance level specified by the plan. **Note 1:** If you cover only yourself in this plan, you need to meet the individual Deductible before the plan applies any Coinsurance or Copay for covered benefits. **Note 2:** If you cover yourself and any dependents, the family Deductible will apply. You must meet the entire family Deductible before the plan applies any Coinsurance or Copay for covered benefits (there is no individual Deductible).		
Calendar Year Out-of-Pocket Maximum	$4,000/Individual $8,000/Family	$8,000/Individual $16,000/Family

Plan Highlights	In-Network	Out-of-Network
• The amount you pay for in-network covered expenses only counts toward your in-network Out-of-Pocket Maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After each eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and x-ray benefit; based on place of service	Plan Pays 70% after deductible Plan Pays subject to Plan's Lab and x-ray benefit; based on place of service

Benefits	In-Network	Out-of-Network
Physician Services		
PCP Office **Specialist Office**	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Benefits	In-Network	Out-of-Network
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Professional Services For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 90% after deductible	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered

Benefits	In-Network	Out-of-Network
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 90% after deductible	Not Covered
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Lab and X-ray **Note:** All lab and x-ray services, including Advanced Radiological Imaging (ARI), provided at Inpatient Hospital are covered under Inpatient Hospital benefit. Emergency Room/Urgent Care Facility are covered the same as Emergency Care/Urgent Care services.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Advanced Radiological Imaging in: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 90% after deductible Plan Pays 70% after deductible
Emergency Care • Outpatient Professional Services **Urgent Care** • Outpatient Professional Services	Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 90% after deductible Plan Pays 90% after deductible
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after deductible	Plan Pays 90% after deductible

Benefits	In-Network	Out-of-Network
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility • Non-LifeSOURCE Inpatient Facility **Inpatient Professional Services** • LifeSOURCE Facility • Non-LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	Plan Pays 100% after deductible Plan Pays 90% after deductible Plan Pays 100% after deductible Plan Pays 90% after deductible	Not Covered Not Covered Not Covered Not Covered
Maternity Initial Visit to Confirm Pregnancy **Global Maternity Fee** All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges **Office Visits in Addition to Global Maternity Fee** (Performed by OB/GYN or Specialist) **Delivery Facility** Inpatient Hospital, Birthing Center	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Covered same as Plan's Inpatient Hospital benefit	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Benefits	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90%	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

Benefits	In-Network	Out-of-Network
Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. **The following are excluded:** • 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. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	after deductible Plan Pays 90% after deductible	
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder Inpatient Outpatient – Physician's Office Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	Plan Pays 90% after deductible	Not Covered

Excluded Services

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP)
Preferred Provider Organization (PPO) Core

Open Access Plus (OAP)
Preferred Provider Organization (PPO) Core

Summary of Benefits Medical Plan: PPO Core

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $400/Individual and $800/Family Out-of-network providers: $800/Individual and $1,600/Family Individual Deductible applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual and $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Calendar Year Deductible	$400/Individual $800/Family	$800/Individual $1,600/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Deductibles. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and x-ray benefit, based on place of service	Plan Pays 70% after deductible Plan Pays subject to Plan's Lab and x-ray benefit, based on place of service
Physician Services		
PCP Office **Specialist Office** • All services including Lab and X-ray • Plan Pays 100% after your Copay	You Pay $20 Copay You Pay $35 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $35 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $35 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility Services • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Benefits	In-Network	Out-of-Network
Outpatient		
Outpatient Facility Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation (includes coverage for developmental delays) **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $25 Copay	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $25 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear; replacement batteries	Plan Pays 90% after deductible	Not Covered

Benefits	In-Network	Out-of-Network
Cochlear Implants	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Lab and X-ray in: • Physician's Office • Specialist Office • Independent Lab • Outpatient Facility **Note:** Emergency Room/Urgent Care Facility lab and x-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 90% Plan Pays 90%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging in: • Physician's Office • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit. **Note 3:** Emergency Room/Urgent Care Facility lab and x-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $150 Copay Per Visit	
Urgent Care • Urgent Care Facility • Outpatient Professional Services	You Pay $35 Copay	

Benefits	In-Network	Out-of-Network
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after deductible	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility • Non-LifeSOURCE Inpatient Facility **Inpatient Professional Services** • LifeSOURCE Facility • Non-LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	Plan Pays 100% Plan Pays 90% after deductible Plan Pays 100% Plan Pays 90% after deductible	Not Covered Not Covered Not Covered Not Covered
Maternity Initial Visit to Confirm Pregnancy • PCP Office Visit • Specialist Office Visit **Global Maternity Fee** (All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges) **Office Visits in Addition to Global Maternity Fee** Performed by Physician Office Performed by OB/GYN or Specialist **Delivery Facility** Inpatient Hospital, Birthing Center	You Pay $20 Copay You Pay $35 Copay Plan Pays 90% after deductible You Pay $20 Copay You Pay $35 Copay Covered same as Plan's Inpatient Hospital benefit	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $35 Copay Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Benefits	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $35 Copay Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Surgical and Non-Surgical Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $35 Copay Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Benefits	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	You pay $20 Copay	Not Covered
• Specialist Office	You pay $35 Copay	Not Covered
• Inpatient Facility	Plan Pays 90% after deductible	Not Covered
• Outpatient Facility	Plan Pays 90% after deductible	Not Covered
• Inpatient Professional Services	Plan Pays 90% after deductible	Not Covered
• Outpatient Professional Services	Plan Pays 90% after deductible	Not Covered
Surgeon Charges Lifetime Maximum: $10,000		
Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered.		
The following are excluded:		
• 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.		
• Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management:		
• Inpatient utilization review and case management		
• Outpatient utilization review and case management		
• Partial Hospitalization		
• Intensive outpatient programs		
Mental Health or Substance Abuse Disorder		
Inpatient	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient – Physician's Office	You Pay $35 Copay	Plan Pays 70% after deductible
Outpatient – All Other Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Note 1: Calendar Year Maximum: Unlimited		
• Services are paid at 100% after you reach your Out-of-Pocket Maximum.		
• Inpatient includes Rehabilitation, Residential Treatment, and Detoxification.		
• Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.		
Note 2: ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient		
Telephone or Video Consultations		
Services Provided by MDLive		
• Telephone consultation	You Pay $20 Copay	Not Covered
• Video/online consultation		

Excluded Services

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP)
Preferred Provider Organization (PPO) Select

Open Access Plus (OAP)
Preferred Provider Organization (PPO) Select

Summary of Benefits Medical Plan: PPO Select

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $0/Individual and $0 family Out-of-network providers: $500/Individual and $1,000/Family	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 100%	Plan Pays 70% after deductible
Calendar Year Deductible	None	$500/Individual $1,000/Family
• The amount you pay for all covered expenses counts toward your out-of-network Deductible. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and x-ray benefit; based on place of service	Plan Pays 70% after deductible Plan Pays subject to Plan's Lab and x-ray benefit; based on place of service
Physician Services		
PCP Office **Specialist Office**	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility: • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	You Pay $400 Copay Per Admission	Plan Pays 70% after deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible

Benefit	In-Network	Out-of-Network
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit Copay	You Pay $250 Copay Per Facility/Visit	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation • Includes coverage for developmental delay **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $20 Copay	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $20 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 100%	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 100%	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 100%	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 100%	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 100%	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered

Benefit	In-Network	Out-of-Network
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Not Covered
Cochlear Implants	Plan Pays 100%	Plan Pays 70% after deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges. Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Lab and X-ray in: • PCP Office • Specialist Office • Independent Lab • Outpatient Facility **Note:** Emergency Room/Urgent Care Facility lab and x-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging in: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	You Pay$150 Copay Per Scan You Pay $150 Copay Per Scan You Pay $150 Copay Per Scan	Plan Pays 70% after deductible You Pay $150 Copay Per Scan Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $150 Copay Per Visit	
Urgent Care • Urgent Care Facility • Outpatient Professional Services	You Pay $30 Copay Per Visit	

Benefit	In-Network	Out-of-Network
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 100%	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility • Non-LifeSOURCE Inpatient Facility **Inpatient Professional Services** • LifeSOURCE Facility • Non-LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	 $400 Copay Per Visit $400 Copay Per Visit Plan Pays 100% Plan Pays 100%	 Not Covered Not Covered Not Covered Not Covered
Maternity Initial Visit to Confirm Pregnancy: • PCP Office Visit • Specialist Office Visit **Global Maternity Fee** All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges **Office Visits in Addition to Global Maternity Fee** PCP Office Visit Specialist Office Visit **Delivery Facility** Inpatient Hospital, Birthing Center	You Pay $20 Copay You Pay $30 Copay Plan Pays 100% You Pay $20 Copay You Pay $30 Copay Covered same as Plan's Inpatient Hospital benefit	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	 You Pay $20 Copay You Pay $30 Copay You Pay $400 Copay Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay You Pay $400 Copay Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay You Pay $400 Copay Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI), is covered.	You Pay $20 Copay Per Visit You Pay $30 Copay Per Visit You Pay $400 Copay Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

Benefit	In-Network	Out-of-Network
The following are excluded: • 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. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Benefit	**In-Network**	**Out-of-Network**
Mental Health or Substance Abuse Disorder • Inpatient • Outpatient – Physician's Office • Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	You Pay $400 Copay You Pay $30 Copay Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

Open Access Plus (OAP) Indemnity

Open Access Plus (OAP) Indemnity

Summary of Benefits Medical Plan: Indemnity

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	$750/Individual and $1,500/Family Deductible per person applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there other **Deductibles** for specific services?	Yes. See Emergency Care and Urgent Care services.	You must pay this Deductible per visit.
Are there any **out-of-pocket limits** on my expenses?	$3,250/Individual and $6,500/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	Out-of-Area
Maximum Lifetime Benefit	Unlimited
Coinsurance	Plan Pays 80% after deductible
Calendar Year Deductible	$750/Individual $1,500/Family
• Benefit Deductible always applies before plan Deductible and Coinsurance. • The amount you pay for all covered expenses counts toward your Deductible. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.	
Calendar Year Out-of-Pocket Maximum	$3,250/Individual $6,500/Family
• The amount you pay for all covered expenses counts toward your Out-of-Pocket Maximum. • All Coinsurance and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	

Benefit	Out-of-Area
Preventive Care	
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%
Immunizations	Plan Pays 100%
Mammogram, PAP, and PSA Tests • Routine services	Plan Pays 100%
Physician Services	
PCP Office **Specialist Office**	Plan Pays 80% after deductible Plan Pays 80% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	Plan Pays 80% after deductible Plan Pays 80% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	Plan Pays 80% after deductible Plan Pays 80% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 80% after deductible
Inpatient	
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 80% after deductible
Inpatient Hospital Physician's Visit/Consultation	Plan Pays 80% after deductible
Inpatient Professional Services: • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 80% after deductible
Outpatient	
Outpatient Facility Services	Plan Pays 80% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 80% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 80% after deductible

Benefit	Out-of-Area
Chiropractic Care • Calendar Year Maximum: 25 days	Plan Pays 80% after deductible
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private-duty nursing subject to medical necessity • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 80% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 80% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoe**s**	Plan Pays 80% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 80% after deductible
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 80% after deductible
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 80% after deductible
Cochlear Implants	Plan Pays 80% after deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible

Benefit	Out-of-Area
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	
Lab and X-ray in: • Physician's Office • Independent Lab • Emergency Room/Urgent Care Facility • Outpatient Facility	Plan Pays 80% after deductible Plan Pays 80% after deductible $150 Copay/$75 Copay after deductible Plan Pays 80% after deductible
Diagnostic and Advanced Radiological Imaging (ARI) in: • Physician's Office • Independent Lab • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	Plan Pays 80% after deductible Not Applicable Plan Pays 100% after deductible Plan Pays 80% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Note:** Copays are waived if admitted. **Urgent Care** • Urgent Care Services • Outpatient Professional Services **Ambulance Services** If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.)	You Pay $150 Copay Per Visit Plan Pays 100% after deductible You Pay $75 Copay Per Visit Plan Pays 100% after deductible Plan Pays 80% after deductible
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 80% after deductible Plan Pays 80% after deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility **Inpatient Professional Services** • LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	Plan Pays 80% after deductible Plan Pays 80% after deductible
Maternity • Initial Visit to Confirm Pregnancy **Global Maternity Fee** • All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges **Office Visits in Addition to Global Maternity Fee** **Delivery Facility** • Inpatient Hospital, Birthing Center	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Covered same as Plan's Inpatient Hospital benefit

Benefit	Out-of-Area
Abortion – Elective and Non-Elective Procedures • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible
Family Planning – Men's Services Office Visits, Lab and Radiology Tests, and Counseling Surgical Sterilization Procedures for Vasectomy (Excludes reversals) • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible
Family Planning – Women's Services • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services **Note:** Includes coverage for contraceptive devices [i.e., Depo-Provera and Intrauterine Devices (IUDs)] as ordered or prescribed by a Physician. Diaphragms also are covered when services are provided in the Physician's office. • Surgical Sterilization Procedures for Tubal Ligation (Excludes reversals)	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%
Infertility Services Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible

Benefit	Out-of-Area
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI), is covered. **The following are excluded:** • 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. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible
Mental Health and Substance Abuse Disorder Services	
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management • Inpatient Management Only • Inpatient utilization review and case management	
Mental Health or Substance Abuse Disorder • Inpatient • Outpatient – Physician's Office • Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible

Excluded Services

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S.	• Private-Duty Nursing • Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Prescription Drugs

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Prescription Drug Benefit

The prescription drug benefit available to you is based on the medical plan in which you are enrolled. 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. You may also receive a 90-day supply of maintenance medications at either Walgreens or CVS Pharmacies.

The self-funded prescription drug plan is administered by Express Scripts, which 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 Express Scripts network.

Certain drugs may be excluded, or a prior authorization may be necessary in order to receive the prescription or the full quantity your doctor prescribes. In some cases a generic drug may be substituted for a brand-name medication. For a current listing of the categories, including those that require prior authorization you may refer to the Express Scripts website at www.express-scripts.com or contact Express Scripts Member Services at 1-800-685-8869.

A number of clinical programs are offered by Express Scripts 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. A drug must be approved by the U.S. Food and Drug Administration (FDA) to be covered under the plan. Compound drugs that contain non-FDA-approved ingredients are not covered under the plan.

The programs and coverage criteria are subject to change.

The Company reserves the right to amend, terminate, 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.

ⓘ Express Scripts Member Services

Toll-free:	(800) 685-8869
Fax:	(800) 837-0959
Mail:	Express Scripts PO Box 747000 Lexington, KY 45274-7000

Mail Order: www.express-scripts.com or (800) 685-8869

Summary of Benefits: Prescription Drugs

Choice Fund with HSA Pre-65 Retirees

Prescription Drugs Summary		
You Pay		
	In-Network	**Out-of-Network**
Annual Prescription Drug Deductible	Combined With Medical	**Combined With Medical**
Retail 30-Day Supply		
Generic	$10 copay after deductible	**50% Coinsurance after deductible**
Brand	$25 copay after deductible	**50% Coinsurance after deductible**
Non-Preferred	$50 copay after deductible	**50% Coinsurance after deductible**
Mail Order – Home Delivery – Up to 90-Day Supply		
Generic	$15 copay after deductible	**Not Covered**
Brand	$50 copay after deductible	**Not Covered**
Non-Preferred	$100 copay after deductible	**Not Covered**

1. Pharmacy benefits are through Express Scripts.

2. 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 contact Express Scripts at (800) 685-8869 or www.express-scripts.com.

3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised. For any questions, you may contact Express Scripts at (800) 685-8869.

4. Certain drugs may be excluded under the plan for such reasons as clinical cost, not FDA-approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.

5. Note: Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

PPO Core Pre-65 Retirees

Prescription Drugs Summary		
You Pay		
	In-Network	**Out-of-Network**
Annual Prescription Drug Deductible	None	**None**
Retail 30-Day Supply		
Generic	$10 Copay	**50% Coinsurance**
Brand	$25 Copay	**50% Coinsurance**
Non-Preferred Brand	$50 Copay	**50% Coinsurance**
Mail Order – Home Delivery – Up to 90-Day Supply		
Generic	$15 Copay	**Not Covered**
Brand	$50 Copay	**Not Covered**
Non-Preferred Brand	$100 Copay	**Not Covered**

1. Pharmacy benefits are through Express Scripts.

2. 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 contact Express Scripts at (800) 685-8869 or www.express-scripts.com.

