

January 2012

Dear Y-12 Retiree,

Enclosed is your updated Retiree Book of Benefits, which is the Summary Plan Description for the Company's group retiree benefit plans. In some cases, a retiree's household may include a person who has not yet reached age 65 and an individual that is age 65 or older. The book conveniently provides a summary of retiree benefit plans that are currently available to all eligible retirees and their eligible dependents. You should replace this book with any prior Book of Benefits and keep it handy for reference.

The front section applies to all eligible individuals who have, or have not, reached age 65. This "All Retirees" section contains:

- About Your Benefits
- Long Term Care
- Life Coverage
- Pension Plan
- Savings Plan
- Glossary
- Administrative Information
- Contact Information

Eligible individuals under age 65 will also need the information in the "Pre-65 Retirees" section. It contains:

- Medical plan
- Prescription Drugs
- Vision Care
- Dental Plan

Eligible individuals ages 65 or older will also need the information in the "Ages 65 and Older Retirees" section. It contains:

- Medicare Supplement Plan
- Prescription Drugs
- Vision Care
- Dental Plan

If you have any questions, you may contact One Call at 865-574-1500 or 1-877-861-2255.

Table of Contents

Section	Tab
All Retirees	
About Your Benefits	1
Long Term Care	2
Life Coverage	3
Pension Plan	4
Savings Plan	5
Glossary	6
Administrative Information	7
Contact Information	8
Pre-65 Retirees	
Medical Plan	9
Prescription Drugs	10
Vision Care	11
Dental Plan	12
Ages 65 and Older Retirees	
Medicare Supplement Plan	13
Prescription Drugs	14
Vision Care	15
Dental Plan	16

Y-12 BOOK OF BENEFITS

**ABOUT YOUR
BENEFITS**

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



YOUR BOOK OF BENEFITS—ALL RETIREES

Y-12 BOOK OF BENEFITS

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

Your Retiree 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 vision and prescription drugs) and dental plans you had prior to retirement.

If you retired under the pension plan, and you and your spouse are age 65 or over and are enrolled in Medicare Part A and Part B (**but not Part D**), you may enroll in the Major Medical Medicare Supplement Plan (includes prescription drugs), and additionally the UnitedHealthcare dental/vision plan. Upon reaching age 65, your spouse may also be eligible to participate in these post-65 retiree plans.

You may continue your basic life insurance during your retirement. The amount of coverage available to you and the cost of your coverage depend on your age and your earnings just before you retired.

Your savings program and pension plan benefits work with your Social Security benefits and your personal savings to provide your retirement income.

MetLife closed the Long Term Care Plan to new enrollees as of April 30, 2011. However, coverage that was in effect may be continued.

More information about a specific benefit can be found in the section of this book relating to that benefit. General information for pre and/or post 65 retiree benefits is found in the sections About Your Benefits, Administrative Information, and Contact Information.

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

The Patient Protection and Affordable Care Act (PPACA) (Affordable Care Act) is principally the federal healthcare reform statute signed into law in March 2010. Certain retiree only health plans, dental, and vision plans are not subject to the Affordable Care Act. Unlike the other Company sponsored health plans, the Company sponsored health plans for over age 65 retirees are not subject to the Affordable Care Act. The health plans for over age 65 retirees (The Group Welfare Benefit Plan for Retirees of Certain Employers of the U. S. Department of Energy Facilities at Oak Ridge, Tennessee) are separate plans. The Summary Plan Description for all retiree plans – under age 65 and over age 65 retirees– are intentionally included in this book for the convenience of participants within households who need information for both pre- and post-65 retiree benefits. Pre-65 retiree health benefits and post-65 retiree health benefits have been grouped separately and noted accordingly.

Eligibility

Under Age 65 Retiree

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

- Medical (including prescription drugs and vision care)
- Dental
- Long Term Care Insurance (provided you were enrolled by April 30, 2011, which is when new enrollments stopped)
- Basic Life Insurance (provided you had this coverage immediately prior to retirement)
- Supplemental Life Insurance (provided you had this coverage immediately prior to retirement and you were a salaried employee who retired prior to February 1, 2001 or an hourly employee who retired prior to August 1, 2001)
- Pension Plan
- Savings Program (provided you have a deferred account balance).

Over Age 65 Retiree

If you are over age 65 and are retired under the Company's pension plan, you are eligible for the following benefits:

- Major Medical Medicare Supplement Plan (provided you are enrolled in Medicare Part A and Part B, **but not Part D**, and had employer-provided medical coverage immediately prior to age 65).

If you enroll in the medical plan, you will automatically be enrolled in the prescription drug coverage. However, the Major Medical Medicare Supplement Plan and the prescription coverage are not available if you have Medicare Part D prescription drug coverage.

- Dental and Vision combined
- Long Term Care (provided you were enrolled by April 30, 2011, which is when new enrollments stopped)
- Basic Life Insurance (provided you had this coverage immediately prior to retirement)
- Supplemental Life Insurance (provided you had this coverage immediately prior to retirement and you were a salaried employee who retired prior to February 1, 2001, or an hourly employee who retired prior to August 1, 2001)
- Pension Plan
- Savings Program (provided you have a deferred account balance).

If you retire under the pension plan, you and your Eligible Dependents may be eligible for retiree health benefits. If you are not eligible to retire under the pension plan, you are not eligible for retiree medical, prescription drugs, dental, and vision. Eligibility for the pension plan is as noted here and in

the Pension section of this book. The pension plan provides a choice of retirement dates. You can retire with a full pension benefit at age 65 or over. You can also receive a full pension benefit when you retire at age 62 or older, if you have 10 years of Company Service, or when your age and years of Company Service equal 85 or more. You can receive a reduced benefit as early as age 50, if you have at least 10 years of Company Service.

Dependents

When you retire, you may enroll your spouse and other Eligible Dependents for coverage, according to the guidelines listed below.

Medical, Prescription Drugs, Vision and Dental

Your spouse is under age 65 and you are over age 65 —

Your spouse and other Eligible Dependents may continue the medical plan (including prescription drugs and vision care) and the dental plan until your spouse reaches age 65. You must be covered in the plan in order for a spouse or child to be covered as your dependent in the medical or dental plan. 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.

Your spouse is over age 65 and you are under age 65 —

Your spouse and other Eligible Dependents may continue the medical plan (including prescription drugs and vision care) and the dental plan until you reach age 65. You must be covered in the plan in order for a spouse or child to be covered as your dependent in the medical or dental plan. Your spouse must be enrolled in Medicare Part A and Part B (**but not Part D**). Medicare will pay eligible medical expenses as primary payor for your spouse. 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.

Your spouse is over age 65 and you are over age 65 —

The following rules apply to the Major Medical Medicare Supplement Plan (medical and prescription drugs):

- You and your spouse may enroll if both of you are enrolled in Medicare Part A and Part B (**but not Part D**).
- You can enroll only yourself, or yourself and your spouse, when you or your spouse first become eligible at retirement. Dependents acquired after retirement are not eligible.
- You and your spouse must have been covered under the Company's plan, or as an employee in another employer's active medical plan, when you reach age 65. Proof of continuous coverage since your retirement is required.
- If you cancel coverage on yourself, your spouse's coverage will also be canceled. You cannot re-enroll at a later date.
- If you or your spouse enrolls in a Medicare Part D prescription drug plan, your Company coverage will be canceled and you cannot enroll at a later time.

- You can continue Company coverage for yourself but your spouse cannot be covered if you are not enrolled.
- A covered spouse can continue coverage at the Retiree's death under single only coverage. A dependent that is later acquired is not eligible.
- A spouse who is also an active Employee or Retiree has individual eligibility rights.

The following rules apply to the dental plan (dental and vision) for over age 65 retirees and eligible spouse:

- All Retirees and surviving spouses may enroll, without regard to having coverage status under the Major Medical Medicare Supplement Plan.
- A Retiree may elect single only coverage, or dual coverage which also covers the spouse. A spouse cannot enroll unless the Retiree is covered.
- A surviving spouse may only enroll under single coverage.
- The Company does not contribute to the cost of coverage.
- You must enroll when first eligible and retain continuous dental/vision coverage or you will lose coverage and cannot later re-enroll.

Long Term Care

Your spouse is under or over age 65 —

The Long Term Care Plan closed to new enrollees April 30, 2011. However, a retiree, spouse, or surviving spouse may continue coverage as long as premiums are paid on time, although premiums can be increased.

Disabled Child

Prior to a retiree and retiree spouse reaching age 65, medical (including prescription drugs and vision care) and dental coverage may be continued for an unmarried natural or adopted child who is incapable of self-support due to a physical or mental handicap that began before he or she reached the maximum age for coverage under the plan, provided you submit proof of the child's disability to the insurance company within 30 days after the child reaches the maximum age. Additional proof of the child's continuing disability will be required periodically. The current maximum age under the plan is age 26 – except, age 24 for under age 65 dental and for situations under qualified court/medical support orders that qualifies a person in accordance with plan eligibility rules. When your dependents are no longer eligible for health care coverage, they may be eligible to continue coverage for up to 36 months under COBRA. Refer to the "Administrative Information" section for information on COBRA.

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

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

Eligibility ... At a Glance			
Benefit Plan	Who Is Eligible		
	Retirees Only (Regardless of Age)	Retirees and Dependents Under Age 65	Retirees and Spouse Over Age 65
Medical (including Prescription Drugs and Vision Care)		X	
Major Medical Medicare Supplement Plan (including Prescription Drugs) ¹			X
Dental ²		X	X
Long Term Care ³		X	X
Basic and Supplemental Life Insurance ⁴	X		
Savings Program ⁵	X		
Pension Plan ⁶	X		

1 Must be enrolled in Medicare Part A and Part B, but not Part D, prescription drug plan.

2 Over Age 65 plan includes dental and vision coverage. The dental plans for Retirees and Eligible Dependents under age 65 and the dental plan for Retirees and spouses over age 65 are separate and unique plans, as described in the section of this book.

3 The Long Term Care Plan stopped new enrollments after April 2011.

4 You are eligible for basic life insurance only if you had this coverage immediately prior to retirement. You are eligible for supplemental life insurance only if you had this coverage immediately prior to retirement and you were a salaried employee who retired prior to 2-1-2001 or an hourly employee who retired prior to 8-1-2001.

5 You are eligible to continue your participation in the savings program only if you have a deferred balance; you may not make contributions to the savings program after retirement.