3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised. For any questions, you may contact Express Scripts at (800) 685-8869.

4. Certain drugs may be excluded under the plan for such reasons as clinical cost, not FDA-approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.

5. Note: Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

PPO Select Pre-65 Retirees

Prescription Drugs Summary		
You Pay		
	In-Network	**Out-of-Network**
Annual Prescription Drug Deductible	None	**None**
Retail 30-Day Supply		
Generic	$5 Copay	**50% Coinsurance**
Brand	$20 Copay	**50% Coinsurance**
Non-Preferred Brand	$35 Copay	**50% Coinsurance**
Mail Order – Home Delivery – Up to 90-Day Supply		
Generic	$10 Copay	**Not Covered**
Brand	$40 Copay	**Not Covered**
Non-Preferred Brand	$70 Copay	**Not Covered**

1. Pharmacy benefits are through Express Scripts.

2. 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 contact Express Scripts at (800) 685-8869 or www.express-scripts.com.

3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised. For any questions, you may contact Express Scripts at (800) 685-8869.

4. Certain drugs may be excluded under the plan for such reasons as clinical cost, not FDA-approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.

5. Note: Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

Indemnity Pre-65 Retirees

Prescription Drugs Summary		
You Pay		
	In-Network	**Out-of-Network**
Annual Prescription Drug Deductible	None	**None**
Retail 30-Day Supply		
Generic	$10 Copay	**50% Coinsurance**
Brand	$25 Copay	**50% Coinsurance**
Non-Preferred Brand	$50 Copay	**50% Coinsurance**
Mail Order – Home Delivery – Up to 90-Day Supply		
Generic	$15 Copay	**Not Covered**
Brand	$50 Copay	**Not Covered**
Non-Preferred Brand	$100 Copay	**Not Covered**

1. Pharmacy benefits are through Express Scripts.

2. 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 contact Express Scripts at (800) 685-8869 or www.express-scripts.com.

3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised. For any questions, you may contact Express Scripts at (800) 685-8869.

4. Certain drugs may be excluded under the plan for such reasons as clinical cost, not FDA-approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.

5. Note: Infusion therapy drugs are administered under the medical plan.

Your Prescription Drug Plan

This section covers some of the most frequently asked questions about your prescription plan.

The prescription drug plan is a stand-alone plan that covers only FDA-approved medications prescribed by your physician.

Oral and self-injectable medications are covered under the prescription plan and not the medical plan.

Infusion therapy drugs may be administered at an inpatient or outpatient facility, in the doctor's office, or at your home and are covered under the medical plan.

What is covered?

The Plan's prescription drug benefit covers a wide variety of prescription drugs, including generic drugs and brand-name or specialty drugs. Generally, compound drugs are not covered. The formulary and conditions of drug coverage under the Plan may change for a medication that it is not covered.

What is not covered?

Some drugs are not covered, or excluded, from the prescription drug benefit, which means there may be no alternatives to try for coverage. To check whether a medication is excluded, go to www.express-scripts.com or call Express Scripts Member Services.

What is a formulary drug?

A preferred list of drug products is covered that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing, and/or reimbursement. Products are selected on the basis of safety, efficacy, and cost. Certain drugs are excluded from the formulary. The Plan maintains a formulary list. Members can obtain formulary drugs for lower cost. Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products on the formulary list.

Express Scripts has an expert panel of physicians and pharmacists that carefully reviews the drugs on the formulary for safety, quality, effectiveness, and cost. *The formulary and conditions of drug coverage under the Plan are subject to change.* To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to www.express-scripts.com or call Express Scripts Member Services. A pharmacist can also check whether a medication is on the formulary or covered at any time.

What is a generic drug?

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements ensure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

What is a brand drug?

A brand drug is protected by a patent, which prevent other companies from manufacturing the drug while the patent is in effect. A preferred brand drug is a drug that is covered under the Plan. Preferred brand drugs, also known as formulary drugs, are medications that have been reviewed and approved

by the group of physicians and pharmacists, and have been added to the Express Scripts formulary list for the Plan, based on their proven clinical and cost-effectiveness.

A non-preferred brand drug, or non-formulary drug, has not been approved for coverage. If a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and is on the formulary. The formulary changes from time to time as new clinical information becomes available. To determine the status of any particular drug on the Plan's formulary, log onto www.express-scripts.com or contact Express Scripts Member Services.

What is a specialty drug?

A specialty drug is used to treat complex, chronic conditions and is usually a high-cost drug that may require close clinical monitoring and special storage. These medications may be administered orally, inhaled, or given by injection or infusion by a healthcare professional.

Note: *Infusion therapy drugs administered by healthcare professionals either in an inpatient or outpatient facility, or in a physician's office or patient's home, are covered under the Company's medical plan. See the Medical Plan Summary for more information.*

Covered specialty drugs are dispensed by Express Scripts' specialty pharmacy, Accredo.

What is a compound drug?

A medicine that is made of two or more ingredients that are weighed, measured, prepared, or mixed by a pharmacist according to a prescription order. All ingredients must be FDA-approved in order to be considered for coverage by the Plan. Without FDA approval, health risks associated with compounded drugs are not determined and may be high risk, even fatal.

What is a network retail pharmacy?

A pharmacy (also called a retail network pharmacy) that participates in the Plan's contracted network. You must use a network pharmacy or you will pay more for your prescription.

When should a retail network pharmacy be used?

The retail network pharmacy may be used when a medication is needed immediately, or by choice. You simply present your ID card to the pharmacist, along with the doctor's written prescription if it has not been sent electronically, to receive a *30-day supply* of the medicine.

You can find a participating retail pharmacy on the Express Script website at www.express-scripts.com or you may call Express Scripts Member Services or download the Express Scripts mobile app. To download the mobile app for free, search for "Express Scripts" in smartphone app stores.

What if the retail pharmacy is not in the network?

Prescriptions filled at a non-participating retail pharmacy are not covered under the Plan, which means if you fill prescriptions there, you pay the full retail price (or 100% of the cost) of the drug and the amount paid does not count against the Plan's deductible or out-of-pocket maximums.

When should the home delivery mail pharmacy be used?

A mail order pharmacy service is available for prescriptions taken on a regular basis. With mail order, you can receive up to a *90-day supply* of medicine, in most cases at a lower cost than you would pay if you got your prescription at a retail network pharmacy.

Features of the home delivery mail pharmacy?

Prescription bottles are filled by an automated process, which significantly reduces errors. Pill bottles have child-resistance safety caps, but easy-open caps may be requested. The bottles are placed in tamper-proof, weather-resistance packages. Drugs that require refrigeration are shipped in cold packs. Pharmacists are available 24/7 by phone to answer questions.

How can new prescriptions be submitted to the home delivery mail pharmacy?

New prescriptions may be submitted directly from the doctor's office or through the mail.

How can prescriptions be refilled at the home delivery mail pharmacy?

Refills can be ordered electronically downloading and using the Express Scripts mobile app, logging on the website, through the mail, or by phone. Visit www.express-scripts.com to learn more. You may also set prescriptions to renew automatically.

When should the specialty pharmacy, Accredo, be used?

Covered specialty drugs must be dispensed by Express Scripts' specialty pharmacy, Accredo. Enhanced care and services are provided by Accredo for the complex and chronic conditions. Pharmacists specifically trained in the complex and chronic conditions are available at Accredo to assist you and your family member or physician in treating these conditions. Pharmacists are available 24/7 by phone to answer questions. Call Express Scripts Member Services to contact Accredo.

How are claims paid?

Generally, you do not need to submit claims under the prescription plan. You pay the amount that is required by you under the Plan when filling a prescription. If you do submit a paper claim for reimbursement of the cost of a covered drug (for example, if the pharmacy's computer system was not working or the card was left at home), you can obtain a claim form from the Benefits Plan website or Express Scripts website and submit the claim directly to Express Scripts.

What is a benefit exclusion?

A denied prescription may also be referred to as "not covered." This includes a drug or drug class that is not included as a benefit and means there are no alternatives to try or exceptions to coverage. Excluded drugs that are not covered will not be reimbursed by the Plan's pharmacy benefit.

What is prior authorization?

Prior authorization monitors both cost and safety. If a pharmacist tells you that a prescription requires prior authorization, Express Scripts will need to communicate with the doctor to ensure the medicine is right and will verify that the Plan covers the drug. This is similar to when a healthcare plan authorizes a medical procedure in advance. When a prescription requires prior authorization, the doctor can call Express Scripts or prescribe a different medicine that is covered by the Plan. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, the member will pay the normal copay. If the medication is not covered by the Plan, you may pay 100% of the cost of the medicine.

Coverage Reviews

Is there an appeal process for a denied claim?

Yes. There is a specific process that you need to follow when making an appeal request for a denied benefit. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, a panel of clinicians, trained prior authorization staff, or an independent third-party utilization management company. Members are notified of the decision and of any rights to appeal an adverse benefit decision. Under Section 502(a) of ERISA, covered participants have the right to bring a civil action if their final appeal is denied.

Below is an overview of the process and procedure involved with coverage reviews, coverage appeals, and external appeal reviews.

Information about coverage reviews can also be found on Express Scripts website at www.express-scripts.com.

There are *clinical coverage reviews* and *administrative coverage reviews*.

- Clinical coverage review requires a prescription be *prior authorized* before the prescription will be considered for coverage under the plan. When a prescription requires prior authorization, Express Scripts will need to communicate with your doctor to ensure the medicine is right and will verify the plan covers the drug. Only the doctor is able to provide Express Scripts the information needed for the clinical review. If the drug is not covered, you will pay full price for the medication.
- Administrative coverage review is requested by the covered participant and the participant submits information to Express Scripts to support their request. The medicine must be covered by the plan or you will pay full cost of the drug.

Appeals are related to coverage denials; they are not related to procedures addressing member complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations.

Initial Coverage Review

How do I request an initial coverage review?

- To request an *initial clinical coverage review*, *also called prior authorization*, your doctor may submit the request electronically. Information about electronic options can be found at express-scripts.com/PA.
- To request an *initial administrative coverage review*, you may submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

  Complete the form and fax it to 877-328-9660 or mail to:

  Express Scripts
  Attn: Benefit Coverage Review Department
  P.O. Box 66587
  St Louis, MO 63166-6587

How do I request an urgent coverage review?

If the situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request.

In general, an urgent situation is one in which in the opinion of the patient's doctor, the patient's health may be in serious jeopardy or you may be experiencing severe pain that cannot be adequately managed without the medication while you wait for a decision on the review. If you or your doctor believes the health situation is urgent, the doctor must request the expedited review by phone at 800-753-2851.

Urgent clinical appeal requests:

Phone 800-753-2851
Fax 877-852-4070

Urgent administrative appeal requests:

Phone 800-946-3979
Fax 877-328-9660

Level 1 Appeal or Urgent Appeal

How do I request a level 1 appeal or urgent appeal after an initial coverage review is denied?

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

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

Level 2 Appeal

How do I request a level 2 appeal after a level 1 appeal is denied?

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

- Name of patient
- Member ID
- Phone number

- The drug name for which benefit coverage has been denied
- Brief description of why you disagree with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including doctor statements/letters, bills, or any other documents

Clinical appeal requests and administrative appeal requests can be mailed or faxed to the following addresses and fax numbers:

Clinical appeal requests:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
877-852-4070

Administrative appeal requests:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6588
877-328-9660

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Dental Plans

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Dental Benefit Pre-65

The Dental Plans pay benefits for you and your Eligible Dependents for a wide range of dental services and supplies.

The Dental Plans

- Encourages preventive care
- Promotes regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings, and x-rays
- Offers protection for more extensive treatment
- Provides oral surgery and restorative and prosthodontic services
- Offers coverage for orthodontia treatment for your covered children under age 21 in specified plans

Continuing your Delta Dental Plan

You may continue the Delta Dental plan coverage in effect immediately prior to your retirement. This coverage may continue for your Eligible Dependents also covered by the plan immediately prior to your retirement.

Choosing a Dentist – Participating vs. Non-Participating Dentist

Participating dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists who 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 or she is a participating dentist or verify with Delta Dental that your dentist is a participating dentist before receiving any dental services.

Seeing a dentist that participates in Delta’s Preferred Provider Organization (PPO) network or Delta Dental’s Premier network gets you the best discounted rates with no balance billing or paperwork to file. 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.

ⓘ To find a Delta Dental participating PPO or Premium Dentist

- Visit www.deltadentaltn.com and click on “Find a Dentist” or
- Call 1-800-223-3104

To receive dental benefits, select and schedule an appointment with the dental provider of your choice. If the provider participates in the network, you will not be billed for any covered charges that are greater than the contracted fee schedule.

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.

Types of Dental Services

Preventive and Diagnostic Services

- Prophylaxis (cleaning), topical application of fluoride (up to age 19, twice a year), and space maintainers
- Periodontal maintenance cleanings following periodontal therapy
- Oral examination and x-rays to aid the dentist in planning required dental treatment

Preventive and Diagnostic Limitations and Exclusions

- Two oral exams and cleanings, to include periodontal maintenance procedures, per calendar year
- Full-mouth x-rays, which include bitewing x-rays, are payable once in any three-year period
- Two sets of bitewing x-rays twice per calendar year
- Two topical applications of fluoride for members up to 19 years of age per calendar year
- Adult prophylaxis for members under 14 years of age is not allowed
- Space maintainers once per area per lifetime for dependents up to age 15
- Sealants once per tooth per lifetime for occlusal surface of the first and second permanent molars up to age 16. The surface must be free from decay and restorations

Basic Services

- Oral Surgery – extractions and other surgical procedures (including preoperative and postoperative care)
- General Anesthesia and Intravenous Sedation – only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions
- Endodontia – treatment of the dental pulp (root canal procedures)
- Periodontia – treatment of the gums and bones that surround the tooth
- Denture Repairs – services to repair complete or partial dentures
- Basic Restorations – amalgams (silver fillings), composites (white fillings), and prefabricated stainless steel crown restorations for the treatment of decay
- Sealants – resin filling used to seal grooves and pits on chewing surface of permanent molar teeth
- Occlusal guards

Basic Services Limitations and Exclusions

- Restorative benefits are allowed once per surface in a 12-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 of amalgam or composite restorations within 12 months by the same dentist or dental office is not a benefit
- The replacement of a stainless steel crown by the same dentist or dental office within a 24-month period of the initial placement is not a benefit
- Gold foil restorations, porcelain composite, and metal inlays are an optional service
- 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 to members up to age 16. Only one benefit will be allowed for each tooth within a lifetime

Major Services

- Cast Restorations – crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations
- Prosthodontics – procedures for construction of fixed bridges and partial or complete dentures and repair of fixed bridges
- Complete or Partial Denture Reline – chairside 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
- Denture Repairs – services to repair complete or partial dentures

Major Services Limitations and Exclusions

- 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 covered
- Procedures for purely cosmetic reasons are not covered
- Porcelain, gold, or veneer crowns for children under 12 years of age are not covered
- Replacement of any fixed bridges, or partial or complete dentures, that the member received in the previous five years is not covered
- 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 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 covered
- Temporary partial dentures are covered only when upper anterior teeth are missing

Orthodontia Services

Note: Orthodontia services must be specifically elected, at a higher premium.

- Delta Dental will pay benefits for procedures using appliances to treat poor alignment of teeth and/or jaws. Poor alignment must significantly interfere with function to be a benefit

Orthodontia – Limitations and Exclusions

- The orthodontia benefit's maximum age and maximum benefit is noted in the Summary of Benefits
- Delta Dental shall make regular payments for orthodontia benefits
- If orthodontia treatment began prior to enrolling in this plan, Delta Dental will begin benefits with the first payment due to the orthodontist after becoming eligible under this plan
- Benefits end with the next payment due to the dentist after loss of eligibility or immediately if treatment stops
- Benefits are not paid to repair or replace any orthodontia appliance received
- Orthodontia benefits do not pay for extractions or other surgical procedures; however, these additional services may be covered under other benefits of this plan
- 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 orthodontia treatment. Payments will begin in the month following the appliance placement date and are subject to your Copayment percentage and lifetime maximum

Predetermination of Benefits

Predetermination of benefits is an estimate of the cost of certain dental procedures before they are done. 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 your coverage. The dentist and you or Eligible 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 you. 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.

Some facts to remember about your dental plans

- Dependents in military service are not eligible for dental coverage
- Plan limits may apply
- A predetermination of benefits is recommended for major services

General Provisions

- If you need a claim form for services provided by a non-participating dentist, you may contact Delta Dental. 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.
- If you or your covered Eligible Dependent receives 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 you or your covered Eligible Dependent's rights to recover from the other person. You and your 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 you or your 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, 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., step-parent) 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 available to you. If any payment for services was denied, the EOB will give the reason why. If you disagree with the denial, you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request must be received by Delta Dental within 180 days of your 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 you within 30 days after Delta Dental receives the request for review.
- If you do not agree with the first-level review decision, you 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 you receive the first-level review decision. Unless unusual circumstances arise, a decision will be sent to you within 30 days after Delta Dental receives the request for second-level review. If you do not agree with the second-level review decision, you 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 other 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 orthodontia 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 (e.g., equilibration, periodontal splinting, 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 myofascial 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 you or your Eligible Dependent terminates when you or your Eligible Dependent is 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.

ⓘ For more information about what happens to your dental benefits when certain changes or events occur, see the About Your Benefits section.

Delta Dental – Basic and Buy-Up Plans

Pre-65 Retirees

Summary of Benefits		
Delta Dental	**Basic Plan**	**Buy-Up Plan**
Annual Benefit Maximum	$1,500 per person	$2,000 per person
Lifetime Maximum	None	
Annual Deductible	$50 per person	
Preventive and Diagnostic Services*		
Oral Examinations twice every calendar year	Plan pays 100%	
Prophylaxis twice every calendar year (cleanings)	Plan pays 100%	
Full-Mouth x-rays once every three years	Plan pays 100%	
Bitewing x-rays twice every calendar year	Plan pays 100%	
Fluoride twice every calendar year (up to age 19)	Plan pays 100%	
Space Maintainers	Plan pays 100%	
Sealants	Plan pays 80% after deductible	
Basic Services*		
Emergency Palliative Treatment to temporarily relieve pain	Plan pays 80% after deductible	
Minor Restorative Services (fillings, excludes gold) Endodontic Services (root canals) Periodontia Services (to treat gum disease)	Plan pays 80% after deductible	
Oral Surgery (complex extractions and certain surgical procedures)	Plan pays 80% after deductible	
Adjustments and Repairs (to bridges and dentures)	Plan pays 80% after deductible	
Occlusal Guards once per lifetime	Plan pays 80% after deductible	
Major Services*		
Crowns	Plan pays 50% after deductible	
Bridges	Plan pays 50% after deductible	
Partial, full dentures and implants	Plan pays 50% after deductible	
Orthodontia Services*		
Orthodontia Services for Child(ren) (up to age 21)	Not covered	Plan pays 50%
Lifetime Orthodontia Maximum	N/A	$1,500 per person

**Plan limits apply to certain services.*

Dental Benefit Post-65

The Dental Plans pay benefits for you and your Eligible spouse for a wide range of dental services and supplies.

The Dental Plan

- Encourages preventive care
- Promotes regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings, and x-rays
- Offers protection for more extensive treatment
- Provides oral surgery and restorative and prosthodontic services

Eligibility and Enrollment

This plan provides coverage for post-65 retirees and their post-65 spouses only.

- A retiree must elect to participate in the Plan in order to cover his/her spouse.
- Dependent children are not eligible to participate.
- If you enroll and elect to cancel coverage, you will not be allowed to re-enroll in the plan at a later date. This plan will not be offered in future open enrollments.
- If you elect dental coverage, you will receive identification cards from Delta Dental.
- Retirees pay 100% cost for the plan.

For Post-65 retirees and spouses who elect to enroll in the Plan will have premiums deducted from your monthly pension benefit, if possible. For individuals who do not receive a pension benefit or may not have sufficient monies for this additional deduction, you will be invoiced on a monthly basis for your premiums.

Choosing a Dentist – Participating vs. Non-Participating Dentist

Participating dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists who 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 or she is a participating dentist or verify with Delta Dental that your dentist is a participating dentist before receiving any dental services.

Seeing a dentist that participates in Delta’s Preferred Provider Organization (PPO) network or Delta Dental’s Premier network gets you the best discounted rates with no balance billing or paperwork to file. 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.

ⓘ To find a Delta Dental participating PPO or Premium Dentist

- Visit www.deltadentaltn.com and click on “Find a Dentist” or
- Call 1-800-223-3104

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.

Diagnostic and Preventive Benefits, Limitations, and Exclusions:

- All oral examinations and cleanings (prophylaxis).
- Oral exams and cleanings, to include any combination of teeth cleanings (prophylaxes, periodontal maintenance procedures and scaling in the presence of inflammation), are limited to two times in any calendar year. Excludes full-mouth debridement which is covered once per lifetime.
- Members with high risk health conditions may receive a total of four cleanings, to include periodontal maintenance procedures, in any calendar year. Eligible members include:
    - Diabetics with periodontal disease
    - Individuals with renal failure/dialysis
    - Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients)
- Individuals at high risk for infective endocarditis (such as those with a history of infective endocarditis, certain congenital heart defects, artificial heart valves, heart valve defects, hypertropic cardiomyopathy, or mitral valve prolapse).
- Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- X-rays.
    - One set of bitewing x-rays are covered in a calendar year.
    - Full-mouth x-rays and/or panoramic x-rays are covered once within 3 years, unless special need is shown.
- Fluoride. Topical application of fluoride is not a benefit.
- Space maintainers. Space maintainers are not a benefit.

Sealant Benefits, Limitations, and Exclusions

- Sealants are not a benefit

Basic Services, Limitations, and Exclusions

- Simple extractions.
- General Anesthesia and Intravenous Sedation – only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions. General anesthesia and IV sedation are limited to one hour. Any additional minutes are disallowed unless clinical documentation supports additional minutes.
- Minor Restorations – amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.

- Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.
- The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not allowed.
- The replacement, by the same dentist or dental office, of a stainless steel crown within 24 month of the initial placement is not allowed.

- Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.
- Denture Repairs – services to repair complete or partial dentures.
- Oral Surgery – complex extractions and other surgical procedures (including preoperative and postoperative care). Some procedures are limited to once per lifetime. Excludes procedures that are considered medical procedures.
- Endodontia – treatment of the dental pulp (root canal procedures).
  - 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.
  - Postoperative procedures are considered part of the total fee.
- Periodontia – treatment of the gums and bones that surround the tooth
  - 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.
  - Scaling and root planing procedures are allowed once within 24 months.
  - Localized delivery of antimicrobial agents is not a benefit.

Major Restorative Benefits, Limitations, and Exclusions

- 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.
- 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, 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 covered.
- Procedures for purely cosmetic reasons are not covered.
- A prefabricated post and core in addition to crown is payable only on an endodontically treated tooth.

Prosthodontic Benefits, Limitations, and Exclusions

- Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
- 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 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.
- A posterior bridge where a partial denture is constructed in the same arch is not covered.
- Temporary partial dentures are covered only during the healing period for missing upper anterior teeth.

Implant Benefits, Limitations, and Exclusions

- The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits.
- Replacement of implants or imbutments received in the previous five years is not a benefit.
- The removal of an implant is allowed once per lifetime.
- Specialized techniques are not benefits (i.e., bone grafts, guided tissue regeneration, precision attachments, etc.)
- Implant maintenance procedures are allowed once in a 12 month period.

Predetermination of Benefits

Predetermination of benefits is an estimate of the cost of certain dental procedures before they are done. 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 your coverage. The dentist and you or eligible Spouse 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 you. 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.

Some facts to remember about your dental plans:

- Plan limits may apply
- A predetermination of benefits is recommended for major services

General Provisions

- If you need a claim form for services provided by a non-participating dentist, you may contact Delta Dental. 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.
- If you or your covered eligible Spouse receives 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 your or your covered eligible Spouse's rights to recover from the other person. You and your covered eligible Spouse would be required to help Delta Dental in making such a recovery.
- This dental plan does not replace any workers' compensation coverage.
- If you or your covered eligible Spouse 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.
- After a claim is processed, an Explanation of Benefits (EOB) will be available to you. If any payment for services was denied, the EOB will give the reason why. If you disagree with the denial, you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request must be received by Delta Dental within 180 days of your 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 you within 30 days after Delta Dental receives the request for review.
- If you do not agree with the first-level review decision, you may request a second-level review. The manner in which to seek a second-level review will be included with the letter informing you of our first-level review decision. The second-level review decision will be made no later than 30 days from the date we receive your request. If you do not agree with the second-level review decision, you may file civil action in court within one year of the final denial.

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 other 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 orthodontia benefits, if covered

- Treatment to restore tooth structure lost from wear or attrition
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth (e.g., equilibration, periodontal splinting, 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 myofascial pain dysfunction unless specifically listed as a benefit
- 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 you or your eligible Spouse terminates when you or your eligible Spouse is 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.

ⓘ For more information about what happens to your dental benefits when certain changes or events occur, see the About Your Benefits section.

Summary of Benefits – Delta Dental Plan PPO (Point of Service) Post-65 Retirees

Summary of Benefits			
Covered Services	**Delta Dental PPO Dentist**	**Delta Dental Premier Dentist**	**Non-participating Dentist**
	Plan Pays	**Plan Pays**	**Plan Pays***
Annual Benefit Maximum	$1,500 per person	$1,500 per person	$1,500 per person
Lifetime Maximum	None	None	None
Annual Deductible	$50 per person	$50 per person	$50 per person
The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, x-rays, periodontal maintenance, full-mouth debridement and orthodontic services.			
Diagnostic and Preventive			
Diagnostic and Preventive Services – exams and cleanings	100%	100%	*100%
Oral Examinations – twice every calendar year	100%	100%	*100%
Prophylaxis – twice every calendar year (cleanings)	100%	100%	*100%
Full-Mouth x-rays and/or panoramic x-rays – once every three years	100%	100%	*100%
Bitewing x-rays – one set every calendar year and full-mouth x-rays (which include bitewing x-rays) are payable once in any three-year period	100%	100%	*100%
Brush Biopsy – to detect oral cancer	100%	100%	*100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	*100%
Basic Services			
Emergency Palliative Treatment to temporarily relieve pain	80% after deductible	80% after deductible	*80% after deductible
Minor Restorative Services (fillings, excludes gold)	80% after deductible	80% after deductible	*80% after deductible
Simple Extractions – non-surgical removal of teeth	80% after deductible	80% after deductible	*80% after deductible
Other Basic Services – misc. services	80% after deductible	80% after deductible	*80% after deductible
Adjustments and Repairs-to bridges and dentures	80% after deductible	80% after deductible	*80% after deductible
Major Services			
Crown Repair – to individual crowns	50% after deductible	50% after deductible	*50% after deductible
Endodontic Services (root canals)	50% after deductible	50% after deductible	*50% after deductible
Periodontic Services (to treat gum disease)	50% after deductible	50% after deductible	*50% after deductible
Other Oral Surgery – dental surgery	50% after deductible	50% after deductible	*50% after deductible
Major Restorative Services	50% after deductible	50% after deductible	*50% after deductible
Relines and Rebase – to dentures	50% after deductible	50% after deductible	*50% after deductible
Prosthodontic Services – bridges, implants, and dentures	50% after deductible	50% after deductible	*50% after deductible

Summary of Benefits			
Implant Repair – implant maintenance, repair and removal – once per tooth in any five-year period	50% after deductible	50% after deductible	*50% after deductible

* When you receive services from a Non-participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-participating Dentist Fee that will be paid for those services. The Non-participating Dentist Fee may be less than what the dentist charges and you are responsible for that difference

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Vision Plans

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Vision Benefit Pre-65

Vision Service Plan (VSP) 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

Using your VSP benefit is easy.

- **Create an account at www.vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** A list of VSP in-network providers is available at **www.vsp.com** or call **800.877.7195**.
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

Continuing your VSP Plan

You may continue the VSP plan coverage in effect immediately prior to your retirement. This coverage may continue for your Eligible Dependents also covered by the plan immediately prior to your retirement.

When you need vision care, you can go to a VSP network provider or an out-of-network provider.

- Network providers will file your claim with VSP.
- For out-of-network provider claims, mail your claim to VSP at the address below:

  Vision Service Plan
  Attention: Claims Services
  P. O. Box 385018
  Birmingham, AL 35238-5018

Exclusion for Surgery or Disease

The Vision Plan does not cover eye surgery or diseases of the eye. Generally, these conditions may be covered under the medical plan. If you have questions about available vision care benefits not listed in your applicable Vision Plan Summary, please contact VSP.

VSP Vision Features

- No claim forms (in-network)
- No ID cards (your provider will use your social security number to verify benefits)
- Access to large national network

ⓘ For more information about what happens to your vision benefits when certain changes or events occur, see the About Your Benefits section.

Summary of Benefits – Vision

Basic Vision Plan Pre-65 Retirees

Services Covered	In-Network	Out-of-Network
Exam – once every calendar year	Covered in full	**Exam – up to $45**
Lenses – once every calendar year • **Single Vision** • **Bifocal** • **Trifocal** • **Lenticular**	Covered in full	**Single Vision – up to $45** **Bifocals – up to $65** **Trifocals – up to $85** **Lenticular – up to $105**
Frames – once every other calendar year	Covered up to $150 maximum, 20% discount for amount exceeding $150 or $80 allowance at Costco Optical	**Frames – up to $50**
Lens Enhancements – once every calendar year	$55 Standard Progressive $95–$105 Premium Progressive $150–$175 Custom Progressive Average savings of 20–25% on other lens enhancements	**Progressive lenses – up to $65**
Contact Lens – once every calendar year (instead of glasses)	Medically necessary lenses: covered in full Elective lenses: $130 maximum allowance for contacts and contact lens exam (fitting and evaluation) 15% off contact lens exams	**Elective Contacts – up to $105**
Additional Discounts	20% discount on additional prescription glasses and sunglasses at any VSP provider within 12 months of your last exam Laser Vision Correction – average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	**Not Available**

Summary of Benefits – Vision

Alternative Vision Plan Pre-65 Retirees

Services Covered	In-Network	Out-of-Network
Exam – once every calendar year	Covered in full	**Exam – up to $45**
Lenses – once every calendar year • **Single Vision** • **Bifocal** • **Trifocal** • **Lenticular**	Covered in full	**Single Vision – up to $45** **Bifocals – up to $65** **Trifocals – up to $85** **Lenticular – up to $125**
Frames – once every other calendar year	$150 allowance 20% discount for amount exceeding $150 or $80 allowance at Costco Optical	**Frames – up to $47**
Lens Enhancements – once every calendar year	$55 Standard Progressive $95–$105 Premium Progressive $150–$175 Custom Progressive Photochromic and tinted lenses covered in full	**Progressive lenses – up to $65** **Photochromic and tinted lenses – up to $5**
Contact Lens – once every calendar year (instead of glasses)	Medically necessary lenses: covered in full Elective lenses: $175 maximum allowance for contacts and contact lens exam (fitting and evaluation) 15% off contact lens exams	**Elective Contacts – up to $105**
Additional Discounts	20% discount on additional prescription glasses and sunglasses at any VSP provider within 12 months of your last exam Laser Vision Correction – average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	**Not Available**

Vision Benefit Post-65

Vision Service Plan (VSP) 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

Using your VSP benefit is easy.

- **Create an account at www.vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** A list of VSP in-network providers is available at **www.vsp.com** or call **800.877.7195**.
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

When you need vision care, you can go to a VSP network provider or an out-of-network provider.

- Network providers will file your claim with VSP.
- For out-of-network provider claims, mail your claim to VSP at the address below:

  Vision Service Plan
  Attention: Claims Services
  P. O. Box 385018
  Birmingham, AL 35238-5018

Exclusion for Surgery or Disease

The Vision Plan does not cover eye surgery or diseases of the eye. Generally, these conditions may be covered under the medical plan. If you have questions about available vision care benefits not listed in your applicable Vision Plan Summary, please contact VSP.