6 Your participation in the Pension Plan will automatically continue until you die (or until your survivor dies if you have elected a form of payment that provides a survivor benefit).

Enrollment

Under Age 65 Retiree and Dependents

Medical Coverage (including Prescription Drugs and Vision) and Dental Coverage

- You may continue medical and dental coverage for yourself, your spouse, and eligible children.
- If you do not continue coverage at retirement you will not be able to enroll at a later date.

- If you are under age 65 and your spouse is over age 65, you may cover your spouse under your plan. Your spouse must be enrolled in Medicare Part A and Part B (**but not Part D**).
- If you marry after your retirement effective date, you cannot add your newly acquired spouse or children to your medical or dental retiree coverage, nor will they be eligible at open enrollment.
- A surviving spouse may continue his/her medical and dental coverage if he/she gets married, but the newly acquired spouse or children cannot be added.
- If you are under age 65 and have medical or dental coverage when you retire, but elect to cancel the coverage at retirement because of coverage under another employer's active employee group plan, you may later enroll in the Company medical or dental plan if you lose coverage under that employer's plan. You must show proof of loss of coverage and enroll within 30 days of the date of coverage loss.
- A spouse or child cannot be covered under the medical or dental plan unless the Retiree is covered.
- You and your spouse must have continuous medical coverage under the Company plan or in another employer's active employee plan to be eligible to participate in the Major Medical Medicare Supplement Plan upon reaching age 65. You must show proof of loss of coverage and enroll within 30 days of the date of coverage loss.
- Retirees and surviving spouses under age 65 may switch between any medical or dental plan options available during the annual Open Enrollment or delete dependents. However, those individuals who waive coverage when first eligible will not be able to enroll at a later date.
- If you move outside a point-of-service network, you must switch to the Indemnity Plan.

Enrollment forms are available from the Benefit Plans Office. You must enroll for medical and dental and continuation of your basic life insurance within 30 days of retirement.

Over Age 65 Retiree and Spouse

Medical Coverage (including Prescription Drugs) and Dental Coverage (including Vision)

- You and your spouse must be covered for Medicare Part A and Part B (**but not Part D prescription drug coverage**) in order to be eligible for the Major Medical Medicare Supplement Plan.
- If you or your spouse enrolls in Medicare Part D prescription drug coverage, you will be dropped from the Major Medical Medicare Supplement Plan and cannot ever re-enroll again.
- You must enroll in the Major Medical Medicare Supplement Plan within 30 days of your 65th birthday, or within 30 days of your retirement date if you retire after age 65. Enrollment forms are available from the Benefit Plans Office. To enroll, you must elect coverage for yourself only or for you and your eligible spouse. You must authorize the Company to deduct your share of the cost of the coverage you elect from your pension payments. If you fail to give this timely authorization on the enrollment form, neither you nor your spouse will be covered.

- If you or your surviving spouse cancels dental/vision coverage or the Major Medical Medicare Supplement Plan, or if your medical coverage is dropped because you are covered under the Medicare Part D prescription drug plan, you or your surviving spouse cannot re-enroll at a later time.
- An eligible spouse cannot be covered under the medical or dental/vision plan unless the Retiree is covered. This applies if you are a Retiree over or under age 65.
- A surviving spouse may continue medical or dental/vision coverage upon remarriage but cannot add the new spouse. This applies to a surviving spouse of a Retiree regardless of the age at remarriage.
- A Retiree or surviving spouse may enroll in the dental/vision plan, or the medical plan, or both.

Enrollment forms are available from the Benefit Plans Office. You must enroll for medical and dental and continuation of your basic life insurance within 30 days of retirement.

When You May Change Your Elections

There are limited circumstances under which you may change your benefit elections. You may change most savings program elections at any time by contacting Participant Services. You can drop your pre-65 or post-65 retiree medical, or pre-65 retiree dental or group life coverage at any time by signing a cancellation form. In addition, you may drop the UnitedHealthcare dental/vision at the end of the plan year in June. If you drop a retiree benefit plan, you may not later re-enroll. Cancellation forms are available from the Benefit Plans Office.

The term "Retiree" is defined in the Glossary.

Changes at Other Times

Qualifying Life Events

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 or when certain significant changes in cost or in coverage occur.

Examples of a qualifying life event may include:

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

- a change in health coverage due to your spouse's employment
- a "special enrollment period" under the group health plan as required by law
- a qualified medical child support order that may require your child to be covered under the group medical and/or dental plan
- you or your spouse or child becomes eligible (or loses eligibility) for Medicare or Medicaid
- you move outside a point-of-service network – you must change coverage to the Indemnity Plan
- involuntary loss of other group health plan coverage.

You are obligated to submit proof of dependent status for a child or spouse. Documents include a birth certificate, social security card, marriage certificate, tax filings, and any other documents needed to prove eligibility.

Enrollment forms must be completed and submitted to the Benefit Plans Office within 30 calendar days of any qualifying life event. Forms must be received within 30 calendar days in order to be accepted. This includes the birth of a newborn. You may enroll a newborn in MetLife or Delta Dental plans anytime up to age one.

Birth of a child under Tennessee law:

A newborn of a participant is automatically covered under the medical plan for 31 days.

Enrollment forms must be completed and submitted to the Benefit Plans Office within 30 days of the end of the state mandated coverage to continue to cover the newborn. Coverage is effective the first day of the first calendar month after the completed enrollment forms are submitted to the Benefits Plan Office. Enrollment forms must be submitted to the Benefit Plans Office within 30 days of the date of birth, to cover the newborn at the end of the state mandated coverage.

How Changes Affect Your Benefits

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.

Notify the Social Security Administration of any name changes.

Change your benefit elections within 30 days of your marriage. If you remarry after retirement, you cannot add the resulting spouse or children to your medical or dental coverage.

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

Make any beneficiary change to your life insurance.

Steps to Take If You Get Divorced

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.

Notify the Social Security Administration of any name changes.

You must change your benefit elections within 30 days of the date your divorce is final. A copy of the divorce decree is required when you drop coverage for your ex-spouse. You or your ex-spouse has 60 days to notify the Benefit Plans Office in order to obtain COBRA benefits. Refer to the "Administrative Information" section for more information on continuation of coverage.

Add your Eligible Dependents to your medical and dental coverage if a court establishes that you must provide coverage for dependent children.

Update your life insurance and savings program beneficiary records. Life insurance forms are available from the Benefit Plans Office. You can request a savings program beneficiary form by calling the Savings Plan Participant Services information line.

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

Steps To Take If You Are Expecting or Adopting a Child

If You or Your Spouse is Pregnant

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

In-Network Benefits – CIGNA Plan/Network Only

Schedule prenatal appointments. You will pay a physician office copayment only at the initial visit under the point-of-service plans.

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

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

Birth of a child under Tennessee Law:

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

Enrollment forms must be submitted to the Benefit Plans Office within 30 days of the date of birth, to cover the newborn beginning at the end of the state mandated coverage.

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

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

Before the fourth month of pregnancy, you should call CIGNA Member Services to precertify your maternity admission. Refer to the back of your identification card for contact information.

If You Adopt a Child

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

When Your Child Arrives

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

At Death

Upon your death, a family member should notify the Benefit Plans Office. Benefit Plans will assist your family members in completing the appropriate forms.

If You Lose a Spouse or Child

When you lose a spouse or child, you should notify the Benefit Plans Office.

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

Review your beneficiary elections for life insurance and the savings program.

If You or Your Spouse Are Admitted to a Long Term Care Facility

When you or your spouse are admitted to a long term care facility, contact the Benefit Plans Office. Changes in your medical or prescription drug plan may be necessary.

What Happens to Your Benefits If You Die

Here is what happens to your benefits if you die:

Medical (Including Prescription Drugs and Vision Care) and Dental

If your spouse is under age 65, he or she may continue medical coverage (including prescription drugs and vision care) and/or dental coverage by paying the appropriate premiums (full premium cost if you had less than 10 years of full-time service when you retired; retiree share of premium cost if you had more than 10 years of full-time service when you retired).

Your spouse can continue this coverage until he or she becomes age 65. At age 65, your surviving spouse may transfer to the Major Medical Medicare Supplement Plan.

If, when you die, you do not have a spouse but have other Eligible Dependents, your Eligible Dependents may continue their coverage through COBRA. Refer to the "Administrative Information" section for more information on COBRA.

Major Medical Medicare Supplement Plan

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

Long Term Care

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

Life Insurance

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

Pension Plan

Your surviving spouse/beneficiary will receive any survivor benefit. The Benefit Plans Office will contact your beneficiary to provide information about any plan benefits that might be payable.

Savings Program

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

When Coverage Begins

Your coverage will begin according to the following chart, provided you meet the plan's eligibility requirements. With the exception of the Major Medical Medicare Supplement Plan, any coverage you elect for your Eligible Dependents will begin on the same day your coverage begins. Major Medical Medicare Supplement Plan coverage for your enrolled spouse will begin on the first of the month following your spouse's 65th birthday.

Benefit Plan	Your Coverage Will Begin . . .
Medical (including Prescription Drugs and Vision Care)	Retiree or spouse under age 65, Retiree under age 65 with spouse over age 65: If you had coverage immediately prior to retirement, coverage continues at retirement provided you elected to continue your coverage. If you did not have coverage at retirement, your coverage will begin on the day you provide proof of prior medical coverage under another employer's active plan.
Major Medical Medicare Supplement Plan	Retiree and spouse over age 65: Coverage begins on the first day of the month after you retire (or on your retirement date if it falls on the first of the month) or the first day of the month following your 65th birthday if you are under age 65 on your retirement date, provided you enroll within 30 days of becoming eligible. If you enroll more than 30 days after you first become eligible, or during a special enrollment period, your coverage will be effective on the first of the month after 30 days from date of enrollment. Prior employer-provided medical coverage is required.
Dental – MetLife or Delta Dental	Retiree or spouse under age 65, Retiree under age 65 with spouse over age 65: If you had coverage immediately prior to retirement, coverage continues at retirement provided you elected to continue your coverage. If you did not have coverage prior to retirement, your coverage will begin on the day you provide proof of loss of prior dental coverage under another employer's active plan.
Dental/Vision – UnitedHealthcare	Retiree or spouse over age 65: If you had prior employer-provided dental coverage immediately prior to retirement, you must enroll within 30 days of retirement, and the plan's pre-existing condition waiting period will be waived. If you did not have prior employer-provided dental coverage immediately prior to retirement, you must enroll within 30 days of retirement, and the pre-existing condition waiting period must be satisfied. Coverage begins on the first day of the month after you retire (or on your retirement date if it falls on the first of the month) or the first day of the month following your 65th birthday if you are under age 65 on your retirement date, provided you enroll within 30 days of becoming eligible. If you enroll more than 30 days after you first become eligible, or during a special enrollment period, your coverage will be effective on the first of the month after 30 days from date of enrollment.
Long Term Care	Retiree and spouse: With a statement of health, coverage begins on the first of the month following the date the insurance company approves your request for enrollment. (New enrollments stopped on April 30, 2011.)
Basic Life Insurance	Retiree only: If you had basic life insurance coverage immediately prior to retirement, your full coverage will continue until you are age 65 provided you elected to continue this coverage at retirement. At age 65, a reduced amount of coverage continues.
Supplemental Life Insurance	Retiree only: If you had supplemental life insurance coverage immediately prior to retirement and you were a salaried employee who retired prior to 2-1-2001 or an hourly employee who retired prior to 8-1-2001, your full coverage will continue until you are age 65 provided you elected to continue this coverage at retirement. Otherwise, supplemental life insurance ends on the date your employment terminates.
Savings Program	Retiree only: Participation continues if you chose to defer receiving your account when you retired. You may not make contributions to the savings program on or after your retirement date.
Pension Plan	Retiree only: Plan benefits begin the first of the month after you retire unless you chose to defer your benefit. Employees who retire with less than full pension benefits can defer their benefit until they are eligible for a full benefit.

If you change your elections because of a qualifying life event, the changes will be effective on the date of the qualifying life event or as stated by individual plan rules, provided you turn in a change form to the Benefit Plans Office within 30 days of the event.

Paying for Your Benefits

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

Benefit Plan	The Company pays the full cost of coverage	You share the cost of coverage with the Company through	You pay the full cost of coverage through
Medical (including Prescription Drugs and Vision Care)			
If you had at least 10 years of full-time service when you retired		X	
If you had less than 10 years of full-time service when you retired			X
Major Medical Medicare Supplement Plan			
If you had at least 10 years of full-time service when you retired		X	
If you had less than 10 years of full-time service when you retired			X
Dental (under age 65)			
If you had at least 10 years of full-time service when you retired		X	
If you had less than 10 years of full-time service when you retired			X
Dental/Vision (over age 65)			X
Long Term Care			X
Basic Life Insurance			
Full amount (before age 65)		X	
Reduced amount (at age 65 and over)	X		
Supplemental Life Insurance			
Full amount (before age 65)			X
Reduced amount (at age 65 and over – if eligible)	X		
Pension Plan	X		
Savings Plan (until retirement)		X	

When Coverage Ends

Coverage will end on the earliest of the following dates:

- the last day of the period for which your last contribution was made (if you fail to make any required contribution)
- when you die
- the date the plan is terminated.

ⓘ If you have elected a joint-survivor form of payment, pension plan and savings program benefit payments to your named survivor will continue after your death.

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

- pension benefits will end the month of your death
- savings program benefits will be paid to your beneficiary.

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

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

See the “Administrative Information” section for more information about continuing coverage under COBRA and other operations of the retiree plans.

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LONG TERM CARE



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Closed to New Enrollees effective April 30, 2011

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

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

For questions or service contact:

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

Member Service: 1-800-438-6388

Long Term Care Benefits:

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

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

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

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

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

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

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

How the Plan Works

Eligibility

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

These eligible family members could also request enrollment:

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

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

Enrollment – (Prior to April 30, 2011)

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

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

Retirees and their families had to complete a statement of health at enrollment.

Individuals enrolled in the plan as of April 30, 2011 can continue coverage. Thereafter, MetLife will not accept new enrollments.

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

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

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

When Coverage Begins

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

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

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

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

Premium Payments

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

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

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

Changes in Premiums

When you enroll, your premiums will be based on your age as of the time your coverage becomes effective. Except for changes in premium rates for all enrollees, which may occur from time to time,

your premiums remain the same as you get older. If you increase your coverage, your contributions for the additional coverage will be based on your age at the time the change is effective.

No Premiums While Benefits are Paid

You will not be required to pay premiums during any period in which you are receiving benefits. Premiums are waived as of the first day of the month following the date you begin receiving benefits. Your premiums will resume as of the first of the month on or after the date your eligibility for benefits ceases. If you die while covered by the plan, all or a portion of your premiums may be returned to your estate.

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

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

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

If You Stop Paying Premiums

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

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

When Benefits are Paid

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

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

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

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

Waiting Period

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

What the Plan Pays

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

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

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

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

Coordination of Benefits

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

- any federal, state or other government health care plan or law (except Medicaid or Medicare)
- any state or federal Workers' Compensation law
- any employer's liability or occupational disease law

- any motor vehicle no-fault law
 - any other plan which any employer contributes to or sponsors.
-

Covered Services

Initial Care Planning Visit

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

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

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

Nursing Home Care

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

- room and board
- custodial care services.

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

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

Assisted Living Facility Services

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

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

Home Care Services

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

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

It also includes:

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

Respite Care Services

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

Transition Benefit

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

Claiming Benefits Once You Are Authorized

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

To File a Claim

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

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

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

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

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

What the Plan Does Not Cover

This plan does not provide benefits for the following:

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

Concurrent Review

While you receive covered services, MetLife reviews your condition to determine whether the authorization for benefits can be continued. This review may require that MetLife examine your medical records or request additional information from your doctor or other care provider. You and your doctor will be notified if MetLife made a determination to change your benefit eligibility.

Changing Your Selections

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

Inflation Increases

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

Reinstatement

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

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

When Coverage Ends

Your coverage under the plan ends on the earliest of:

- when you reach your total lifetime limit
- at your death
- on the last day of the month your cancellation notice is received by MetLife (you may be eligible for coverage under the non-forfeiture feature as previously described)
- if you fail to pay your premiums within 35 days after MetLife sends a written notice of termination of your coverage as stated in the grace period (you may be eligible for coverage under the non-forfeiture feature as previously described)
- the date the group policy ends, subject to the provisions in "Continuation Coverage"

- the date your employment with the group policyholder terminates, subject to the provisions in “Continuation Coverage”
- if you are an eligible employee or eligible family member of an eligible employee, the date the eligible employee’s employment with the group policyholder terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff or similar circumstances, subject to the provisions in “Continuation Coverage.”

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

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

Continuation Coverage

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

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

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

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

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

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

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

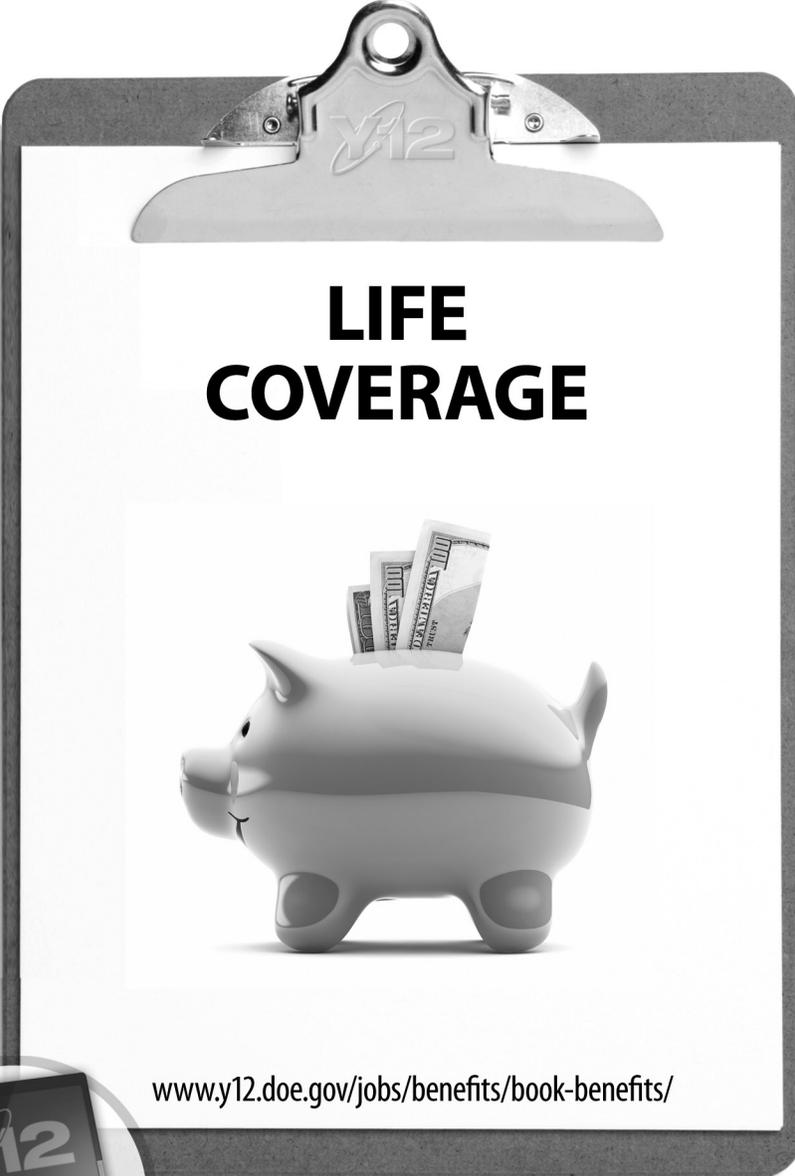
- is effective on the day following your termination of coverage
- provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy
- calculates premium based on your age at inception of coverage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

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

Certificate of Insurance

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

Y-12 BOOK OF BENEFITS



**LIFE
COVERAGE**



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



YOUR BOOK OF BENEFITS—ALL RETIREES

Y-12 BOOK OF BENEFITS

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

Basic and Supplemental Life Insurance Coverage:

- Provides security for your family through basic life coverage.

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

- Added protection could be elected through supplemental life insurance.

While you were an active employee, you may have elected additional life insurance coverage to supplement your basic life coverage in case of your death from any cause. The supplemental coverage of at least one times your Pay would have been available on an optional basis at your cost.

What happens to your benefits when?

For more information about what happens to your life benefits when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” section. Information about the administration of your life insurance benefits can be found in the section entitled “Administrative Information.”

“Pay” is defined in the Glossary.