VSP Vision Features:

- No claim forms (in-network)
- No ID cards (your provider will use your social security number to verify benefits)
- Access to large national network

ⓘ For more information about what happens to your vision benefits when certain changes or events occur, see the About Your Benefits section.

Summary of Benefits – Vision

VSP Choice Post-65 Retiree Vision Plan

Services Covered	In-Network	Out-of-Network
Exam – once every calendar year	Covered in full	**Exam – up to $45**
Lenses – once every calendar year • **Single Vision** • **Bifocal** • **Trifocal**	Covered in full	**Single Vision – up to $45** **Bifocals – up to $65** **Trifocals – up to $85**
Frames – once every other calendar year	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • Or $80 Costco® frame allowance	**Frames – up to $50**
Lens Enhancements – once every calendar year	• $55 Standard Progressive • $95–$105 Premium Progressive • $150–$175 Custom Progressive	**Progressive lenses – up to $65**
Contact Lens – once every calendar year **(instead of glasses)**	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	**Elective Contacts – up to $105**
Diabetic Eye Care Plus Program – as needed	$20 Copay Services related to diabetic eye disease, glaucoma and age-related macular degeneration. Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	**Not Available**
Additional Discounts	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands.1 Go to vsp.com/special offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	**Not Available**

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Retiree Health Reimbursement Arrangement

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Retiree Health Reimbursement Arrangement Post-65

The Company has established the Retiree Health Reimbursement Arrangement (referred to in this SPD as the "Retiree HRA Plan," "RHRA," or in this section as the "Plan") to help Eligible Retirees and their Eligible Spouses pay the cost of qualifying health care expenses. Under the Retiree HRA Plan, participants will be credited with an annual allowance which can be used to pay for qualifying health care expenses on a tax-favored basis.

The following pages describe the rules and operation of the RHRA Plan as clearly as possible with minimal use of the technical terms appearing in the legal documents. However, the official documents remain the final authority, and in the event of a conflict with this SPD, the official documents shall govern. You may request a copy of the plan documents from the Plan Administrator.

The Company reserves the right to amend, modify, reduce, discontinue or terminate the RHRA Plan at any time, including changing the amount that it contributes to each participant's health care account. Nothing in this SPD or the RHRA Plan gives, or is intended to give, any person the right to lifetime benefits, nor is it intended to provide vested benefits.

The Company is the plan sponsor of the RHRA Plan. Certain administrative duties have been delegated to service providers. Specifically, the Company has contracted with Aon to perform certain administrative services with respect to claims through Aon Your Spending Account (YSA).

If you have questions or need more information, you should contact Aon YSA. The contact information is located at the end of this section.

Eligibility and Participation

Eligible Retirees

You are eligible to participate in the RHRA Plan if you are an **"**Eligible Retiree." To be an Eligible Retiree, you must meet all of the following requirements:

1. You terminate your employment with the Company on account of your retirement, and you are eligible to elect to receive benefits under the Company's pension plan.
2. You are age 65.
3. You are enrolled in an employer-sponsored group medical plan immediately prior to your retirement date and the date you enroll in this Plan.
4. You are eligible for and are enrolled in Medicare Part A and Part B.
5. You purchase an individual insurance policy for a Medigap, Medicare Advantage, or Medicare Part D plan through the Aon Retiree Health Exchange.

Rehired Retirees

If you are rehired by the Company (or a related employer), you and/or your spouse's eligibility under the RHRA Plan will terminate immediately prior to your rehire date. Contact your insurance provider to terminate any retiree medical or prescription drug coverage and stop premium billings.

If you satisfy the eligibility requirements (including the requirement that you work the required number of hours), you will be given an opportunity to elect to begin participating in the active medical plan as of your rehire date on the same terms that apply to other similarly situated active employees. You will be required to pay any applicable premium for the coverage you elect.

When you later terminate your employment with the Company (or a related employer), you may be eligible to continue the Health Account you had before you were rehired.

Ineligible Employees

You are not eligible for coverage under the RHRA Plan if prior to your retirement:

- You were classified by your employer as a temporary employee, leased employee, or an independent contractor
- You were a non-resident alien with no U.S. source income
- Your terms and conditions of employment were determined by a collective bargaining agreement with a union or an affiliate thereof representing such persons and with respect to whom inclusion in this Plan has not been specifically provided for in the collective bargaining agreement

It is expressly intended that individuals not treated as an Eligible Retiree by the Company are to be excluded from participation in the RHRA Plan under all circumstances. Therefore, an independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party, as an eligible retiree will not be considered an Eligible Retiree for periods before the Company implements the reclassification, even if the decision applies retroactively.

The Plan Administrator, in its sole discretion and in accordance with the RHRA Plan documents, will determine whether you are eligible to participate in the RHRA Plan as an Eligible Retiree.

Eligibility of your Spouse

If you are an Eligible Retiree, your Spouse is eligible to participate in this Plan if all the following requirements are met:

1. Eligible Spouse as of the date you retire;
2. The Spouse is enrolled in an employer-sponsored group medical plan immediately prior to your retirement date.
3. Age 65.
4. Eligible for and enrolled in Medicare Part A and Part B.
5. Purchases an individual insurance policy for a Medigap, Medicare Advantage or Medicare Part D plan through the Aon Retiree Health Exchange.

An individual who satisfies the above eligibility criteria is referred to as an “Eligible Spouse.” Your Spouse will not be eligible to participate in this Plan unless you are enrolled in this Plan or the Company’s retiree medical plan for eligible pre-65 retirees.

For purposes of this Plan, your “Spouse” is your legal spouse.

Your spouse is not eligible for coverage under this Plan if he or she is covered under the Company’s medical plan as an active employee or is under age 65.

Enrollment

To enroll in this Plan, you must purchase medical coverage through the Aon Retiree Health Exchange within the designated time period. Eligible individuals will receive information regarding enrollment in coverage offered through the Aon Retiree Health Exchange generally 90 days prior to the date that they turn age 65. The enrollment forms must be completed and returned within the time period designated by Aon.

If an individual does not enroll when first eligible, he or she will not be given another opportunity to enroll in this Plan unless the individual declined to enroll because he or she was enrolled in another employer-sponsored group medical plan and the coverage under the other plan terminates. The Plan Administrator may require the individual to provide proof of such other coverage.

In addition, if an individual enrolls in the Plan and later terminates participation, he or she will not be given another opportunity to enroll in the Plan.

HRA Plan Benefits

Your Plan Benefits

After your enrollment in a medical and/or prescription plan offered through the Aon Retiree Health Exchange, a RHRA Account (the "Health Account") will be established in your name. ***Each month, the Company will credit to your Health Account an amount equal to 1/12 of the Annual Employer Contribution which will be communicated to you before the new plan year begins***. If you enroll in the RHRA Plan during the middle of the year, the Annual Employer Contribution will be prorated to reflect your partial year of participation.

If your Eligible Spouse is also enrolled in a medical and/or prescription plan offered through the Aon Retiree Health Exchange, the Health Account will be established in your name, but it will be shared jointly by you and your Eligible Spouse. This means that the Annual Employer Contribution will be credited to a single Health Account.

If your Eligible Spouse becomes eligible to participate in this Plan before you do, a Health Account will be established in your name, but the Annual Employer Contribution will be limited to the amount contributed on behalf of the Eligible Spouse. Once you enroll, you will share the Health Account with your Eligible Spouse.

If you and your Spouse were both employed by CNS and you are both individually eligible for coverage, a separate Health Account will be established for each of you.

Once the Health Account is established, you may begin to request reimbursement of Qualifying Health Care Expenses (described below). The RHRA is not designed to fund all the health care expenses incurred for any particular year, but is intended to help pay for some retiree health expenses on a non-taxable basis. At the end of each year, any unused balance in your Health Account will be carried over to the next year to be used for Qualifying Health Care Expenses provided you remain a participant in the RHRA Plan.

Eligible Expenses

You may use the amount credited to your RHRA to request reimbursement for you and your Eligible Spouse's Qualifying Health Care Expenses. The following types of expenses are considered "Qualifying Health Care Expenses."

- Premiums incurred for coverage purchased through the Aon Retiree Health Exchange (e.g., Medicare Advantage, Medigap or Medicare Part D).
- Amounts paid as copays, coinsurance and deductibles under the coverage described in the first bullet provided they qualify as medical care expenses under Code Section 213(d).

Remember: If you are not yet eligible to participate in the Aon Retiree Health Exchange but an RHRA is established on behalf of your Eligible Spouse, you may not submit your own medical expenses for reimbursement.

For a complete listing of eligible expenses you should contact Aon.

Expenses Not Eligible

Certain health care expenses may not be reimbursed from your RHRA. Some examples of expenses that are not eligible for reimbursement include:

- Expenses incurred before you or your Eligible Spouse are covered under the RHRA Plan
- Expenses incurred after your or your Eligible Spouse's coverage under the RHRA Plan terminates
- Premiums for long-term care benefits, disability benefits and life insurance benefits
- Premiums for medical coverage provided by an employer-sponsored health plan or coverage purchased outside of the Aon Retiree Health Exchange
- Expenses that are paid on a pre-tax basis through a cafeteria plan
- Medicare Part B premiums and Medicare Part B and D income-related monthly adjustment amount charges deducted from your Social Security check or billed directly from Medicare
- Medicare late enrollment penalty premium surcharge

Reimbursement Procedures

To obtain reimbursement of a Qualifying Health Care Expense, a claim form must be submitted to YSA, also referred to as the "Claims Administrator." The contact information for YSA is provided in the Administrative Information section of this SPD.

Supporting documentation must be provided with the claim in the form required by the Claims Administrator, including an itemized bill or receipt from the provider or the insurer that indicates that the medical expense has been incurred and the amount of the expense. You must provide a written statement that the medical expense has not been reimbursed and reimbursement will not be sought from any other health plan. If the expenses are eligible, you will receive a check (or, if available, by direct deposit) and the amount paid will be deducted from your RHRA. If the request is rejected as not eligible, you will be notified.

Additional information regarding the claim forms and procedures on how to complete and where to send the forms may be obtained from the Claims Administrator. You are responsible for the validity of the information on your claim forms. Similarly, you are responsible for making certain that all expenses submitted for reimbursement are eligible expenses. Before submitting your claim form and the appropriate substantiation, you should retain a copy of the submitted materials.

Payment of Claims

Eligible claims submitted for reimbursement will be paid up to the available balance of your RHRA. Once you have exhausted the balance of your RHRA, no further reimbursements will be made until additional funds are credited to your RHRA.

Claim Procedures

If the Claims Administrator denies all or part of your claim for Plan benefits, you will be notified. This notice will include: (i) the specific reasons for the denial; (ii) the specific reference to the pertinent Retiree HRA Plan provisions on which the denial is based; (iii) a description of any material or information necessary for you to perfect the claim; and (iv) the appropriate information as to the steps to be taken if you wish to appeal the denied claim.

If additional information is needed to process the claim, the Claims Administrator will notify you or your beneficiary. If, for reasons beyond the control of the Claims Administrator, an extension of time is required to process your claim, you will receive written notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the 30-day period. In no event shall the extension exceed a period of an additional 15 days from the end of the initial 30-day period.

If the Claims Administrator denies your claim (e.g., you request for reimbursement) due to inadequate documentation, you have 45 days to provide the requested information, and during the time that a request for information from you is outstanding, your claim will be pended.

Appealing a Denied Claim

If you disagree with the Claims Administrator’s decision, you will have 180 days to request a review by filing a written appeal with the Plan Administrator. As a part of such appeal, you or your representative may: (i) review pertinent documents; and (ii) submit issues and comments in writing relating to the denied claim. The Plan Administrator will reconsider your claim, taking into account all comments, documents and other information that you have submitted in support of your claim, and will notify you of its determination within 60 days after receipt of the request for review. If the Plan Administrator denies all or part of your appeal, you will be notified. This notice will include: (i) the specific reasons for the denial; (ii) the specific reference to the pertinent Retiree HRA Plan provisions on which the denial is based; (iii) a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and (iv) a statement of your right to bring an action under Section 502(a) of ERISA.

You also have the right to receive a copy of any internal rule, guideline, protocol or other similar criterion relied upon in the claim determination, if any, or a statement of your right to receive a copy of such internal rule, guideline, protocol or other similar criterion, upon request and free of charge.

Non-Benefit Claims

If you want to file a formal claim that relates to something other than benefits (e.g., an eligibility claim), you must file your claim in writing with the Plan Administrator. The Plan Administrator (or its delegate) will respond to all such claims within the time frames and in the manner that claims for benefits are decided (described above). All appeals of such claims must also be filed with the Plan Administrator within 180 days of the denial. The Plan Administrator will respond to all such appeals within the time frames and in the manner described above.

Exhaustion of Administrative Remedies and Limitations on Actions

You must use and fully exhaust all of your actual or potential rights under the Plan's administrative claims and appeals procedures by filing an initial claim and then filing a timely appeal of any denial before filing suit in court. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Failure to follow the Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.

Discretionary Authority

The Plan Administrator and the Claims Administrator (with respect to any matters delegated to the Claims Administrator) have the exclusive discretionary authority to construe and to interpret the Retiree HRA Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the RHRA Plan will be paid only if the Plan Administrator or the Claims Administrator, as applicable, decides in its discretion that a participant is entitled to them.

Termination of Plan Coverage

An individual will terminate participation in this Plan on the date that any of the following occur:

- He or she dies;
- He or she fails to comply with any administrative procedures set forth in the RHRA Plan or established by the Plan Administrator or the Claims Administrator;
- He or she fails to satisfy the applicable eligibility requirements;
- He or she fails to pay the applicable premiums for Medigap, Medicare Advantage, or Medicare Part D plan purchased through the Aon Retiree Health Exchange and the policy terminates;
- He or she is hired or rehired by the Company;
- He or she elects to terminate participation;
- He or she is no longer enrolled in Medicare Part A and Part B;
- The RHRA Plan is terminated; or
- His or her coverage under the individual policy purchased through the Aon Retiree Health Exchange is terminated (whether voluntarily or involuntarily).

Except as provided below, your Eligible Spouse's coverage under the RHRA Plan will terminate on the same date that your coverage terminates. In addition, if you are participating in the Company's retiree medical plan for pre-65 retirees and that coverage terminates (whether voluntarily or involuntarily), other than on account of your death, and you are not eligible for this Plan, your Eligible Spouse's participation in this Plan will terminate.

In the event that you die, your Eligible Spouse may continue to participate in the RHRA Plan. However, the Annual Employer Contribution will be adjusted going forward to reflect that you are no longer participating.

If you or your Eligible Spouse terminates participation in the RHRA Plan, you (or your representative) may continue to submit claims for reimbursement of Qualifying Health Care Expenses in accordance with the RHRA Plan's procedures until the balance in your account is exhausted, but you will not receive any additional Annual Employer Contributions. The right to spend down your RHRA will not apply if the RHRA Plan is terminated.

Continuation of HRA Coverage

Your Eligible Spouse may extend coverage under the RHRA Plan when coverage would otherwise end because of certain life events known as "qualifying events." The option to extend coverage is called "COBRA coverage." COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the RHRA Plan because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage will be required to pay for COBRA continuation coverage.

Under COBRA, your Spouse will become a qualified beneficiary if he or she loses coverage under the RHRA Plan because of a divorce. In that situation, your former Spouse may be entitled to continue coverage in the RHRA Plan if he or she pays the entire cost of coverage, plus 2% to cover administrative expenses. The required monthly premiums may change, but affected individuals will be notified of any such change.

The Plan Administrator must be notified within 60 days of the date you and your Spouse divorce (or the date coverage is lost as a result of the qualifying event, if later). The notice must be given to the Service Center at 1-865-574-1500 (local) or 1-877-861-2255 (toll-free). You must provide your former Spouse's name, address and phone number and the date of the divorce. The notice must be provided no later than the applicable deadline for giving the notice. If this notice is not timely and properly provided, your former Spouse will not be permitted to elect COBRA continuation coverage.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered, when appropriate. Your former Spouse will have 60 days from the date of the COBRA election notice (or the date coverage is lost, if later) to elect to continue to participate in the RHRA Plan through COBRA. To elect COBRA continuation coverage, your former Spouse must complete the election form and return it as directed in the election materials.