Basic Life Insurance

While you were actively employed, basic life insurance of at least two times your Pay was available on an optional contributory basis. This coverage pays benefits to your beneficiary in the event of your death from any cause while you are insured, if you continue this coverage at retirement. When you reach age 65, your life insurance will be reduced.

Benefit Amounts

If You Continue Active Service – At Age 65 and After

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

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

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

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

During Retirement – At Age 65 and After

If you retire at age 65 or later, a reduced amount of basic life insurance coverage will continue for the rest of your life, provided you had basic life insurance coverage for at least one year immediately preceding retirement. This reduced coverage is currently provided at no cost to you. The amount of basic life insurance will be reduced as follows:

- If you had basic life insurance coverage for at least one year but less than five years immediately preceding your retirement, your reduced insurance will be \$625.
- If you had basic life insurance coverage for at least five years immediately preceding your retirement, the amount of your reduced insurance will be the greater of:
 - 1% of your basic life insurance amount just before retirement times your years of service (including any fraction of a year), plus \$500, with a minimum of \$2,500 or 25% of your basic life insurance just before retirement, up to a maximum of \$10,000; or
 - 20% of your basic life insurance just before retirement.

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

Any difference between what was covered during active service and the basic life insurance reduced amount can be converted to an individual policy within 30 days from the date benefits were reduced by contacting MetLife.

During Retirement – Before Age 65

If you retire before age 65, are eligible for an immediate pension benefit, and had basic life insurance coverage for at least one year immediately preceding retirement, you had one of the following options:

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

Supplemental Life Insurance

While you were an active employee, supplemental life insurance was available on an optional contributory basis. This option while you were an active employee provided coverage in addition to basic life insurance coverage in the amount of at least one times your Pay. This coverage provides added protection to your beneficiary in the event of your death from any cause while you are insured. You must have had basic life insurance in order to elect this coverage.

In addition, as an active employee, you had an option to purchase supplemental life insurance coverage for your spouse (up to age 70) and your eligible dependent children from 6 months to 19 years (up to age 24 years if a full-time student). This option allowed you to purchase \$10,000 to \$50,000 in increments of \$10,000 for your spouse and \$10,000 for each dependent child.

Eligible spouse and dependent coverage ends when an active employee terminates employment. It also ends at retirement, when an individual goes on long-term disability, upon divorce, or when a dependent is no longer eligible.

The “Conversion Privileges” at the end of this section outlines the option to convert to an individual policy.

Benefit Amounts

During Retirement – Before Age 65

If you retired before age 65, prior to February 1, 2001, for salaried employees or prior to August 1, 2001, for hourly employees, and you were eligible for an immediate pension benefit and you had supplemental life insurance coverage for at least one year immediately preceding retirement, you were eligible to continue coverage under the following options:

- continue your supplemental life insurance amount until age 65 by continuing to make your regular premium payments. After age 65, any difference between what was covered during active service and the reduced amount can be converted to an individual policy within 30 days from the date benefits were reduced by contacting MetLife; or
- take the reduced supplemental life insurance amount immediately at no cost to you.

During Retirement – At Age 65 and After

If you retired at age 65, or later prior to February 1, 2001 for salaried employees or prior to August 1, 2001 for hourly employees, a reduced amount of supplemental life insurance coverage will continue for the rest of your life at no cost to you. The amount of coverage is based on your years of plan participation, as shown below:

- If you had less than one year of prior participation, the benefit amount is \$0.
- If you had at least one year, but less than five years' participation, the benefits amount is \$312.
- 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 else
 - (b) 10% of your supplemental life insurance amount just before retirement.

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 what was covered during active service and the reduced amount can be converted to an individual policy within 30 days from the date benefits were reduced by contacting MetLife.

If You Continue Active Service – At Age 65 and After

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

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

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

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

During Retirement – At Any Age

Your supplemental life insurance coverage terminates unless you convert it to an individual policy. Refer to "Conversion Privileges" at the end of this section if you would like to convert to an individual policy. (This termination applies to salaried employees retiring after February 1, 2001, and to hourly employees retiring after August 1, 2001).

For salaried employees retiring after February 1, 2001, and hourly employees retiring after August 1, 2001, your supplemental life insurance terminates unless you convert it to an individual policy within 30 days from retirement. You may contact MetLife to convert the coverage. Refer to "Conversion Privileges" at the end of this section.

Living Benefit

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

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

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

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

Payment of Benefits

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

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

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

Naming Your Beneficiary

You may name anyone as your beneficiary and you may change your beneficiary designation at any time by completing the appropriate form available from the Benefit Plans Office. Forms are also available on the Forms web page. The beneficiary you name for basic life insurance benefits will automatically be your beneficiary for supplemental life. If you do not designate a beneficiary, basic and supplemental life insurance benefits will be paid to your estate.

Tax Consequences

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

Claiming Benefits

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

When Coverage Ends

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

- when you die
- the date you are no longer considered eligible and (if eligible) you elect not to continue coverage
- the last day of the month for which your last contribution was made if you fail to make any required contribution
- the date the plan is terminated.

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

Conversion Privileges

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

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

If your life insurance coverages terminate, you may contact the insurance company to request a conversion form.



**PENSION
PLAN**



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



YOUR BOOK OF BENEFITS—ALL RETIREES

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

The Pension Plan

- **Provides a benefit which adds to your other retirement income**

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

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

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

What happens to your pension benefits when...

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

Receiving Benefit Payments

If You Are Receiving Benefit Payments

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

If Your Benefit Has Not Started

If you retired before age 65, you may elect to start your benefit at any time, with 30 days notice to the Benefit Plans Office.

If you have retired, your plan benefits will begin no later than the first of the month after you reach age 70-1/2.

Pension Benefit Amount

The amount of your pension benefit is determined when you retire based on the plan's formula (and your creditable 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.

Normal Forms of Payment

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

For Married Employees

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

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

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

For Single Employees

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

Optional Forms of Payment

If you wish, you may choose an optional form of payment when you elect to receive your benefits. If you are married, you will need your spouse's written consent, witnessed by a notary public or a representative of the Plan Administrator, in order to elect a form of payment other than the 50% joint and survivor benefit.

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

Life Annuity Option for Married Employees

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

50% Survivor Benefit Option

You can elect a reduced pension in order to provide continuing income to an unmarried dependent child under age 23 or a dependent parent, but not to both dependent children and parents.

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

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

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

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

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

75% Surviving Spouse Option

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

For a table of 75% Surviving Spouse reduction factors, contact the Benefit Plans office.

Level Income Option

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

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

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

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

Applying for Benefits

Upon your request, the Benefit Plans Office will provide you with the necessary information and instructions for receiving benefits and completing payment forms.

In case of your death, your spouse, other beneficiary or personal representative should notify the Benefit Plans Office and request information about any plan benefits that might be payable as a result of your death.

If the appropriate forms are not completed and submitted, or if any information requested by the Benefit Plans Office is not provided, benefits will be delayed.

Social Security

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

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

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

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

Re-employment After Retirement

If you have been receiving pension payments and return to work at the Company, your pension plan benefits will be suspended during your period of re-employment until you reach age 70-1/2 — when you may choose to begin your benefits.

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

Other Important Information

Withholding taxes

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

Direct Deposit of Payments

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

Change of Address

It is important that you notify the Company of any change in your address 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, including claims information, can be found in the section entitled "Administrative Information."

Y-12 BOOK OF BENEFITS



SAVINGS PLAN



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



YOUR BOOK OF BENEFITS—ALL RETIREES

Y-12 BOOK OF BENEFITS

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

The Savings Plan

Lets your account grow tax-deferred

Your existing account balance is tax-deferred, which means you will not pay federal income taxes on this amount until you take the money out of the Savings Plan, under IRS rules at that time.

Provides 24-hour access to account information

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

What happens to your benefits when...

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

Your Savings Plan Account

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

The Savings Plan Information Sources

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

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

To reach Participant Services

In the United States:
1-800-777-4015

International:
1-512-344-3000

Telecommunications Device for the Deaf:
1-877-852-4289

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

Participant Services Representatives:
8 a.m. – 10 p.m. Eastern time, Monday–Friday (except on days when the New York Stock Exchange is closed)

Internet Access:
To access the Savings Plan via the Internet, please use the following URL:
<https://www.401kaccess.com>

When you call Participant Services, you will need your PIN and a touch-tone telephone to use the voice response unit. If you do not have a touch-tone telephone, call Participant Services and speak to a customer service representative.

You received your PIN and web password with your activation kit. You may change your PIN and password to personalize it at any time. Your PIN and password are confidential and should be kept in a safe place. If you lose your PIN or password, you may call Participant Services or log on to the Internet site and a copy of the number will be sent to your home. You may also request a password reminder from the Internet site to be mailed or emailed to you, provided you have setup your email preference. For security reasons, you can never get your PIN over the phone. If you deferred distribution of your Savings Plan account value, your savings will remain invested in the Savings funds as you direct.

You may not defer payment beyond December 31 of the year in which you reach age 70 1/2 or the date you retire if you worked for the Company beyond age 70 1/2.

Accessing the System

Log on to the Internet by typing <https://www.401kaccess.com>.

To log on to your account, simply go to the log-in screen, press log-in, enter your account number and your password, and press submit.

Working With the Plan

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

Your Investment Options

You can transfer existing balances—in 1% increments—among the investment options up to 12 times a year, and in any event at least once per quarter. Transfers completed before 4:00 p.m. Eastern time will be effective that day, assuming it is a business day and the New York Stock Exchange is open; otherwise, changes will be effective the next business and market trading day. Confirmation of your transaction will be mailed within two business days.

Any investment involves some degree of financial risk. Actual investment results for your Savings Plan contributions will vary depending on the fund or funds in which they are invested. Investment information can be found online at www.401kaccess.com.

Detailed information about each of the funds currently available under the Savings Plan is provided in the chart on the following pages. This data is provided for informational purposes only. Before making any investment decision, you should also review the fund prospectuses and fact sheets.

Neither the Company, the Savings Plan nor the Retirement and Savings Plan Committee makes any representation that the past performance of these funds is a guarantee or indicative of their future performance. The Retirement and Savings Plan Committee may change the funds at any time. The funds are valued at market daily. The funds are not protected by any federal or state deposit insurance program.

Investment Earnings

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

Investment Option Summary

Transaction Processing

The transactions you request through Participant Services will ordinarily be processed within the times specified in this book of benefits. However, in certain circumstances, such as technical problems with the Internet site or telephone service, you may experience difficulty in making your request, or your transaction may be delayed. Please remember that the information line is no more than a telephone line.

Telephone service can be interrupted from time to time and, further, a high volume of telephone calls can overload the system and prevent calls from being answered. Transactions may also be delayed. For example, if market conditions require a daily volume limit on trades in an asset, there is suspension in trading of an asset, or in the event of a major market or systems disruption. You will be informed if a transaction is not completed on the day requested, and the transaction will be completed as soon as administratively possible thereafter, based on the unit prices in effect when the transaction is completed.

Reward vs. Risk

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

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

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

- When will you need the money in your accounts?

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

- What are your investment goals?

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

- Are your investments sufficiently diversified?

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

Investment Option Summary

Fund Name	Investment Objectives	Investment Strategy
Stable Value Fund (Commingled Fund) (most conservative)	Maximum safety of principal, stable income and liquidity.	To invest in investment contracts and high quality intermediate duration fixed income securities and money market instruments.
Intermediate-Term Investment Grade Bond Fund (MBFIX) (more conservative)	Conservation of capital with attractive total returns.	To invest in undervalued investment grade securities in the fixed income market, with an average portfolio maturity ranging from 3 to 7 years.
American Balanced Fund (RLBFX) (conservative to moderate)	Appreciation of capital, current income and long-term capital growth.	To invest in a diversified portfolio of assets including stocks, bonds, and other fixed income securities, responding to market changes by shifting its asset allocation.

Investment Option Summary (cont.)

Fund Name	Fund Holdings	Factors Affecting Performance	Fund Manager
Stable Value Fund (Commingled Fund) (most conservative)	High quality investment contracts issued by insurance companies, banks, or other financial institutions. High quality short-term money market instruments to provide additional diversification and liquidity.	Lower risk of principal; however, higher inflation risk, because its expected rate of return is usually lower than the other options and may not outpace inflation.	Invesco Advisers, Inc.
Intermediate-Term Investment Grade Bond Fund (MBFIX) (more conservative)	U.S. Treasury bonds U.S. Agency bonds Mortgage-backed bonds Corporate bonds	Inflation expectations and interest rate changes affect performance. Long-term decisions made by the fund manager and the nature of the fund's investments should be expected to provide higher returns and higher risks as compared to the Stable Value Fund.	Wells Fargo Funds Montgomery Asset Management
American Balanced Fund (RLBFX) (conservative to moderate)	Stocks in key sectors of the U.S. economy Small amount of non-U.S. securities High quality corporate and government bonds.	Subject to stock market risk and volatility. Bond values tend to vary inversely with interest rates. Long-term decisions made by the fund manager and the nature of the fund's investments may provide higher returns and higher risks as compared to a long-term bond portfolio.	Capital Research and Management Company (CRMC)

Investment Option Summary (cont.)

Fund Name	Investment Objectives	Investment Strategy
Indexed Equity Fund (moderate)	Replication of the Standard & Poor's 500 Index investment performance.	To fully replicate the Standard & Poor's 500 Index portfolio through passive management, trading only when there is a change to the index. Offers exposure to approximately 70% of the U.S. equity market.
The Investment Company of America (RICFX) (moderate to aggressive)	Long-term growth of capital and income, with an emphasis on future dividends and capital appreciation.	To invest in "blue-chip" companies with proven track records of rising earnings and dividends.
Allianz NFJ Dividend Value (NFJEX) (aggressive)	Long-term growth of capital and income.	To invest in stocks of companies whose securities have low valuations and that pay or are expected to pay dividends.
The Growth Fund of America (RGAFX) (aggressive)	Long-term capital growth.	To invest in a wide range of companies that appear to offer superior opportunities for long-term growth.
New Perspective Fund (RNPFX) (more aggressive)	Long-term capital growth.	To invest in large established companies in world markets, focusing on changing global trade patterns and related growth opportunities.

Investment Option Summary (cont.)

Fund Name	Fund Holdings	Factors Affecting Performance	Fund Manager
Indexed Equity Fund (moderate)	Primarily large U.S. stocks in identical proportions to the Index. Small amount of money market securities to maintain liquidity.	As a fund investing primarily in common stocks, the fund is subject to market risk – the possibility that common stock prices will decline over short or even extended periods.	State Street Bank and Trust Company
The Investment Company of America (RICFX) (moderate to aggressive)	Primarily stocks and a small percentage of bonds issued by large, well-known U.S. companies. May include non-U.S. securities.	Stocks are subject to market risk. Bond values tend to vary inversely with interest rates. Long-term decisions made by the fund manager and the nature of the fund's investments may provide higher returns and higher risks as compared to a balanced portfolio.	Capital Research and Management Company (CRMC)
Allianz NFJ Dividend Value (NFJEX) (aggressive)	U.S. common stocks Some fixed income securities and other equities such as convertible preferred stocks.	Stocks are subject to market risk. Long-term decisions made by the fund manager and the nature of the fund's investments may provide higher returns (and higher risks) as compared to a balanced portfolio. Due to the contrarian approach, there is the potential that the common stock prices will decline over short or even extended periods.	Allianz Global Investors Fund Management, LLC
The Growth Fund of America (RGAFX) (aggressive)	Primarily U.S. securities May include foreign securities. May invest up to 10% in debt securities rated below investment grade.	Subject to stock market risk and volatility; there is the potential that the common stock prices will decline over short or even extended periods	Capital Research and Management Company (CRMC)
New Perspective Fund (RNPFX) (more aggressive)	Stocks of companies in major world markets, including the U.S.	Subject to global market risks, such as exchange rates, currency fluctuations, and political and social instability.	Capital Research and Management Company (CRMC)

Investment Option Summary (cont.)

Fund Name	Investment Objectives	Investment Strategy
Small Cap Value Fund (GSSIX) (more aggressive)	Long-term growth of capital	The fund will invest at least 80% of its assets in securities of small companies, which the managers feel are undervalued.
Small Cap Growth Fund (WFSIX) (more aggressive)	Seeks to achieve long-term capital appreciation through a diversified portfolio of equity securities of small and medium capitalization companies.	Under normal market conditions, the fund invests at least 80% of its total assets in equity securities of U.S. companies, such as common and preferred stock. The fund generally invests in small companies with capitalization of \$2 billion or less. The fund may retain securities that it has already purchased even if the company outgrows the fund's capitalization limitations.
International Growth Fund (RERFX) (more aggressive)	Seeks to provide long-term growth of capital by investing in companies based outside the United States.	Invests in securities of strong, growing companies based chiefly in Europe and the Pacific Basin, ranging from small firms to large corporations. The fund can only own securities of issuers domiciled outside the United States, except a nominal portion that—for liquidity purposes—may be held in U.S. dollars and/or equivalents.

Investment Option Summary (cont.)

Fund Name	Fund Holdings	Factors Affecting Performance	Fund Manager
Small Cap Value Fund (GSSIX) (more aggressive)	Common stock issued by small capitalization companies	The securities of small capitalization companies generally involve greater risks than those associated with larger, more established companies, and may be subject to erratic price movements. Securities of such companies may lack sufficient liquidity to enable the fund managers to effect sales at an advantageous time or without a substantial drop in price.	Goldman Sachs Asset Management
Small Cap Growth Fund (WFSIX) (more aggressive)	U.S. common and preferred stock issued by small and medium-sized companies.	In addition to risk factors associated with investing in the stock market in general, small and mid-sized companies trade less frequently and in lower volume than the shares of larger companies. This could result in significantly higher volatility in their share price over short and extended periods of time. Small and mid-sized companies may also have more business risk due to limited product lines and less access to financial capital.	Wells Fargo Funds Management
International Growth Fund (RERFX) (more aggressive)	Stocks of large and medium-sized international companies.	Subject to global market risks, such as exchange rates, currency fluctuations, and political and social instability.	Capital Research and Management Company (CRMC)

Withdrawals from Your Deferred Account

If you choose to defer distribution of your total account value, you may make partial withdrawals of your savings during retirement, within certain plan limits. To request a withdrawal, contact Participant Services.

Plan Payouts

When you decide to receive your payout, you have a choice of payout methods. You may elect to receive:

- a single lump-sum payment of your total account value;
- a partial payment, provided you have a remaining balance of at least \$10,000;
- monthly installment payments of your account value over a fixed period of 10, 15, or 20 years (as long as this method meets the IRS minimum distributions requirements), with monthly recalculations based on market value and the remaining payment period;
- monthly installment payments over a period equal to your life expectancy or the joint life expectancy of you and your spouse, with monthly recalculations based on market value and the remaining payment period. Life expectancies are recalculated each year;
- monthly installments using the uniform life expectancy table with monthly recalculations based on market value and the remaining payment period. Life expectancies are recalculated each year;

or

- a fixed dollar installment amount that you choose. The fixed amount may be changed by you while installment payments are still ongoing.

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

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

If you die, your beneficiary will generally receive your Savings Plan balance in a lump sum. If, at the time of your death, you were eligible for a pension from the Company's Retirement Plan, your spousal beneficiary may elect a lump-sum payment or monthly installment payments over a five-year period. If your spouse is your beneficiary, your spouse may choose to receive a lump-sum payout or may request a rollover to an IRA. If your beneficiary is not your spouse, your beneficiary may choose to receive a lump-sum payout or may request a rollover to an IRA account established for such rollover. If, at the time of your death, you were already receiving installment payments over the joint life expectancy of you and your spouse, the installment payments will continue to be paid to your spouse.

Electing a Payout Method

To apply for a Savings Plan payout, you should call Participant Services at 1-800-777-4015. If you die with a remaining balance in the plan, your beneficiaries should contact the recordkeeper for information on obtaining a distribution.

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

Naming Your Beneficiary

Your beneficiary is the person you name to receive benefits from the Savings Plan if you die with a vested balance remaining in your Savings Plan account. Your beneficiary can be anyone you wish. However, if you have been married for at least one year and you wish to name someone other than your spouse, you must have your spouse's written and notarized consent.

Be sure to keep your beneficiary designation up to date. If you do not make a beneficiary designation and you have been married for at least one year at the time of your death, your spouse will receive the value of your vested Savings Plan account. If you are single and do not name a beneficiary, your vested Savings Plan account will be paid to your estate.

You may change your beneficiary at any time. Simply contact Participant Services at 1-800-777-4015, or use the Internet to request a beneficiary form. Your beneficiary election will be effective when Participant Services receives your completed form.