If COBRA is elected, a Health Account will be established for your former Spouse with a balance equal to the balance in your Health Account as of the date of the divorce. If, after the divorce, you or your former Spouse requests reimbursement for Qualifying Health Care Expenses incurred before the divorce, the amount of the reimbursement will be deducted from both your Health Account and the Health Account of your former Spouse.

COBRA continuation coverage is a temporary continuation of coverage and may only be continued for up to a total of 36 months. COBRA coverage will terminate before the end of the 36-month period if any of the following occur:

- Your former Spouse becomes covered under another group health plan after electing 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
- All of the Company's group health plans are terminated

- An event occurs that would otherwise cause participation in the RHRA Plan to terminate (e.g., your former Spouse terminates coverage purchased through the Aon Retiree Exchange)

Your former Spouse will be notified of the cost of continuing participation in this Plan if he or she experiences a qualifying event. The first premium must be paid within 45 days of the election date; after that, premiums will be due and payable on the first day of the month. The first premium should cover the premium due from the date coverage is lost through the date COBRA is elected, plus any monthly premium that becomes due during the 45-day payment period. There will be a 30-day grace period to pay each subsequent monthly premium. This premium does not cover the cost of individual coverage purchased through the Aon Retiree Exchange. You must pay that separately.

If the initial premium payment is not made by the end of the 45-day payment period, your former Spouse will lose all COBRA rights and coverage will not take effect. If a subsequent monthly premium payment is not made by the end of the 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the last month for which the premium payment was timely made and all COBRA rights will be lost.

It is important to keep the Plan Administrator informed of any changes in address and/or marital status. It is also important to keep a copy for your records of any notices you send to the Plan Administrator.

Administrative Information

Name of Plan

The official name of the Plan is the Retiree Health Reimbursement Arrangement.

ⓘ Identification Numbers

The Employer Identification Number assigned by the Internal Revenue Service to the Retiree HRA Plan Sponsor is 45-4482782. The plan number for the Retiree HRA Plan is 521.

Information on the Plan Administrator

The Plan Administrator of the RHRA Plan is the Benefits and Investment Committee The Plan Administrator is the "named fiduciary" for the RHRA Plan under ERISA and has full discretion to exercise its duties hereunder. The Plan Administrator may adopt rules and procedures as to how the RHRA Plan operates and has authority to exercise discretion in performing its duties. The business address and business telephone number for the Plan Administrator are the same as the Plan Sponsor's. The Plan Administrator is the designated agent for the service of legal process.

ⓘ Information on the Claims Administrator

The Claims Administrator is:

Aon Your Spending Account
Phone: 844 695 8293

The Plan Administrator has contracted with the Claims Administrator to assist in the handling of benefit determinations under the RHRA Plan and to provide assistance in the administration of the RHRA Plan. The Claims Administrator will have the authority to make initial benefit determinations under the RHRA Plan and direct payments with respect to the RHRA Plan, and will have such other responsibility and authority as delegated by the Plan Administrator.

Plan Type

The RHRA Plan described in this SPD is a “welfare benefit plan” for purposes of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

Plan Year

The financial and other records for this Plan are kept on a Plan Year basis. The Plan Year begins on January 1 of each year and ends on the following December 31.

Plan Funding

The cost of providing Plan benefits under this Plan (including expenses associated with Plan administration) are paid out of the general assets of the Company. The Health Account established for participants is merely a bookkeeping account on the Company’s records; it is not funded and does not bear interest or accrue earnings of any kind.

Plan Amendment and Termination

The RHRA Plan has been established with a bona fide intention and expectation that it shall be continued indefinitely. However, the Company shall not have any obligation whatsoever to maintain or continue the RHRA Plan or any level of RHRA Plan benefits for any length of time. The Company reserves the right to modify, reduce, suspend, amend or terminate (in whole or in part) this Plan at any time. The Company does not promise any specific level of RHRA Plan benefits or RHRA Plan coverage at or during retirement.

Benefits for claims occurring after the effective date of a RHRA Plan amendment, modification or termination are payable in accordance with the revised RHRA Plan documents. All statements in this SPD and all representations by the Company or its personnel are subject to the above right of amendment and termination. The right to modify, reduce, suspend, amend or terminate (in whole or in part) this Plan at any time applies, without limitation, even after an individual’s circumstances have changed by retirement or otherwise.

Statement of ERISA Rights

The following statement is required by federal law and regulation. As a participant in the RHRA Plan described in this SPD you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

Examine without charge at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the RHRA Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the RHRA Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain printed copies upon written request to the Plan Administrator of documents governing or supporting the operation of the RHRA Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

In certain circumstances, an Eligible Spouse may continue health care coverage for himself or herself if there is a loss of coverage under the Retiree HRA Plan as a result of a qualifying event. He or she may have to pay for such coverage. Review this SPD and the documents governing the Retiree HRA Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your RHRA Plan, called “fiduciaries” of the RHRA Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a RHRA Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a RHRA 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 the RHRA Plan documents or the latest annual report from the Retiree HRA 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. However, in no event will you be allowed to file suit in state or Federal court until you have exhausted the administrative remedies available under the Retiree HRA Plan, including following the appropriate claims procedure as described above.

In addition, if you disagree with the RHRA Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that 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 the RHRA Plan, you should contact the CNS Benefit Plans Office or Aon. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your former employer, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Catastrophic Prescription Drug Benefit

The Catastrophic Prescription Drug Benefit plan is available to eligible retirees or spouses who reach the catastrophic coverage stage under their Medicare Part D plan. To be eligible for this plan, you must meet all four of the following requirements:

1. Be enrolled in a Medigap/Medicare Advantage plan through the Aon Retiree Health Exchange
2. Be enrolled in a Medicare Part D plan through the Aon Retiree Health Exchange, unless a Medicare Advantage plan with Part D coverage is chosen
3. Be enrolled and receiving monthly contributions under the RHRA plan, and
4. Be eligible for the catastrophic coverage stage under the Medicare Part D plan

The catastrophic coverage stage is the phase you reach once you are out of the Medicare prescription drug coverage gap under your Medicare Part D plan. Once you reach the catastrophic coverage stage, you will only pay a small coinsurance amount or copay for covered drugs for the remainder of the plan year. If eligible, you can request reimbursement for these catastrophic out-of-pocket prescription expenses once an account has been approved and activated for you through Aon. These contributions are Company funded and are in addition to the monthly RHRA contributions you receive.

The Catastrophic Prescription Drug Plan can only be used to reimburse prescription expenses for the eligible retiree or spouse that reaches the catastrophic coverage stage of their Medicare Part D prescription plan. It cannot be used to reimburse expenses for other dependents.

Account Activation for the Catastrophic Prescription Drug Benefit

Prior to submitting your catastrophic claims for reimbursements, you must request an account be activated. Following are the steps to activating an account:

1. You must complete and submit an Account Activation Form request. Information is available by calling the Aon Retiree Health Exchange at 1-844-695-8293.
2. Along with your Account Activation form, you must also provide an Explanation of Benefits (EOB) or other statement showing you've reached the catastrophic coverage stage under your Medicare Part D plan. The EOB statement must include: (a) Name of Insured; (b) Date of Statement; and (c) Annual out-of-pocket amount.
3. After confirming you've reached the catastrophic coverage stage of your Medicare Part D plan, Aon will create an account for you. For eligible spouses, the account will be established under the retiree name.

Because Medicare limits are reset every year, a new account activation form must be submitted each year when you have reached the catastrophic phase in your plan.

Eligible Prescription Drug Claims

Prescription drug claims eligible for reimbursement are the out-of-pocket prescription costs you incur after reaching the catastrophic coverage stage under your Medicare Part D plan in a calendar year.

Eligibility Period for Incurred Claims

Eligibility Period for catastrophic claims incurred is from the date you meet the catastrophic coverage stage under your Medicare Part D Plan through the end of the calendar year.

Receiving a Reimbursement

After your Catastrophic Prescription Drug Benefit Plan account is activated:

- The retiree's regular Retiree HRA Plan account (single or joint) **must be depleted** before reimbursements will be issued for catastrophic prescription claims.
- Claims for eligible prescription drug expenses can be submitted online via the Aon website https://retiree.aon.com/cns.
- A paper claim form is available for download on the website or by calling the Aon Retiree Health Exchange at 1-844-695-8293.
- With each claim form, you'll need to provide an itemized receipt that shows all of the following:

    1. Service provider's name
    2. Date of service
    3. Description of service
    4. Who the service is for; and
    5. The out-of-pocket amount year are claiming for reimbursement.

As with other claims, EOBs from your insurance carrier are also acceptable forms of supporting documentation for out-of-pocket expenses.

- Claims incurred during the eligibility period must be submitted to Aon by March 31 of the following year to receive reimbursement
- There are no limits on the reimbursements for catastrophic prescription claims during a calendar year

Life Insurance

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Life Insurance

If you are an eligible retiree, you may continue your Basic Life coverage benefit if you had coverage for one year immediately preceding your retirement. Basic Life coverage pays benefits to your beneficiary in the event of your death from any cause while you are insured.

Basic Life – During Retirement – Before Age 65

If you retired before age 65, you can elect to:

- Continue your full Basic Life coverage in effect at retirement until age 65 by making your regular premium payments, or
- Elect reduced Basic Life coverage provided at no cost to you. See the reduction rules under Basic Life – During Retirement – At Age 65 or Later.

If electing to continue your full Basic Life coverage, when you reach age 65, your coverage will automatically be reduced. See Basic Life reduction rules below under Basic Life – During Retirement – At Age 65 or Later.

Basic Life – During Retirement – At Age 65 or Later

If retired at age 65 or later, you will receive a reduced Basic Life amount provided at no cost to you. Your reduced amount is determined on the number of years you participated in the Basic Life plan immediately prior to your retirement and when you retired.

Basic Life Reduction Rules **for retirees who retired prior to 4/1/2018**:

- If you retired prior to 4/1/2018 and participated in the Basic Life plan for at least 5 years immediately preceding your retirement, your reduced basic life amount will be the greater of (a) or (b) below:
  - (a) 1% of your Basic Life 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; or
  - (b) 20% of your Basic Life coverage just before retirement.
- If you had Basic Life coverage for at least one year but less than five years immediately preceding your retirement, your reduced insurance will be $625.

Basic Life Reduction Rules **for retirees who retired on or after 4/1/2018**:

- If you retired on or after 4/1/2018 and participated in the Basic Life plan for at least 5 years immediately preceding your retirement, your reduced basic life amount will be
  - (a) 20% of your basic life coverage just before retirement.
- If you had Basic Life coverage for at least one year but less than five years immediately preceding your retirement, your reduced basic life amount will be $625.
- If you had Basic Life insurance coverage for less than one year immediately preceding your retirement, then your reduced basic life amount will be $0.

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

Supplemental Life (Closed Plan)

This Supplemental Life benefit is only available to Pension Eligible retirees who were either a **salaried employee who retired prior to February 1, 2001 or an hourly employee who retired prior to August 1, 2001** and had Supplemental Life insurance coverage for one year immediately preceding retirement.

Supplemental Life – During Retirement – Before Age 65

If you retired before age 65, you can:

- Continue your full Supplemental Life coverage until age 65 by continuing to make your regular premium payments, or
- Elect reduced Supplemental Life coverage immediately at retirement and provided at no cost to you. See reduction rules under Supplemental Life – During Retirement – At Age 65 or Later.

If you elect to continue your full Supplemental Life coverage, your coverage will automatically reduce when you reach age 65. See the reduction rules under Supplemental Life – During Retirement – At Age 65 or Later.

Supplemental Life – During Retirement – At Age 65 or Later

If you retired at age 65 or later, your Supplemental Life coverage is reduced and provided at no cost to you. Your reduced amount is determined on the number of years you participated in the Supplemental Life plan immediately prior to your retirement.

Supplemental Life Reduction Rules:

- If you had five years or more participation, the benefit amount is the greater of (a) or (b) below:
  - (a) 1% of your Supplemental Life insurance amount just before retirement times your years of service (including any fraction of a year), plus $250; minimum of $1,250; or 12.5% of your supplemental life insurance just before retirement, up to a maximum of $5,000; or
  - (b) 10% of your Supplemental Life insurance amount just before retirement.
- If you had Supplemental Life insurance coverage for at least one year but less than five years immediately preceding your retirement, your reduced Supplemental Life amount is $312.
- If you had Supplemental Life insurance coverage for less than one year immediately preceding your retirement, then your reduced Supplemental Life amount is $0.

If you retired after age 65, the amount of your reduced life insurance will be calculated using the amount of your supplemental life insurance at age 65.

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

Life and Accidental Death and Dismemberment Benefits for the following classes of Eligible Retirees:

- **Former Grandfathered WSI Retirees who transitioned to Y-12 on 10/1/2013**
- **Former Non-Bargaining WSI Employees with hire dates prior to 6/4/2007 (closed group as of 10/29/2012) (excludes subcontractors)**
- **IGUA** Central Alarm Station Operators, Central Training Facility Instructors, and Beta 9 Operators **Employees hired prior to 1/1/2016**
- **IGUA Security Police Officer Employees hired prior to 8/15/2016**

If you were enrolled in Basic Life preceding your retirement, you could continue coverage in the Basic Life, Basic Accidental Death and Dismemberment (Basic AD&D), Retiree Supplemental Life and Supplemental Accidental Death and Dismemberment (Supplemental AD&D) plans.

Basic Life and Retiree Supplemental Life insurance pay benefits to your beneficiary in the event of your death from any cause while you are insured.

Basic AD&D and Retiree Supplemental AD&D insurance pay benefits only in the event of a death as a result of an accident or accidental dismemberment. If you should die as a direct result of and within 12 months of the date of an accident, the amount of your coverage will be paid to your Beneficiary in a lump sum. Your Beneficiary is the same as designated under your basic life benefit.

Basic Life and Basic AD&D – During Retirement – Before Age 65

If you retired before age 65, you can elect to:

- Continue your full Basic Life and Basic AD&D coverage at 2x annual pay in effect at retirement up to a maximum of $500,000 until age 65 by making your regular premium payments (basic AD&D coverage amount will be equal to your basic life coverage); **or**
- Elect reduced Basic Life and Basic AD&D coverage immediately at retirement and provided at no cost to you. Your reduced coverage will be 20% of the 2x annual amount in effect at retirement up to a maximum of $100,000 life (Basic AD&D amount will be equal to your Basic Life amount)

If you elect to continue your full Basic Life and Basic AD&D coverage, when you reach age 65, your Basic Life amount will automatically reduce to 20%, up to a maximum of $100,000 and your Basic AD&D amount will reduce and be equal to your Basic Life reduced amount.

Basic Life and Basic AD&D – During Retirement – At Age 65 or Later

If retired at age 65 or later, you will receive a reduced Basic Life and Basic AD&D amount provided at no cost to you.

The reduced amount of coverage is:

- 20% of your Basic Life coverage in effect at retirement up to a maximum of $100,000 (Basic AD&D amount will also reduce and be equal to your Basic Life reduced amount)

Retiree Supplemental Life and Supplemental AD&D

If enrolled in Basic Life coverage for at least one year preceding your retirement, you will be eligible to elect to continue Supplemental Life and Supplemental AD&D insurance benefit at retirement. Your Supplemental AD&D amount will equal your Supplemental Life amount.

Retiree Supplemental Life and Supplemental AD&D – During Retirement – Before Age 65

If you retired before age 65, you can elect either to:

- Continue your full Supplemental Life & Supplemental AD&D coverage at 1x annual pay up to a maximum of $500,000 until age 65 by making your regular premium payments; **or**
- Elect reduced Supplemental Life & Supplemental AD&D coverage provided to you at no cost. Your reduced coverage will be the greater of 10% of your 1x annual pay in effect at retirement up to a maximum of $50,000 **or** $5,000 of coverage.

If you elect to continue full Supplemental Life and Supplemental AD&D coverage, when you reach age 65, your coverage will automatically reduce to the greater of $5,000 or 10% of your 1x annual pay at retirement with a $50,000 maximum.

Retiree Supplemental Life and Supplemental AD&D – During Retirement – At Age 65 or Later

If retired at age 65 or later, you will receive a reduced Supplemental Life and Supplemental AD&D amount provided at no cost to you.

Your reduced benefit coverage will be the greater of $5,000 or 10% of your 1x annual pay at retirement with a $50,000 maximum.

Your Supplemental Life and Supplemental AD&D beneficiary is the same as designated under your basic life benefit.