Taxation of Withdrawals and Final Payouts

In general, your before-tax contributions, Company matching contributions, and investment earnings on all types of contributions other than Roth contributions are taxable when you receive them. The actual tax treatment will depend on your age at the time of receipt. You can find more information about tax treatment of Savings Plan distributions in the "Special Tax Information Notice," which is included with your quarterly statement and also available by calling Participant Services.

Before Age 59-1/2

If you receive a payment before you reach age 59 1/2 and you do not roll it over, then, in addition to the regular income tax, you may have to pay an extra tax equal to 10% of the taxable portion of the payment. The additional 10% tax does not apply to your payment if it is:

- paid to you because you separate from service with your employer during or after the year you reach age 55,
 - paid to you because you retire due to disability,
- or*
- paid to you as equal (or almost equal) payments over your life or life expectancy (or you and your beneficiary's lives or life expectancies).

You can avoid the income and 10% tax if you roll the taxable portion of your payment over into an IRA or other eligible retirement plan within the time period permitted by law.

Beneficiaries are never subject to the additional 10% tax, regardless of your age at death.

At Age 59 1/2 or Later

If you make a withdrawal or receive a Savings Plan distribution after age 59 1/2, you will not have to pay the 10% tax penalty. If you were at least age 50 on January 1, 1986, the law generally makes 10-year forward averaging (based on 1986 tax rates) available as an alternative, as well as special capital gains treatment provided you were a participant before 1974.

To be sure you are using your benefits to their full advantage, you should check with a tax advisor regarding the specific requirements for using these and other forms of favorable treatment that may apply to your payout. The Benefit Plans Office cannot give you tax advice.

Roth Contributions

Special rules apply to payments of Roth contributions and earnings on those contributions. Payments of the Roth contributions are not subject to federal income tax. Earnings on your Roth contributions will be subject to federal income tax unless the distribution occurs at least five years after you make your first Roth contribution or rollover Roth contributions from a former employer, and the distribution is made after you turn 50 1/2, upon your death, or upon your disability.

Rollovers and Withholding

Withdrawals and lump-sum distributions of your before-tax contributions and Company matching contributions, your after-tax contributions, or your Roth contributions, as adjusted for investment earnings and losses, can be rolled over to an IRA, a Roth IRA, or other eligible retirement plan. Required minimum distributions to employees who have terminated and reached age 70 1/2 or retired from the Company after age 70 1/2, and distributions paid out in installments are not eligible for such a rollover. You may roll over the non-taxable (i.e., your after-tax contributions) portion of your distribution to an IRA, Roth IRA, or other eligible retirement plan. 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, Schwab Retirement Plan Services will send you a check payable to the trustee of the eligible IRA, Roth IRA, or plan you designate. If you elect a direct rollover, no federal tax withholding will apply to your rollover amount. The portion that is not rolled over will be subject to mandatory 20% tax withholding.

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

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

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

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

Your Quarterly Statement

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

You also have access to your account statement any time by visiting <https://www.401kaccess.com>. You can create an online statement for any period of time within the last 24 months. After you log in, choose Account Performance, Account Statements, then click the quarterly statement you wish to review.

Claiming Benefits

To apply for a Savings Plan payout, you should call Participant Services at 1-800-777-4015. Your beneficiaries should contact the Benefit Plans Office.

If you elect a lump-sum payout, you will be mailed the payout generally within two business days. If you elect to receive installment payments, you will receive a form to complete. Installment payments generally will be mailed on the second business day of each month.

Other Important Information

Change of Address

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

Voting Your Shares

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

Investment Fees and Expenses

The Savings Plan incurs administrative fees and investment management fees. The administrative fees are the costs to the Savings Plan and your Savings Plan Account, including recordkeeping, accounting, trustee functions, and legal services. The Company pays some of these fees. Some fees are paid by the Savings Plan and charged to all Participant accounts. Fees for items directly related to your account, such as loan processing, hardship withdrawal processing, or domestic relations order processing, may be charged to your account. Administrative fees will be shown on your quarterly statement.

Investment management fees are the costs to manage the investment options under the Savings Plan, including investment advice, brokerage fees, commissions, and account maintenance fees. Investment management fees vary by investment and are deducted from your investment returns. Investment management fees for the mutual funds are described in the fund prospectuses. The fees will be shown on your quarterly statement.

Responsibility for Investment Decisions

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

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

Confidentiality of Investment Directions

Your investment directions for all Savings Plan funds are administered by Schwab Retirement Plan Services and handles all purchases and sales in the name of the Savings Plan without identifying individuals, so your transactions remain confidential.

The Retirement and Savings Plan Committee is responsible for monitoring compliance with the procedures that ensure confidentiality. You may contact the Committee at the following address:

Attn: Savings Plan Administrator
602 Scarboro Road, MS-8258
Oak Ridge, TN 37830-8258

Your Other Benefits

Before-tax savings under the Savings Plan reduce your taxable income; that is, they are not reported as taxable income on your W-2 earnings statement. However, they are included in determining your Social Security taxes and benefits.

Savings with before-tax dollars has no effect on your other pay-related benefits (e.g., life insurance, disability coverage, and retirement income). These benefits provide financial protection and security based on your full basic rate of pay.

Plan Funding and Expenses

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

Tax Treatment

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

① Call Participant Services or use the Internet for ...

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

Administrative Information

Information about the administration of the Savings Plan can be found in the section entitled “Administrative Information.”

Y-12 BOOK OF BENEFITS

GLOSSARY

Annual Pension Benefit	Assisted Living Facility	Physician
Average Straight-Time Monthly Earnings	Continuing Care Retirement Program	Point-of-Service Plan
Beneficiary	Continuing Care Retirement Services	Pre-certification
Birthing Center		Prescription Drugs
Child		Primary Care Physician
COBRA		Prosthetic Services
Coinsurance	Impairment	Qualifying Life Event
Company	Indemnity	Reasonable and Customary Charge
Company Service	In-Network	Rollover Contributions
Conduit IRA	Lifetime Maximum	Retiree
Conversion Privilege	Limb	Retiree Board
Copayment	Major Medical/Medicare Supplement	
Credited Service	Member	
Crown	Member	
Deductible	Myofascial	
Dependent Child	Necessary	
Dependent Parent	Network	
Durable Medical Equipment	Network Management	
Early Retirement	Network Pharmacy	
Elective Surgery	Normal Retirement	
Eligible Dependents	Nurse	
Eligible Earnings	Orthodontic Treatment	
Emergency	Orthotics	
Emergency Admission	Out-of-Network Benefits	
ERISA	Out-of-Pocket Maximum	
Fixed Bridgework	Paralysis	
Full Denture	Partial Denture	
Full-Time Student	Pay	
Home Health Aide	Periodontal Splinting	
Home Health Services	Periodontics	
	Personal Identification Number (PIN)	

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



YOUR BOOK OF BENEFITS — ALL RETIREES

Y-12 BOOK OF BENEFITS

Sometimes, to describe a benefit plan accurately, some technical terms must be used. This Glossary contains brief definitions to help you understand some terms used throughout this book.

Glossary

Annual Pension Benefit

Amount of pension benefit provided under the plan formula.

Average Straight-Time Monthly Earnings

The average of your highest earnings for three years during the last ten years just before you retire. Refer to the "Pension Plan" section for information on how average straight-time monthly earnings are calculated.

Beneficiary

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

Birthing Center

An institution which is established, licensed and operated in accordance with the laws of legally authorized agencies to furnish room and board, services of qualified nurses and a certified nurse midwife to expectant mothers. One or more nurses must be on duty at all times. To qualify as a Birthing Center, an institution must:

- have available at all times, under an established agreement, the services of a physician
- maintain daily medical records on all patients
- have agreements with hospitals that will accept patients requiring inpatient hospital care at once.

Child

For medical, prescription drugs, dental, vision, and health care spending account, a child is defined as:

- (1) Your natural child,
- (2) Your legally adopted child (or a child who is lawfully placed with you for legal adoption),
- (3) Your stepchild,
- (4) A foster child (an individual who is lawfully placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction),
- (5) A child where you have legal guardianship, custody, or conservatorship by court order or an agreement with a state or other governmental agency,
- (6) A child who is recognized as an alternate recipient in a "Qualified Medical Child Support Order ("OMCSO") enforceable with respect to the plan.

In the case of a child described in items 1 through 4 and item 6 above, the child is under age 26, except for dental, which is under the age of 24.

In the case of foster children, you must expect to raise the child to adulthood. A child who is living with you temporarily or for whom you have temporary custody does not qualify as a foster child. A child who has been placed in your home by a welfare or social service agency under an agreement where the agency retains control of the child or pays for support or maintenance of the child does not qualify as a foster child. Further, you and the foster child must have a "parent-child" relationship (as described below).

A child must meet the requirements below in the case of a child described in item 5 above. Or as in the case for the employee assistance plan, a child described in items 1 through 6 above must meet these requirements:

- The child is not married.
- The child is under age 24 (26 in New Hampshire, 25 in Montana and 25 in Washington).
- You must be able to claim the child as a dependent on your federal income tax return (without regard to any gross income limitations on a dependent).
- You provide over 50% of the child's support during the calendar year.
- The child lives with you in a "parent-child relationship" for the entire calendar year. The child is considered to have lived with you during periods of time when one of you, or both, are absent due to handicap, disability, illness or education. A "parent-child relationship" means that you are exercising parental authority, responsibility and control over the child by caring for, supporting, disciplining and guarding the child, including making decisions about the child's education and health care. If you are not the child's biological parent, the "parent-child relationship" must be with you, not the child's biological parent.

A child who is permanently and totally disabled before reaching the maximum coverage age above may continue to be covered regardless of age provided that he or she remains permanently disabled and is primarily dependent on you for support.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985; this federal law allows you and your eligible dependents to continue health care coverages under certain circumstances when coverage would otherwise end.

Coinsurance

The percentage of charges you are required to pay under the plan.

Company

Babcock & Wilcox Technical Services Y-12, LLC.

Company Service

The total elapsed time between the date you begin employment with the Company and your last day of work. The Pension Plan uses Company Service to calculate pension benefits – except to determine your eligibility for a vested pension benefit, which uses Credited Service. (Service Credit or Company Service Credit, as referenced under the benefit plans in this book, means Company Service.)

Conduit IRA

A temporary Individual Retirement Account that you use to hold rollovers between two employers' qualified plans.

Conversion Privilege

Your right to convert a group medical, life insurance or special accident insurance policy into an individual policy.

Copayment

The amount you and your enrolled dependents are required to pay for the services received – in addition to any Coinsurance or Deductible. Deductibles are not reduced by Copayments.

Credited Service

All the time you work for the Company, from your first hour of service until you sever from service. Credited Service is used for vesting purposes. Refer to the Pension Plan section for more information on credited service.

Crown

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

Deductible

The Deductible is the amount you and your enrolled dependents are required to pay each year for covered expenses before the plan pays, and is in addition to any Coinsurance or Copayments.

Dependent Child

For the pension plan

Your natural or adopted child, stepchild or foster child who is under age 23 and who qualifies as your dependent child for federal income tax purposes.

Dependent Parent

For the pension plan

Your natural parent or stepparent who qualifies as your dependent for federal income tax purposes.

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

Your eligible dependents are:

- the person who is recognized under applicable law as your spouse
- a Child described above in this Glossary.

For Spouse and Dependent Life Insurance

Your Eligible Dependents are your spouse under age 70 and your unmarried children from age 6 months to 19 years (up to age 24, if a Full-Time Student).

Eligible Earnings

Your straight-time earnings divided by straight-time hours, then multiplied by scheduled hours.

Emergency

A serious accident or sudden illness that is life-threatening or could result in a long-term medical problem, such as uncontrolled bleeding, seizure or chest pain.

Emergency Admission

Any hospital admission for an inpatient stay for a condition which:

- has a sudden and unexpected onset, and
- requires prompt care to protect life, relieve severe pain or diagnose and treat symptoms which, with delay, could result in serious injury.

ERISA

The Employee Retirement Income Security Act of 1974, as it may be amended from time to time.

Fixed Bridgework

Permanently inserted artificial teeth joined to inlaid or crowned natural teeth on either side called abutments. A fixed bridgework for anterior teeth often requires two abutments on either side.

Full Denture

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

Full-Time Student

For spouse and dependent life insurance coverage.

A person who is enrolled full-time in any accredited school, including a trade or vocational training program.

Home Health Aide

A person who is trained to assist a person with daily living in his or her home after surgery or injury and who reports to and is under the direct supervision of a home health care agency. A home health aide can assist with personal hygiene, changing dressings and mobility.

Home Health Services

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

Hospice Facility

An institution or part of one which primarily provides care for terminally ill patients and fulfills any licensing requirements of the state or locality in which it operates.

Hospice Program

A coordinated, interdisciplinary program of care designed to meet the physical, psychological, spiritual and social needs of dying persons and their families. A hospice program may also provide palliative and supportive medical, nursing and other health services through home or inpatient care during the terminal illness.

Hospice Care Services

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

Hospital

A Hospital is an institution constituted, licensed and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities needed to diagnose and treat injury and sickness. It is an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital as a provider of services under Medicare and is accredited by the Joint Commission on the Accreditation of Hospitals.

A Hospital can specialize in treatment of mental illness, alcoholism, drug addiction, or other related illness. It can also provide residential treatment programs, but only if it is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions. It provides all treatment for a fee, by or under the supervision of physicians on an inpatient basis with continuous 24-hour nursing service by qualified nurses.

Any institution which is exclusively a place for rest, a place for the aged or a nursing home will not be considered a Hospital.

Hour of Work

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

Imputed Income

The IRS requires you to be taxed on the value of employer-provided group life insurance over \$50,000. The taxable value of this life insurance is called "imputed income". Even though you don't receive cash, you are taxed as if you received cash in an amount equal to the value of this coverage. IRS issues rate tables for purposes of imputing income under group term life insurance.

Indemnity Plan

A medical plan in which you can use any provider you choose.

In-Network Benefits

Health care services or items provided by your primary care physician, or authorized services or items provided by another participating provider.

Lifetime Maximum

The maximum amount of eligible benefits a plan will pay for an individual during his or her lifetime. Beginning with the 2011 plan year, a lifetime maximum does not apply to essential health benefits under the medical plan for active employees. A lifetime maximum continues to apply to non-essential health benefits under the medical plan for active employees and continues to apply to all benefits under the retiree medical plan in accordance with the Affordable Care Act of 2010.

Limb

An arm or a leg.

Major Medical Medicare Supplement Plan

A medical plan available to retirees or a covered spouse who is age 65 or over and enrolled in Medicare Part A and Part B. The plan is designed to supplement your Medicare Part A and Part B coverage and to provide coverage for certain expenses for which no Medicare benefits are payable.

Member Services

The customer service unit of the plan's third party vendor or claims administrator with responsibility for administering or insuring the plan of benefits.

Mental Health Provider

The company responsible for authorizing mental health and alcohol/drug abuse treatment for Medical Plan participants.

Myofunctional Therapy

Correcting and/or retraining of the muscles in order to correct an orthodontic disorder.

Necessary Services and Supplies

Any services or supplies, other than bed and board, that are necessary for your treatment and are administered during hospital confinement. Necessary Services and Supplies will also include professional ambulance service to or from the nearest hospital where the necessary medical treatment can be provided, and any charges for the administration of anesthetics during hospital confinement. Necessary services do not include special nursing, dental or medical services.

Network

A group of health care providers who have agreed to provide care for pre-negotiated rates, as well as to comply with quality assurance procedures, patient service standards, and compliance with all applicable laws and regulations.

Network Manager

The health plan that sets up and manages a network of providers and administers out-of-network benefits.

Network Pharmacy

A pharmacy that has contracted with the pharmacy benefit management company to provide prescription drugs under a contractual arrangement for discounted costs.

Normal Retirement

Retirement at age 65.

Nurse

A Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse. A nurse is a professional who has the right to use the respective title and the respective abbreviation R.N., L.P.N. or L.V.N.

Orthodontic Treatment

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

Orthotics

A custom-molded rigid insert that, when placed in the shoe, distributes the patient's weight equally throughout the foot and leg and relieves the stress from any one particular area.

Out-of-Network Benefits

Care that does not qualify as in-network.

Out-of-Pocket Maximum

The maximum you have to pay for eligible medical expenses in one plan year. Once you reach this amount, the medical plan pays 100% of eligible expenses for the rest of that plan year.

All eligible medical expenses count toward the Out-of-Pocket Maximum, except for expenses for prescription drugs, mental health/alcohol and drug abuse treatment, amounts above reasonable and customary charges and any penalties for failing to pre-certify services.

Beginning with the 2014 plan year, an Out-of-Pocket Maximum does not apply to essential health benefits under the medical plan for active employees. An Out-of-Pocket Maximum for essential health benefits under the medical plan for active employees is limited to \$750,000 for the 2011 plan year, \$1,250,000 for the 2012 plan year and \$2,000,000 for the 2013 plan year. An out-of-pocket maximum continues to apply for non-essential health benefits. This healthcare reform requirement may apply to a retiree in 2014.

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.

Pay

For insurance benefits – when you were an active employee

Your annual basic rate of pay, determined as described in the Life Insurance section, before any before-tax salary reductions. Pay does not include overtime, bonuses or any other form of extra compensation.

For Retirees

If you are a retiree, your pay is your annual pension benefit.

Periodontal Splinting

Stabilizing or immobilization of periodontically involved teeth. Splinting may be accomplished with acrylic resin bit guards, orthodontic band splints, wire ligation, provisional splints and fixed prosthesis.

Periodontics

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

Personal Identification Number (PIN)

The number that allows you to access Savings Program account information through the information line.

Physician

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

Point-of-Service Plan

A medical plan through which you may receive care in-network (at the highest level of benefits) or out-of-network (at a lower level of benefits).

Precertification

The process used to certify the clinical treatment, the medical necessity and length of a hospital confinement.

Prescription Drugs

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

Primary Care Physician

A physician – generally an internist, general/family practitioner or pediatrician – whom you select to coordinate all your medical care within the Point-of-Service network.

Prosthodontic Services

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

Qualifying Life Event

An event described in the “About Your Benefits” section which may permit a change in coverage or election on a pre-tax basis.

Reasonable and Customary Charge

For medical coverage

A rate that the claims administrator determines is the normal charge made by providers in your geographic area for a similar service or supply. The nature and severity of the injury or sickness will be considered. If the claims administrator considers your medical expenses more than

Reasonable and Customary, you will be responsible for paying the additional amount. Charges in excess of the Reasonable and Customary charge do not count toward your Deductible or Out-of-Pocket Maximum.

For dental coverage

A rate for dental services that is determined by the claims administrator by taking into account:

- the usual fees charged by dentists with similar training and experience in your geographic area
- any unusual circumstances or complications that require special skill, experience or additional time.

If the claims administrator considers your dental expenses more than Reasonable and Customary, you will be responsible for paying the additional amount. These charges do not count toward your Deductible.

Rollover Contributions

Distributions from another employer's qualified plan that you deposit into your Savings Program account.

Retiree

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

Room and Board

All charges commonly made by a hospital for rooms and meals and all general services and activities needed for the care of registered bed patients.

Routine

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

Service Credit

Refer to the "Company Service" definition in the Glossary.

Skilled Nursing Facility

A licensed institution, other than a Hospital, which specializes in physical rehabilitation or provides skilled nursing and medical care on an inpatient basis. The institution must maintain on the premises all facilities necessary for medical treatment. Such treatment is provided for compensation and must be under the supervision of physicians and provide Nurses' services.

Space Maintainers

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

Straight-Time Earnings – while an active employee

Your basic rate of pay, including executive incentive compensation, shift premiums and hourly COLA, but not including overtime.

Terminally Ill

A medical prognosis of six months or less to live.

Total Disability or Totally Disabled

For basic and supplemental life insurance – while an active employee

You are considered Totally Disabled if, because of an illness or injury:

- you cannot do your job, and
- you cannot do any other job for which you are qualified by your education, your training or your experience.

Urgent Care

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

Vesting

Ownership interest in your pension plan benefits and Company matching contributions under the Savings Program. You have an irrevocable right to a benefit when you are fully vested.