Any difference between your reduced amount and the original amount of Supplemental Life coverage can be converted to an individual policy within 30 days from the date benefits were reduced. **Refer to "Conversion Privileges" at the end of this section for more information.**

Basic AD&D and Supplemental AD&D – Dismemberment Benefits

You may be eligible for an AD&D benefit payment if you should lose eye sight, speech, hearing, a limb, or become paralyzed as a direct result of an accident. Dismemberment benefits are paid to the retiree.

If you should lose sight, speech, hearing, limb, or become paralyzed as a result of and within 12 months of the date of an accidental injury which was a direct and sole result of the accidental injury, you will receive the following benefits in a lump sum.

Dismemberment benefits are paid based on your retiree Basic and Supplemental Life amounts and maximums in effect at the time of accident.

The Basic and Supplemental AD&D plans pay at:

25% for the loss of:

- Thumb and index finger of the same hand
- Paralysis of one arm or leg

50% for the loss of:

- A hand permanently severed at or above the wrist but below the elbow
- A foot permanently severed at or above the ankle but below the knee
- Sight in one eye
- Speech or loss of hearing
- Paralysis of both legs
- Paralysis of the arm and leg on either side of the body

75% for the loss of:

- An arm permanently severed at or above the elbow
- A leg permanently severed at or above the knee

100% for the loss of:

- Any combination of hand, foot, or sight in one eye
- Speech and loss of hearing
- Brain Damage
- Coma: 1% monthly beginning on the seventh day of the Coma for a duration of the Coma to a maximum of 60 months.

Note: If you sustain more than one covered loss due to an accidental injury, the amount MetLife will pay on behalf of any such injured person will not exceed the full amount of coverage.

MetLife Exclusions

Applies to the following plans:

- **Basic Accidental Death and Dismemberment (AD&D)**
- **Supplemental Accidental Death and Dismemberment (AD&D)**

Benefits will not be paid under this section for any loss caused or contributed to or by:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound or from food poisoning;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision, reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to, the National Guard of the United States or the national guard of any other country;
- any incident related to travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger; travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight, except for self-preservation;
- travel in an aircraft or device used for testing or experimental purposes, by or for any military authority, or for travel or designed for travel beyond the earth’s atmosphere;
- committing or attempting to commit a felony;
- the voluntary intake or use by any means of any drug, medication, or sedative, unless it is taken or used as prescribed by a Physician; or an "over the counter" drug, medication, or sedative taken as directed;
- alcohol in combination with any drug, medication, or sedative; or poison, gas, or fumes; or
- war, whether declared or undeclared; or act of war, insurrection, rebellion, or active participation in a riot.
- exclusion for intoxication – no benefits will be paid under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person’s blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

Other Information Under the MetLife Plans

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.

For life and supplemental coverage, the Beneficiary you name for basic life insurance benefits will automatically be your Beneficiary, unless you elect otherwise in writing.

If you do not designate a Beneficiary or if you do not have any living Beneficiary(ies), benefits will be paid to your estate.

Costs for Coverage

You and the Company share the cost for some plans and the Company pays the cost for others.

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 statement as "other income."

Imputed income does not apply to accidental death and dismemberment coverage.

Living Benefit

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

You may receive up to 80% of the amount of your basic life with a maximum living benefit of $500,000 of your basic 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 for basic life coverage. This is also known as the Accelerated Benefits Option.

Payment of Benefits

If the death benefit amount payable to a Beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your Beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date it is established, and the account provides for a guaranteed minimum rate. Your Beneficiary can access the TCA balance at any time without charge or penalty, simply by writing drafts in an amount of $250 or more. Your Beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. **Note:** The TCA is not a bank account and is not a checking, savings, or money market account.

Conversion Privileges

Within 31 days after your basic life insurance coverage reduces, you may convert all or part of this coverage to an individual insurance policy without taking a medical examination. The cost for individual coverage will be based on the insurance company's regular premium rates for the type and amount of insurance available to you through the conversion privilege. If your life insurance coverage terminates, you may contact the Benefit Plans Office to request a conversion form.

MetLife Group Universal Life Insurance (GUL) – During Retirement

Group Universal Life insurance coverage can continue on a direct bill basis at retirement. You will need to contact MetLife at 1-800-846-0124 to determine any action you need to take for your individual situation and within what timeframe.

Glossary

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Glossary

This Glossary contains brief definitions to help you understand terms used throughout this book.

Beneficiary

The person, organization, or trust that you name to receive any life, accident, pension plan, or 401(k) savings plan benefits if you die.

Benefits and Investment Committee (BIC)

Appointed by the Company's board of managers to serve as the Plan Administrator for Company benefit plans.

Benefits Appeals Committee (BAC)

Considers escalated participant appeals related to eligibility, benefit determination, or denials not delegated to other third-party administrators.

Board of Managers

Those Managers, as a group, appointed by the Company members in accordance with the Company Operating Agreement to manage the Company.

Calendar Year Annual Deductible

Individual Deductible (All medical plans)

The amount you pay on an individual plan before eligible claims are paid under the Plan's coinsurance arrangement.

Family Deductible

Choice Fund with HSA plan

There is no individual deductible for a dual or family plan. All eligible family members contribute towards the family plan Deductible. Once the family Deductible has been met, the plan will pay each eligible family member's expenses based on the Coinsurance level specified by the plan.

All other medical plans

After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. The other eligible family members continue to contribute toward the remaining portion of the family Deductible. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.

Child

For medical, prescription drugs, dental, and vision, a child is defined as:

1. Your biological child
2. Your legally adopted child (or a child who is lawfully placed with you for legal adoption)
3. Your stepchild
4. A child for whom you have been granted permanent legal guardianship or permanent custody prior to the child's 18th birthday by court order or an agreement with a state or other governmental agency
5. A child who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) enforceable with respect to the plan

In the case of a child described above, the child must be under age 26.

In the case of a child described in item 4 above, the child must meet the following requirements:

- The child is under age 26.
- You must be able to claim the child as a dependent on your federal income tax return without regard to any limit on the gross income that the child may earn.
- You provide over 50% of the child's financial support during the calendar year.
- The child lives with you in a "parent-child relationship." 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 and incapable of self-support (as determined by the Plan Administrator) before reaching the maximum coverage age above may continue to be covered as a child regardless of age, as long as he or she remains permanently and totally disabled and is primarily dependent on you for support.

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.

Code

The Internal Revenue Code of 1986, as amended.

Coinsurance

Your share of the cost of a covered health service, calculated as a percent of the allowed amount of the service.

Company or Employer

Management and Operating contractor for the Department of Energy. The current Management and Operating contractor is Consolidated Nuclear Security, LLC.

Conversion Privilege

Your right to convert a group medical and life insurance policy to an individual policy.

Copayment or Copay
The fixed dollar amount you and your Eligible Dependents are required to pay for covered services when received.

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 Eligible Dependents are required to pay each year for covered expenses before the Plan pays, and is in addition to any Coinsurance or Copayments. The deductible amount does not apply to in-network preventive care and immunizations.

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, and vision

Your eligible dependents are:

- Your Spouse
- A Child described above in this Glossary

Eligible Retirement Plan(s)
The following are the types of plans that may be considered Eligible Retirement Plans for rollover purposes:

- Any plan qualified under Internal Revenue Code Section 401(a), which might include:
  - 401(k) plans,
  - Defined benefit (pension) plans,
  - Employee Stock Ownership Plans,
  - Money purchase pension plans, and
  - Stock bonus plans.
- 403(b) tax-sheltered annuity plans;
- Certain governmental Section 457 plans;
- SIMPLE 401(k) plans;
- 403(a) annuity plans; and
- Federal thrift plans under Section 7701(j).

The following types of plans are **not** eligible retirement plans for rollover purposes:

- Excess plans,
- Top Hat plans, and

- Stock Option plans.

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 now in effect and hereafter amended, and any regulations issued under ERISA.

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

Home Health Services
Skilled health care services that the insurance company has determined are medically appropriate to provide in the home.

Hospice Care
Any services provided by a hospital, skilled nursing facility, home health agency, hospice, or any other licensed facility or agency under a hospice program.

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.

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 medical, diagnostic, surgical care, 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.

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 do not 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 a physician, authorized services or items provided by another participating provider contracted with your insurance provider.

Inpatient
You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You are still an outpatient if you have not been formally admitted as an inpatient, even if you are getting emergency department services, observation services, outpatient surgery, labs, tests, or x-rays. You or a family member should always ask if you are an inpatient or an outpatient.

Investment Fund(s)
Each designated investment alternative specified by the Plan Administrator as an investment option in which you may elect to have your Plan account invested.

Limb
An arm or a leg.

Loss
For purposes of life insurance plans, 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.

Maximum Reimbursable Charge
For the Medical Plan
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 Maximum Reimbursable Charge do not count toward your Deductible or Out-of-Pocket Maximum.

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- The provider’s normal charge for a similar service or supply, or
- A policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.
- The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna.

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.

Member Services / Customer Services / Participant 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.

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 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.

Orthodontia Treatment
Treatment 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 is provided by a physician, facility, or other service provider not contracted with the third-party administrator 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.

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.

Participant
An eligible employee who has become a participant in the Plan and who has not received a complete distribution of his or her vested Plan account balance for 401(k) Savings Plan and the Pension Plans.

Periodontal Splinting
Stabilizing or immobilization of periodontal involved teeth. Splinting may be accomplished with acrylic resin bite guards, orthodontia band splints, wire ligation, provisional splints, and fixed prosthesis.

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

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.

Pre-certification/Pre-Admission Certification
The process used to certify the clinical treatment, the medical necessity, and length of a hospital confinement prior to receiving service.

Prescription Drugs
Medication prescribed by a physician for the treatment of an illness or injury.

Primary Care Physician (PCP)
A licensed physician – generally an internist, general/family practitioner, or pediatrician – whom you generally select to coordinate all your medical care within the network.

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

Retiree
A retiree is a former employee who at the time of termination of employment was eligible to commence a pension plan retirement benefit.

Routine
A situation that does not require immediate attention, such as immunizations or annual exams.

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 licensed Physicians and provide Nurses' services.

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

Spouse
The individual recognized as your lawful spouse in accordance with the laws in the jurisdiction where the marriage took place. The term spouse does not include a domestic partner or party to a civil union. You will be required to show proof that your spouse is your lawful spouse.

Trustee
The person or entity appointed by the Benefits and Investment Committee to act as trustee for the Plan's trust fund, and any additional or successor trustee or trustees.

Trust Fund
The fund established by the Company pursuant to the trust agreement with the trustee to hold the assets of the Plan. It includes all of the assets held by the trustee under the trust agreement to be used to pay benefits provided by the Plan and to defray reasonable expenses of administering the Plan.

Urgent Care
Services for a situation that requires prompt medical attention, but is not life threatening.

Vested Terminated Participant
A former employee who at the time of termination of employment had a vested interest in the Pension Plan or 401(k) Savings Plan, but in the case of the Pension Plan, such former employee at the time of termination of employment had not satisfied the requirements to retire and commence a pension benefit.

Vesting
Ownership interest in your pension plan benefits and Company contributions under the 401(k) Savings Plan. You have an irrevocable right to a benefit when you are fully vested.

Administrative Information

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Administrative Information

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 under the Employee Retirement Income Security Act of 1974 (ERISA). 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.

This section is to be read along with each of the sections of this book which summarize the key provisions of the Company's benefit plans. Keep in mind that any discussion in this section of rights or protections under ERISA applies only to the ERISA plans unless indicated otherwise.

Nothing in this document shall be construed as an employment contract or employment agreement. The Company may unilaterally change the provisions contained herein anytime at its own discretion.

Plan Sponsor

ⓘ Consolidated Nuclear Security, LLC is the sponsor of the employee benefit plans described in this book. You can reach the plan sponsor as follows:

Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

Plan Administrator / Claims Administrator

ⓘ Consolidated Nuclear Security, LLC has delegated authority to the Benefits and Investment Committee to serve as the Plan Administrator of the employee benefit plans described in this book. You can reach the Plan Administrator as follows:

Benefits and Investment Committee
Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

In carrying out its responsibilities under the plans, the Benefits and Investment Committee, as 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 to other persons or entities. For example, the Plan Administrator has retained one or more third-party administrators to provide certain administrative services with respect to one or more of the welfare plans, including making determinations as the "claims administrator" regarding participant claims for benefits. The contact information for the claims administrators is located later in this section of this book. In addition, with

respect to the retirement plans, the authority to make initial claims determinations has been delegated to an employee of the Company. The appeals of such determinations are decided by the Benefits Appeals Committee.

ⓘ The Benefit Appeals Committee may be contacted as follows:

Benefit Appeals Committee
Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

A person or entity to whom these duties have been delegated acts with the discretionary authority granted to the Plan Administrator.

The term “Company” means Consolidated Nuclear Security, LLC.

The term “Benefit Plans Office” refers to the Company’s benefits department located in Oak Ridge, Tennessee.

Employer Identification Number

The employer identification number assigned by the Internal Revenue Service to the Company is 45-4482782.

Plan Documents

This book summarizes the key features of each of the employee benefit plans sponsored by the Company and serves as the summary plan description for each of the plans for purposes of ERISA. It applies to eligible employees of the Company, including those represented by collective bargaining agreements 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. Summaries of the plans are included in the tabs of this book. **All statements made in this book are subject to the provisions and terms of the plan 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 or Department of Labor 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 at a nominal charge. In addition, once each year you will receive a copy of the summary annual reports of the plans’ financial activities (if applicable), 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 book. Requirements under the law and the terms of benefits are set forth in the insurance company’s certificate of coverage for the insured coverage. In the event of any conflict between the summaries in this book and such certificate of coverage the provisions of such certificate of coverage shall control. You may

request a copy of such certificate of coverage by following the steps outlined in the Administrative Information 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. The procedure for 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 or, in some cases, the claims administrator. All completed forms must be submitted to the appropriate office, as described throughout this book, within any time period required by the administrator.

You have the right to file a formal claim for benefits, ask whether you have a right to any benefits or appeal the denial of a claim for benefits under each of the plans. Your authorized representative may do this on your behalf. You must follow each plan's procedures for appointing an authorized representative unless your claim is an "urgent" health care claim. For additional information regarding these procedures, you should contact the Plan Administrator. If your claim is an urgent health care claim, you may appoint your health care provider to act as your authorized representative without following these procedures. References to the term "you" in this section, include the participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person.

With respect to the welfare plans, the Plan Administrator has delegated to the claims administrator (or delegates) the discretion to interpret plan provisions, construe unclear terms, and otherwise make all decisions and determinations, including factual determinations and whether welfare plan benefits are owed and in what amount. The Plan Administrator retains responsibility for determining whether an individual is eligible to participate in a welfare plan.

Where a claims administrator has been appointed, the claims administrator is listed in a chart located later in this section under the heading "Other Administrative Facts." The Benefits and Investment Committee (or its delegate) acts as the claims administrator with respect to eligibility and enrollment determinations for all of the plans and any matter not delegated to a third-party service provider or to the Benefits Appeals Committee. In addition, the Benefits Appeal Committee has been appointed to handle all appeals related to retirement plan claims and all appeals with respect to eligibility and enrollment determinations for all of the welfare plans. If you have a question about who acts as the claims administrator with respect to a particular benefit or plan, you should contact the Plan Administrator.

To make a formal claim for benefits, you must file a written claim with the Plan Administrator or, where applicable, the claims administrator. The way in which you file a claim for benefits and appeal any claim that is denied (or any other adverse benefit determination) will differ depending on the type of benefit that is offered under the plan. An adverse benefit determination includes any denial, reduction or termination of a benefit, a failure to make a payment, or, in the case of the Company's medical plans, a rescission of coverage. Following are the types of claims procedures contained herein:

- The Health Claims Procedures, which are special procedures that apply to claims related to the Company's health plans.
- The General Claim Procedures, which apply to claims related to all of the Company's other ERISA-covered plans.

Exhaustion of Administrative Remedies and Limitations on Actions

You must use and fully exhaust all of your actual or potential rights under each plan's administrative claims and appeals procedures by filing an initial claim and then seeking a timely appeal of any denial (or other adverse benefit determination) before you file a lawsuit. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue).

Failure to follow the administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination or any other matter covered by this provision. In the case of the pension plans and 401(k) savings plans, if you wish to pursue an adverse determination on appeal, you must file the lawsuit within one year of the date of the final decision on appeal.

Discretionary Authority

Depending upon the circumstances, the Plan Administrator, the Benefits Appeals Committee, or the claims administrator (with respect to any matters delegated to the claims administrator) have the discretionary authority to construe and to interpret the plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the plan will be paid only if the Plan Administrator, the Benefits Appeals Committee or the claims administrator, as applicable, decides in its discretion that a participant is entitled to them.

Health Claims Procedures

You may file claims for health plan benefits, either yourself or via an authorized representative appointed by you or the court. Either you or your authorized representative may appeal an adverse claim decision. Benefit programs covered by the Health Claims Procedures include the medical plan, prescription drug plan, dental plan, vision plan, and the retiree HRA plan (including the catastrophic drug plan).

Initial Health Claims

If you file a claim for health benefits, you will receive a notice from the claims administrator regarding the claim according to the procedures described below. The procedure by which your claim will be decided varies depending on the type of claim that is filed.

Urgent Health Care Claims

If you file an Urgent Care Claim, you will receive notice of the benefit determination 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. Notice of the benefit determination may be oral, with a written or electronic confirmation to follow within 3 days.

An Urgent Care Claim is a claim filed by a claimant relating to medical care provided under the plan if (1) the plan requires the claimant to notify the plan or receive approval prior to receiving the medical care, and (2) a delay in treatment could seriously jeopardize the person's life or health or the ability to regain maximum function, or in the opinion of a physician with knowledge of the person's medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is the subject to the claim. 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 layperson who possesses an average knowledge of health and medicine or by a physician with knowledge of your medical condition.

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 (provided it is not an Urgent Care 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 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-day or 30-day period.

For example, these periods 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 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 five 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 which was previously approved for a specific period of time or number of treatments, 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 Initial Health Claim Decision

For claims and other adverse benefit determinations that relate to the medical plan, the claims administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings)
- The specific reasons for the adverse benefit determination, including the denial code (and its meaning), and a description of any standard that was used in denying the claim

- References to the specific plan provisions on which the benefit determination is based, including plan limitations or exclusions
- 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 internal 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
- A description of available external review processes, including information regarding how to initiate any appeal
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

For all other claims and adverse benefit determinations relating to any other health plan, including the dental plan, vision plan, and the retiree HRA plan, the claims administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

- The specific reasons for the adverse benefit determination with reference to the specific plan provisions on which the benefit determination is 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.

In all cases, 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.

In addition, 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.

Appeal of a Health Claim

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. 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 determination will be final.

To file an appeal, you must submit it in writing to the claims administrator, except for Urgent Care Claims. If you appeal, you will be notified of the decision not later than 72 hours (Urgent Care Claim), 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 (as that term is defined in ERISA).

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 regarding 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.

An expedited appeal for Urgent Care Claims may be initiated by a telephone call to the claims administrator. If you appeal an Urgent Care Claim, all necessary information, including the appeal decision, will be communicated to you by telephone, facsimile, or other similar method. The contact information for the claims administrator is located at the end of this Administrative Information section. If you have questions about how to submit an appeal, you should contact the Plan Administrator.

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 claims administrator 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.

For purposes of medical claims, you may review your claim file and present evidence and testimony in support of your claim. In addition, before your appeal is decided, you will be given, free of charge, any new or additional evidence considered, relied upon, or generated by the claims administrator in connection with your claim. This evidence will be given to you as soon as possible and sufficiently in advance of the date on which the appeal decision is required to be provided to give you a reasonable opportunity to respond before that date.

Notification of Health Claim Appeal

For appeals that relate to the medical plan, if your appeal is denied in whole or in part, the claims administrator will provide you with a written or electronic notification that will include:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings).
- The specific reason(s) for the adverse benefit determination, including the denial code (and its meaning), and a description of any standard that was used in denying the claim.
- References to the specific plan provisions on which the benefit determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
- A description of available external review processes, including information regarding how to initiate any appeal.
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

For appeals that relate to any other health plan, including the dental plan, vision plan, and retiree HRA plan, if your appeal is denied in whole or in part, the claims administrator will provide you with a 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;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits; and
- A statement describing any voluntary appeal procedures offered by the plan and your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In all cases, 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). Although, you may request an external review of certain types of medical plan claims. This external review process is completely voluntary.

Your Right to an External Review

Federal law gives you the right, in certain circumstances, to have an adverse benefit determination reviewed by an external independent review organization after you exhaust your rights under the internal claims and appeals procedure. The following is a general description of the external review process. However, you should review your notice of adverse benefit determination carefully. The notice may contain updated information in the event the external appeals process changes.

Types of Eligible Determinations

The external review process under the medical plan gives you the opportunity for review of a final internal adverse benefit determination, and in limited cases, an adverse benefit determination conducted pursuant to applicable law. Your request will be eligible for external review only if it qualifies as one of the following:

- Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, and level of care, effectiveness of a benefit or experimental or investigational determinations).
- Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission.

External review procedures do not apply to any other adverse determination, including eligibility appeals.

External Review Request

You must submit the request for external review form to the claims administrator within 123 calendar days of the date you received the notice regarding your final internal adverse benefit determination (or adverse benefit determination, if applicable). If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file for a voluntary external review, any applicable statute of limitations will be tolled while the external review is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However external review is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for external review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Within five business days following the date the external review request is received, the claims administrator will complete a preliminary review to determine whether you meet the requirements for an external review. To be eligible, you must meet the following requirements:

- You are or were covered under the medical plan at the time the item or service was requested or, in the case of a retrospective review, were covered under the medical plan at the time the health care item or service was provided;
- The denied appeal does not relate to your failure to meet the requirements for eligibility under the terms of the medical plan;
- You have exhausted the internal appeal process; and
- You have provided all the information and forms required to process an external review.

If the claims administrator does not adhere to the federal requirements for handling internal claims and appeals, you are deemed to have exhausted the internal claims and appeal process unless such failure was (1) De Minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the medical plan's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, you are entitled to an explanation of the medical plan's basis for asserting that it meets this standard.

Within one business day after completing the preliminary review, the claims administrator will send you a written notice regarding your request. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information. If the request is not complete, the notice will describe the information or materials needed to make the request complete and you will have the later of the remaining time within the four month filing period or 48 hours following receipt of the notification to perfect your external review request.

Procedures After your External Review Request is Approved

If your external review request is eligible, the claims administrator will assign it to an Independent Review Organization (IRO) as required under federal law to conduct the external review. The assigned IRO will notify you in writing of the request’s eligibility and acceptance for external review. You may submit in writing to the assigned IRO within ten business days following the date the notice is received additional information that the IRO must consider when conducting the external review. Any additional information received by the IRO from you will be shared with the claims administrator and the plan. Upon receipt of this information by the claims administrator and the plan, the claims administrator may reconsider its prior appeal decision and may reverse the prior denial of the internal appeal. If the claims administrator reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly and the external review will be terminated.

If the external review is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision to the extent required under applicable law:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan, you, or your treating provider;
- The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

The IRO will deliver a notice of the final external review decision to you and the claims administrator. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review Requests

You may also make an expedited external review request to the claims administrator at the time you receive (1) a denied urgent care internal claim if you have also filed at the same time an internal appeal; (2) a denied urgent care internal appeal; or (3) a denied internal appeal, which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility. Upon receipt of such a request, the claims administrator will determine whether you are eligible for an expedited external review. If you are eligible, the claims administrator will notify you immediately. The IRO will follow the procedures discussed above with respect to standard external reviews, provided that certain procedures will be provided on an expedited basis as follows:

- The claims administrator must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and
- Upon a determination that a request is eligible for external review following preliminary review,

the claims administrator will assign an IRO. The IRO will provide notice of the external review decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, the claims administrator and the plan.

Foreign Language Assistance (Medical Plan only)

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the health plan must provide the following language assistance:

- Oral language services in the applicable non-English language for claims, appeals, and external review;
- Upon request, an explanation of benefits (EOB) or other adverse benefit determination in the applicable non-English language; and
- Provide in English versions of EOBs and other adverse benefit determinations a statement in any applicable non-English language indicating how to access the language services.

If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact the claims administrator or the Benefit Plans Office.

General Claims Procedures (Non-Health)

You may file claims for plan benefits, either yourself or via an authorized representative appointed by you or the court. Either you or your authorized representative may appeal an adverse claim decision. Benefit programs that are covered by the General Claim Procedures include the Pension Plan, the 401(k) Savings Plan, the Life Plan, and the Long-Term Care Plan.

Initial General Claims (Non-Health)

If you file a claim for benefits other than health benefits and other than to commence your benefits, you will receive a notice from the Plan Administrator (or claims administrator for non-retirement benefits) regarding the claim according to the procedures described below.

If you file a claim for non-health benefits (other than to commence your benefits), 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 of Initial Claim Decision

The Plan Administrator (or claims administrator for non-retirement benefits) will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, 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 and appeals 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 and within any applicable time limit. In the case of the pension and 401(k) savings plans, the lawsuit must be filed within one year of the date of the final decision on appeal.

Appeal of a General Claim (Non-Health Claim)

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 60 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 seek a reconsideration of your claim later, and the initial claim determination or other adverse benefit determination will be final.

To file an appeal, you must submit it in writing to the Benefits Appeals Committee (or for non-retirement benefits to the claims administrator). The contact information for the Benefits Appeals Committee and the claims administrator is located at the end of this Administrative Information section.

You will 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 (as that term is defined in ERISA). 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.

Notification of General Claim Decision on Appeal

If your appeal is denied in whole or in part, the Benefits Appeals Committee, Plan Administrator, or claims administrator will provide you with a 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
- Your right 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, and within any applicable time limit to file the action. In the case of the pension and 401(k) savings plans, the lawsuit must be filed within one year of the date of the final decision on appeal

The following table summarizes the deadlines for filing an appeal.

Y-12 Plan – Pension	Upon receipt of an adverse benefit determination, the Member shall have 60 days following receipt of the notice to request an appeal of the determination.
Y-12 Plan – 401(k)	Upon receipt of an adverse benefit determination, the Member shall have 60 days following receipt of the notice to request an appeal of the determination.

Legal Process

ⓘ Any legal process relating to a benefit plan should be directed to the plan's Agent for Service of Legal Process, which is:

CT Corporation System
300 Montvue Road
Knoxville, TN 37919-5546

CT Corporation System
1999 Bryan Street
Suite 900
Dallas, Texas 75201-3136

Legal process may also be served upon the plan trustee (where applicable) or the Plan Administrator.

Plan Termination and Amendment

The Company expects and intends to continue the plans in your benefits program, but reserves its right to amend and/or terminate each of the plans, in whole or in part, without notice. 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 liabilities 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 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. 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 401(k) Savings Provisions

There are a few special provisions that apply only to the 401(k) Savings Plan and Pension Plan.

Assets Upon Termination

If the 401(k) 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 Beneficiary(ies) 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 without enough money to pay all benefits, the PBGC will step in to pay pension benefits, within limits applicable at that time.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Disability benefits payable by the Pension Plan 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 five 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 https://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 401(k) 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 401(k) 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 401(k) 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 401(k) 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 Beneficiary(ies) 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 a legal order requiring a parent to provide medical support to a child (for example, in cases of legal separation or divorce). In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order that is issued by an appropriate court or administrative agency and contains certain information. A QMCSO must be provided to the Plan Administrator. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. The QMCSO may not require the plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the plan.

Health Insurance Portability and Accountability Act (HIPAA)

The health plans operate in accordance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) with respect to protected health information (PHI). For purposes of the plans, 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 plans. Additional information about your rights under HIPAA is provided separately in a Notice of Privacy Practices.

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).

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 the following:

- 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.

Compliance with the Affordable Care Act

It is the Company's policy and intent to comply with all applicable provisions of the Affordable Care Act and its related regulations and other governmental guidance. The Company will investigate fully any complaint that the Company or the health plans have not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the Company or the health plans have violated a provision of the Affordable Care Act, you are encouraged to share your complaint with the Company by contacting the Benefit Plans Office. Please provide as much information as you can regarding your complaint to help the Company with its investigation. The Company will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

Other Administrative Facts

Specific Plan Information

Plan name	Plan number	Plan type	Plan year
Retirement Program Plan for Employees of Consolidated Nuclear Security, LLC at the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	001	Defined Benefit	Calendar
Savings Program for Employees of Consolidated Nuclear Security, LLC at 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
Health Benefits (Medical, Dental, Vision, Prescriptions)	506	Welfare	Calendar

Plan name	Plan number	Plan type	Plan year
Other Consolidated Nuclear Security, LLC Health and Welfare Benefit Plans			
Long-Term Care	518	Welfare	Calendar
Retiree Health Reimbursement Arrangement (RHRA)	521	Welfare	Calendar

Insurer, Claims Administrator, or Trustee	Source of contributions	Source of benefits
Northern Trust Company serves as Trustee for the assets of the Pension Plans and 401(k) Plans The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Employee and Company	Pension Plans: Benefits are paid through group annuity contracts and assets in the trust
Voya Financial serves as Recordkeeper for the 401(k) Plans Voya Financial P.O. Box 55772 Boston, MA 02205-5772	Employee and Company	401(k) Plans: Benefits are paid by the Plan Trustee from assets held in the trust for the 401(k) Plans
Metropolitan Life Insurance Company Life Insurance Long-Term Care	Employee/Retiree and Company	Benefits are paid from an insurance contract
Prudential Insurance Company of America Long-Term Care	Retiree	Benefits are paid from an insurance contract
Cigna Group Insurance	Company	Benefits are paid from an insurance contract
Medical: Administered by Cigna Dental: Administered by Delta Dental of Tennessee Vision: Administered by Vision Service Plan (VSP) Prescription: Administered by Express Scripts	Employee/Retiree and Company	Benefits are paid through claims administrator and paid from employee contributions and general assets of the Company.
Retiree Health Reimbursement Arrangement (RHRA) for eligible Post-65 Retirees: Administered by Aon	Company	Benefits are paid through claims administrator and paid from general assets of the Company

Note: COBRA rights for the Retiree Health Reimbursement Arrangement (RHRA) plan can be found the under the Post-65 Retiree HRA of this SPD.

Your Rights Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their eligible family members the opportunity to continue health coverage (called COBRA coverage) in certain circumstances when coverage would otherwise be lost. (For COBRA purposes, a loss of coverage includes an increase in the cost of such coverage.) The plans providing medical (including prescription drug), dental, and vision benefits are eligible for COBRA coverage as described in this section. These benefits are referred to in this section as "COBRA-Eligible Plans." This portion of the Administrative Information section is considered your "Initial COBRA Notice" and generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

ⓘ Certain aspects of COBRA continuation coverage are administered by Allegiance COBRA Services, Inc., which is referred to in this section as the "COBRA Administrator." The contact information for the COBRA Administrator is:

Plan Administrator
Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

COBRA continuation coverage is a continuation of coverage under the COBRA-Eligible Plans when coverage would otherwise be lost because of a life event known as a Qualifying Life Event. Specific Qualifying Life Events are identified below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified Beneficiary is someone who will lose coverage under a COBRA-Eligible Plan because of a Qualifying Life Event. Depending on the type of Qualifying Life Event, employees, Spouses of employees, and dependent Child(ren) of employees may be qualified Beneficiary(ies). Qualified Beneficiaries who elect COBRA continuation coverage will be required to pay for COBRA continuation coverage.

In addition to COBRA continuation coverage, you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally does not accept late enrollees. Additional information is provided below.

Eligibility and Coverage

Your covered Spouse will become a qualified beneficiary if he or she loses coverage under a COBRA-Eligible Plan because any of the following Qualifying Life Events happens:

- You die; or
- You and your Spouse divorce.

Also, if you reduce or eliminate your Spouse's coverage under a COBRA-Eligible Plan in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for your Spouse even though his or her coverage was reduced or eliminated before the divorce.

Your covered dependent Child(ren) will become qualified Beneficiaries if they lose coverage under a COBRA-Eligible Plan because any of the following Qualifying Life Events happens:

- You die;
- You and your Spouse divorce; or
- The Child stops being eligible for coverage under the Plan as a "dependent child."

Child(ren) born to or placed for adoption with you during the continuation coverage period may also elect continuation coverage, as long as you have elected COBRA coverage for yourself. The coverage period will be determined according to the date of the Qualifying Life Event that gave rise to your COBRA coverage.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Life Event. If a proceeding in bankruptcy is filed with respect to the Company and that bankruptcy results in the loss of coverage of any retiree employee coverage by a COBRA-Eligible Plan, the retired employee will become a qualified Beneficiary with respect to the bankruptcy. The retired employee's covered surviving Spouse, and covered dependent Child(ren) will also become qualified Beneficiaries if the bankruptcy results in the loss of their coverage under a COBRA-Eligible Plan.

Required Notice of Qualifying Events

Under the law, you or a covered Eligible Dependent (or a representative) has the responsibility to inform the Plan Administrator of an initial Qualifying Life Event, such as a divorce or a Child's loss of dependent status under the COBRA-Eligible Plan. To be eligible for continued coverage, you or your covered Eligible Dependent (or a representative) must inform the Benefits Plan Office within 60 days after the later of the event or the date on which coverage would otherwise end because of the event. In addition, in the event of the birth or adoption of a Child after the Qualifying Life Event, you must notify the COBRA Administrator of the birth or adoption of the Child whom you wish to enroll under the COBRA-Eligible Plan. The notice procedures are described below. (The Company must notify the COBRA Administrator of your death.) If this notice is not timely and properly provided, the qualified Beneficiary will not be permitted to elect COBRA continuation coverage.

COBRA Election Period

Once the COBRA Administrator receives notice that a Qualifying Life Event has occurred, COBRA continuation coverage will be offered, when appropriate, to each of the qualified Beneficiary(ies). Each qualified Beneficiary will have an independent right to elect COBRA continuation coverage for 60 days from the later of the date coverage is lost under the COBRA-Eligible Plan or the date of notification to elect continuation coverage.

To inform the COBRA Administrator that you want COBRA continuation coverage, you must complete the election form and submit it to the COBRA Administrator as directed in the COBRA election notice. If mailed, the election form must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided at the time of the Qualifying Life Event. The following are not acceptable as COBRA elections and will not preserve your COBRA rights: oral communications, including in-person or telephonic statements about an individual's COBRA coverage, and electronic communications (other than by enrolling online).

You may elect COBRA continuation coverage on behalf of your eligible Spouse, and you or your Spouse may elect COBRA continuation coverage on behalf of your eligible Child(ren). If you or your eligible Spouse elects COBRA continuation coverage without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified Beneficiary(ies) with respect to that Qualifying Life Event.

When making the decision of whether to elect COBRA continuation coverage, there may be other available options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible. It is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

Additional information is provided below.

Description and Maximum Length of COBRA Coverage

If you continue coverage, you will receive coverage identical to that provided under the COBRA-Eligible Plan for similarly situated employees or family members. If the Company changes the benefits provided under a COBRA-Eligible Plan during your COBRA continuation period, your COBRA continuation coverage will also be changed in the same manner.

COBRA continuation coverage is a temporary continuation of coverage and may only be continued for certain specified time periods depending upon the Qualifying Life Event.

- **36-Month Period.** When the Qualifying Life Event causing loss of coverage is your death, your divorce, or a Child losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. If the Qualifying Life Event is your death and your Eligible Dependent receives extended coverage under the medical plan (as described in the Medical Plans section), the maximum COBRA period will be reduced by the length of that extended coverage.

The maximum COBRA coverage period for your newborn or newly-adopted Child is measured from your original Qualifying Life Event. To be enrolled in a COBRA-Eligible Plan, the Child must satisfy the otherwise applicable plan eligibility requirements. A person who becomes the Spouse of a qualified Beneficiary (including a new Spouse of an employee) or dependent Child of a qualified Beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a qualified Beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if any one of the following events occurs:

- The qualified Beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals; if the other plan has such limitations, COBRA coverage will end when those limitations expire).
- The qualified Beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA continuation coverage.
- 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 terminates its group health plans.

If, during the period of COBRA coverage, a qualified Beneficiary becomes covered, after electing COBRA, under other group health plan coverage, the qualified Beneficiary (or a representative) must notify the COBRA Administrator in writing within 30 days of the later of:

- the date the other coverage becomes effective, or
- the exhaustion or satisfaction of any pre-existing condition exclusions affecting the qualified Beneficiary.

If, during the period of COBRA coverage, a qualified Beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, the qualified Beneficiary (or a representative of either) must notify the COBRA Administrator in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

The procedures for providing this notice are described below.

If notice of these events is not timely and properly provided, the qualified Beneficiary's COBRA coverage may be terminated retroactively and the qualified Beneficiary may be required to repay a portion of the benefits received.

A qualified Beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA coverage is provided subject to the qualified Beneficiary's eligibility for coverage. The COBRA Administrator reserves the right to terminate a qualified Beneficiary's COBRA coverage retroactively if he or she is determined to be ineligible.

COBRA Premium Payments

A qualified Beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage.

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 election rights be can be mailed to you.

Notice Procedures

As a condition of receiving COBRA coverage, you or your covered dependent (or a representative) must notify the Plan Administrator or COBRA Administrator when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial Qualifying Life Events
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Each of these events, including the time period for providing notice of the event, has been discussed previously. Unless directed otherwise in the COBRA election notice (if applicable):

- All other notices must be provided to the COBRA Administrator. The notice must contain the name, address and phone number of the covered employee (or formerly covered employee) and/or each qualified Beneficiary experiencing the COBRA-related event, the name of the COBRA-Eligible Plan, the COBRA-related event being reported and the date of such event. You must also provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred.

If mailed, the notice must be postmarked no later than the applicable deadline for giving the notice. If the notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all qualified Beneficiaries who are required to give the notice.

Additional documentation supporting the notice may be required. If such information is requested and it is not provided within 15 business days of the request, the notice will not be considered timely and continuation coverage may not be available.

Keep the Plan Informed

In order to protect your family's rights, you should keep the Company and the COBRA Administrator informed of any changes in the addresses of your family members. If you have changed your marital status, or you or your Eligible Dependents have changed addresses, it is your responsibility to notify the COBRA Administrator. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance

Program. You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

If you enroll in COBRA Coverage, it may temporarily limit your Marketplace options. If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

If You Have Questions

Questions concerning your COBRA-Eligible Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

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, all plan documents.
- Obtain, upon written request to the Plan Administrator, copies of all plan documents and other plan information. The Plan Administrator may charge a reasonable fee 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, you may request information concerning the total value of your 401(k) Savings Plan accounts by logging on to the recordkeeper's website or calling the recordkeeper. You may also receive a quarterly statement showing the value of your account, type of contributions and the amount that is vested.

Continue Group Health Plan Coverage

Continue health care coverage for a Spouse or Eligible Dependents if there is a loss of coverage under the plans as a result of a Qualifying Life Event. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights.

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 plans. The people who operate your plans, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants, and Beneficiary(ies).

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. However, in no event will you be allowed to file suit until you have exhausted the administrative remedies available under the plans, including following the appropriate claims procedure as described above.

In addition, if you disagree with the Plan Administrator’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.

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Contacts

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Contacts

The following chart provides contact information for questions you may have regarding benefits provided under the CNS Benefits Program.

For questions:	Contact:	At:
Enrollment and Benefits Information **Life Insurance** **Basic Life** **Supplemental Life** **Basic Accidental Death and Dismemberment**	CNS Benefits Plans Office	Phone: 865-574-1500 or toll-free 1-877-861-2255 Monday – Thursday 8:00 a.m. – 4:30 p.m. ET E-mail: benefits@cns.doe.gov
Medical	Cigna	Phone: 1-855-247-0884 www.myCigna.com
Prescription Drugs	Express Scripts	Phone: 1-800-685-8869 www.express-scripts.com
Dental	Delta Dental	Phone: 1-800-223-3104 www.deltadentaltn.com
Vision	Vision Service Plan (VSP)	Phone: 1-800-877-7195 www.vsp.com
401(k) Savings Plan	Voya Financial	Phone: 1-877-267-8692 http://cns.voya.com
Group Universal Life (GUL) Insurance	MetLife	Phone: 1-800-846-0124 www.mybenefits.metlife.com
Long-Term Care	Y-12: MetLife	Phone: 1-800-438-6388
Aon Retiree Health Exchange (Post-65 Retirees) **Retiree Health Reimbursement Account (RHRA)**	Aon	Phone: 1-844-695-8293 https://retiree.aon.com/cns For HRA account information: Phone: 1-844-695-8293 and say “HRA” or ask for “representative” to connect with an Aon Retiree Health Exchange customer service representative then warm transferred to Your Spending Account (YSA).
COBRA	Allegiance Services, Inc.	Phone: 1-800-259-2738 www.askallegiance.com
Direct Billing for Insurance Continuation	CNS (get info from accounting)	Billing Contact Billing address to mail check: CNS PO Box 2009 MS 8265 Oak Ridge, TN 37831
Where to Get Social Security and Medicare Questions Answered	Social Security and Medicare	Social Security: 1-800-772-1213 www.socialsecurity.gov Medicare: 1-800-633-4227 www.medicare.gov

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Aon Retiree Health Exchange

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Aon Retiree Health Exchange

The Company has partnered with Aon Hewitt to offer Medicare-eligible retirees and their spouses an opportunity to have one-on-one consultation with a Medicare coordinator who can help find an individual insurance plan that meets each person's needs, and supplements Medicare benefits to protect from unexpected medical costs. The Company does not offer or have any responsibility for the individual insurance policies purchased through the Aon Retiree Health Exchange.

Aon Retiree Health Exchange is a voluntary benefit, **not** subject to the Employee Retirement Income Security Act of 1974 (ERISA). The individual insurance products are not subject to ERISA because the Company has not established or maintained the individual insurance products.

Aon Retiree Health Exchange offers the following services:

- Medicare Advantage Plans, offered by private Medicare-approved insurance companies, provide the same coverage as Parts A and B and may offer additional coverage such as Prescription Drugs, Dental, and/or Vision care, as well as additional benefits that promote healthy lifestyles.
- Medicare Supplement Plans, offered by private Medicare-approved insurance companies, are designed to pay many of the costs not paid by Parts A and B. There are 11 different plans, each with different levels of coverage.
- Prescription Drug Plans (Part D), offered by private Medicare-approved insurance companies, provide coverage for prescription drugs as determined by Medicare. This coverage may be included as part of many Medicare Advantage Plans and is also available as a stand-alone policy to complete your coverage with a Medicare Supplement plan.

A Retiree Health Reimbursement Arrangement benefit will be provided to eligible CNS retirees and their eligible spouses as defined under the Retiree Health Reimbursement Arrangement (RHRA).

Eligibility

To participate in the Aon Retiree Health Exchange, the pension-eligible retiree, retiree spouse, or retiree surviving spouse **must meet all** of the following requirements:

- Be age 65 or older
- Enrolled in an employer-sponsored group medical plan immediately prior to your retirement date and the date you enroll in this Plan
- Be enrolled in Medicare Part A and Part B

The retiree spouse (unless you are a surviving spouse) will not be eligible to participate unless the retiree is enrolled in the Aon Retiree Health Exchange or the Company's retiree medical plan for eligible pre-65 retirees.

The retiree spouse or surviving spouse is not eligible for coverage in the Aon Retiree Health Exchange if he or she is covered under the Company's medical plan as an active employee or is under age 65.

Eligibility Effective Date

Aon Retiree Health Exchange eligibility effective date is the date of Medicare eligibility for those who obtain Medicare eligibility after retirement. For those who become Medicare-eligible while active, the Aon Retiree Health Exchange eligibility date is the date of retirement. The initial enrollment period for electing coverage through the Aon Retiree Health Exchange is seven months. This includes the three months prior to becoming Medicare-eligible, the month turning Medicare-eligible, and the three months following Medicare eligibility.

Example: *Participant turns age 65 on 02/15/2018. Medicare eligibility begins on 02/01/2018. Aon Retiree Health Exchange eligibility also begins on 02/01/2018. The enrollment period for Aon Retiree Health Exchange coverage begins on 11/01/2017 until 05/31/2018.*

Example: *Active employee is age 67 and begins the Intent to Retire process 90 days prior to retirement date of 07/01/2018. Aon Retiree Health Exchange eligibility begins 04/01/2018 when the Intent to Retire process starts. The enrollment period for Aon Retiree Health Exchange coverage continues through 10/31/2018. If the employee did not use Intent to Retire but a termination status was sent on the CNS file, the enrollment period would begin on 07/01/2018 as the effective date of the status on CNS file and continue through 10/31/2018.*

The Aon Retiree Health Exchange coverage start date is always the first day of the month and the coverage end date is always the last day of the month. Examples of coverage ending could be as a result of death or voluntary disenrollment.

Enrollment

Aon Retiree Health Exchange will notify eligible retirees or retiree spouses of their enrollment opportunity for coverage, generally 90 days prior to the date they turn age 65. Eligible individuals will receive the Aon Retiree Exchange Medicare Insurance Guide and Education materials, including appointment information and RHRA (if eligible) information.

Eligible enrollment periods include:

- Retirees/Spouses who attain age 65
- New retirees who are age 65 or older
- Enrolled participants and/or dependents will receive an Aon Retiree Health Exchange communication to notify recipients of any action (if applicable) they must take during Medicare's annual enrollment period (October 15 – December 7)
- Enrolled participants and/ or dependents will be notified of possible mid-year changes (Centers for Medicare and Medicaid Services (CMS) limitations apply)

Additional information regarding the enrollment period is provided below.

Aon Retiree Health Exchange will send various post cards providing the following appointment information:

- A reminder to confirm appointment 10 days prior, if not confirmed
- Confirmation of appointment date and time*
- A reminder to retiree of appointment*
- A final reminder if confirmed appointment was missed; sent Monday after the missed appointment

*If confirmed less than 7 days in advance, a notice will not be sent

The Aon Retiree Health Exchange supports enrollments in various ways:

- Telephonic (enrollment can be completed over the phone with telephonic signature; this is the preferred method of enrollment)
- Prefilled paper form (for retirees who prefer to have printed materials)
- Online enrollment (online applicable collection up to signature requirements)

The enrollment forms must be completed and returned to the Aon Retiree Health Exchange within the time period designated by Aon.

Aon Retiree Health Exchange facilitates the enrollment for the participant with the carriers, including the following:

- All paperwork (e.g., Medicare Advantage enrollment forms, HIPAA Certificates of Group Health Coverage)
- Signature requirements

Rehired Retirees

If you are rehired by the Company (or a related employer), please be sure to contact your insurance provider and the Aon Retiree Health Exchange to terminate any retiree medical or prescription drug coverage and stop premium billings.

ID Cards

Individual health plan providers are responsible for mailing ID cards. Delivery timing varies by carrier.

Paying for Premiums

If the retiree or spouse enrolls through Aon Retiree Health Exchange, each participant will be direct billed by the carrier for their individual premiums for the medical coverage they elect.

Individual carriers are responsible for billing participants for their coverage, collecting payment, posting payment to participant's account, and terminating coverage due to nonpayment of premiums.

Aon Retiree Health Exchange Customer Service

Aon Retiree Health Exchange Benefit advisors are available to provide participants with information on the following:

- Plan details during enrollment process (e.g., covered services, copays, formularies)
- Participating providers
- Medicare Parts A and B (e.g., enrollment process and timing)
- Medicare enrollment and status
- If eligible, HRA balances and reimbursements

Aon Retiree Health Exchange Advocacy Services

Aon Retiree Health Exchange provides advocacy services to participants enrolled in an individual insurance plan via the Aon Retiree Health Exchange.

Advocates are available to assist retirees in resolving issues with carriers, including:

- Covered services
- Access to care
- Claims payment
- Billing (not including premium reimbursement)

Advocates are available to provide retirees with information on:

- How plan works (e.g., referrals)
- Questions to ask carrier
- Data carrier is requesting

Advocates will work with carriers to ensure that disputed claims were processed with all pertinent facts.

Advocates will follow up with the participant to explain the carrier's response, any requests for additional information, and claims appeal procedures and will confirm that the issue has been resolved.

ⓘ Participants can contact the Aon Retiree Health Exchange at the following phone number or website:

Phone: (844) 695-8293

Website: www.retiree.aon.com/cns