ADMINISTRATIVE INFORMATION

Claiming Benefits
Employer Identification Numbers
Health Claims Review and Appeal Procedures
Health Insurance Portability and Accountability Act
Legal Process
Other Administrative Facts
Plan Documents
Plan Sponsor and Administrator
Plan Termination and Amendment
Qualified Domestic Relations Order
Qualified Medical Child Support Order
Special Pension and Savings Provisions
Your Rights Under COBRA
Your Rights Under ERISA

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YOUR BOOK OF BENEFITS — ALL RETIREES

This section contains information on the administration and funding of all the plans described in this book, as well as your rights as a plan participant. It is important for you to understand your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

Plan Sponsor and Administrator

Babcock and Wilcox Technical Services Y-12, LLC (B&W Y-12) (formerly known as BWXT Y-12, LLC) is the sponsor and the plan administrator of the employee benefit plans described in this book. You can reach the plan administrator at:

Babcock & Wilcox Technical Services Y-12, LLC
c/o Benefits Plan Administrator
P.O. Box 2009
Oak Ridge, TN 37831-8267
865-574-1500

In carrying out its responsibilities under the plans, the plan administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the plan administrator are final, conclusive, and binding on all persons. The plan administrator may delegate some or all of these duties. A person to whom these duties have been delegated acts with the discretionary authority granted to the plan administrator.

The term "Company" means Babcock & Wilcox Technical Services Y-12, LLC, also known as B&W Y-12.

The term "Benefit Plans Office" refers to the Company's benefits department.

Employer Identification Numbers

The employer identification number assigned by the Internal Revenue Service to B&W Y-12 is 54-1987297.

Plan Documents

This book summarizes the key features of each of the plans in the Company's benefits program and applies to eligible retirees of the Company, including those represented by collective bargaining units to the extent that they have been negotiated and accepted by the duly certified representatives of participating units. Complete details of each of the plans can be found in the official plan documents, insurance contracts, and trust agreements (as applicable) that legally govern the operation of the plans. **All statements made in this book are subject to the provisions and terms of those documents.** Copies of those documents, as well as the latest annual reports of plan operations and plan descriptions as filed with the Internal Revenue Service are available for your review any time during normal working hours in the office of the plan administrator. Upon written request to the plan administrator, at the address previously mentioned, copies of any of these documents will be furnished to a plan participant or beneficiary, generally within 30 days, at a nominal charge. In addition, once each year you will receive a copy of the summary annual reports of the plans' financial activities, which will be made available to you at no charge. In the event of a conflict between the official plan documents and the summaries in this book, the plan documents are controlling.

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

Claiming Benefits

You or your beneficiary must file the appropriate forms to receive any benefits, or to take any other action under any of the plans, as described throughout this book. Claiming benefits and appealing the denial may differ for different types of plans and different types of benefits under each plan. The following section describes claims and appeals procedures based on the type of claim and the type of plan. Claiming benefits and appealing the denial may differ for different types of plans and different types of benefits under each plan. The following section describes claims and appeals procedures based on the type of claim and the type of plan. All forms required to take any action under the plans are available through the Benefit Plans Office. All completed forms must be submitted to the appropriate office, as described throughout this book.

If your claim is denied, you cannot bring a lawsuit to recover benefits under the plan unless you have exercised, in a timely manner, all appeal rights available to you under the plan's administrative claims procedures for a denied claim and your appeal(s) seeking benefits have been denied by the plan. Any such lawsuit may not be filed after one year (180 days for the Savings Plan or the Pension Plan), from the date the final decision on appeals is issued. If you do not file suit within this period, the final determination of your appeal will be binding and cannot be challenged by you in court.

Health Claims Review & Appeal Procedures

You may file claims for health plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An “authorized representative” means a person you authorize, in writing, to act on your behalf with respect to a claim or appeal for benefits. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a medical claim involving urgent care, a health care professional with knowledge of your condition may act as your authorized representative, unless you have designated a different authorized representative. References to “you” in this section are intended to include references to your authorized representative.

If your claim for benefits is denied, you cannot bring a lawsuit to recover benefits under the plan unless you have timely exercised all appeal rights available to you under the plan’s administrative claims procedures for a denied claim and your appeal(s) seeking benefits have been denied by the plan. Any such lawsuit may not be filed after one year from the date the final decision on appeals is issued. If you do not file suit within this period, the final determination of your appeal will be binding and cannot be challenged by you in court.

Urgent Health Care Claims

If the plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the plan or your physician determines that it is an Urgent Care Claim, you will be notified of the decision as soon as possible, but not later than 72 hours after the claim is received unless you fail to provide sufficient information for the plan to make a decision.

“Urgent Care” means services received for a sudden illness, injury or condition that is not an emergency condition, but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person’s health or ability to regain maximum function; this includes a condition that, in the opinion of a physician with knowledge of your medical condition, would subject a person to severe pain that could not be adequately managed without prompt treatment. The determination of whether a claim is an Urgent Care Claim will be made by an individual acting on behalf of the plan applying the judgment of a prudent lay person who possesses an average knowledge of health and medicine or by a physician with knowledge of your medical condition who determines the claim involves urgent care.

If there is not sufficient information to decide the claim, you will be notified of the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. You will be notified of the decision as soon as possible, but not more than 48 hours after the end of that additional time period (or after receipt of the specified information, if earlier).

Other Health Claims (Pre-Service and Post-Service)

If the plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision as soon as possible, but not later than 15 days after receipt of the pre-service claim. For

other health claims (post-service claims), you will be notified of the decision as soon as possible, but not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period.

For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a plan representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Health Treatment

If you are receiving an ongoing course of treatment, you will be notified in advance if the plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, you must request an extension of the course of treatment at least 24 hours before its expiration. You will be notified of the decision within 24 hours after receipt of the request.

Notification of Health Claim Decision

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

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

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request.

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit when applying the terms of the plan to the participant's medical circumstances, an explanation of the scientific or clinical judgment for the denial will be provided, or the denial will state that such an explanation is available upon request at no cost to you. In the case of an Urgent Care Claim, the

above information may be provided orally within the timeframes described in the Urgent Care Claims section, provided that a written or electronic notification as described is furnished to you no later than 3 days after the oral notification.

Information Pertaining to the Filing of an Appeal of an Adverse Benefit Determination for a Health Claim

You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial claim determination will be final. You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

For claim appeals, the Claim Administrator has been delegated exclusive rights to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. The appeal must be submitted in writing, except for Urgent Care Claims. An expedited appeal for Urgent Care Claims may be initiated by a telephone call to Member Services. You or your authorized representative may appeal the claim. All necessary information, including the appeal decision, will be communicated to you or your authorized representative by telephone, facsimile, or other similar method. You will be notified of the decision on an appeal of an Urgent Care Claim no later than 72 hours after the appeal is received.

In reconsidering any denial that is based in whole or in part on a medical judgment, (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate) the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the plan relies on their advice in making any benefit determinations.

Notification of Health Claim Decision on Appeal

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

- the reasons for the decision, again with reference to the specific plan provisions on which that decision is based
- that you are entitled to receive—upon request and free of charge—reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits

- your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

A lawsuit may not be filed more than one year after the date of the final decision on appeal.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial—applying the terms of the plan to your medical circumstances—or a statement that such an explanation is available will be provided to you free of charge upon request.

The plan's claims review procedures do not generally include any voluntary levels of appeal (such as voluntary arbitration).

Finally, you and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Other Claims Review and Appeal Procedures (non-health claims)

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

Notice of Adverse Benefit Determination for Other Claims

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

Notification on Other Claim Decisions

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

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

Other Claim Appeal of an Adverse Benefit Determination

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

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

Notification of Other Claims Decision on Appeal

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

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

For claims under the Savings Plan and the Pension Plan, you may not file a lawsuit disputing a claim determination more than 180 days after the plan administrator makes a final decision on appeal.

Legal Process

Any legal process relating to a benefit plan should be directed to the plan's Agent for Service of Legal Process.

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

Agent for Service of Legal Process:

Babcock & Wilcox Technical Services Y-12, LLC
CT Corporation System
800 S. Gay Street, Suite 2021
Knoxville, TN 37929

Plan Termination and Amendment

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

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

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

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

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

Special Pension and Savings Provisions

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

Maximum Benefits

Federal tax laws impose certain limitations on the benefits and contributions under qualified retirement plans. These limitations generally apply only to highly compensated employees. You will be notified if these limitations apply to you. More information is available from the Benefit Plans Office.

Top-Heavy Provisions

Under current tax law, the Pension Plan and Savings Plan are required to contain provisions that apply in the event that a significant portion of the plan's benefits are payable to highly compensated employees. These provisions – called "top-heavy" rules – provide for accelerated vesting of plan benefits and certain minimum benefit accruals in the event the plans become top-heavy. The plans are not top-heavy now. Therefore, the top-heavy rules are not likely to affect your benefits under the plans.

A more detailed explanation of the provisions will be provided if and when these plans become top-heavy.

Loss of Retirement Benefits

Other than failing to meet the age and service requirements for a benefit, there are no plan provisions which would cause you to forfeit your Pension Plan benefits. Under the Savings Plan, you are always 100% vested in your own contributions and you become 100% vested in Company matching contributions after you complete three years of Credited Service (definition in the Glossary). Even after three years of credited service, you are fully vested in your Company matching contributions in the Savings Plan, but the investment choices you make will affect that balance.

Benefits Restrictions

If at any point, the funding level of the Pension Plan, as determined in accordance with IRS rules, falls below 80%, restrictions on certain forms of benefit payments must be applied. A more detailed explanation of the provisions will be provided if and when these restrictions apply.

Assets Upon Termination

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

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

Pension Benefit Guaranty Corporation

Your pension benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (i.e., ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits, within limits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- normal and early retirement benefits,
- disability benefits if you become disabled before the plan terminates
- certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- some or all of benefit increases and new benefits-based plan provisions that have been in place for fewer than 5 years at the time the plan terminates
- benefits that are not vested because you have not worked long enough for the Company
- benefits for which you have not met all of the requirements at the time the plan terminates

- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age
- non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

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

For more information about the PBGC and the benefits it guarantees, ask the plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Washington, D.C. 20005-4026, or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <http://www.pbgc.gov>.

Assignment or Alienation of Benefits

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

Qualified Domestic Relations Order

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

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

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

Qualified Medical Child Support Order

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

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

Health Insurance Portability and Accountability Act (HIPAA)

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

Other Administrative Facts

Specific Plan Information

Plan name	Plan number	Plan type	Plan year
Retirement Program Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	001	Defined Benefit	Calendar
Savings Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	009	Defined Contribution and 401(k) Plan	Calendar
The Group Welfare Benefit Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee provides for the following benefits:			
Group Life Insurance	506	Welfare	Calendar
Health Benefits (Medical, Dental, Vision)	506	Welfare	Calendar
Prescription Drug Plan	515	Welfare	Calendar
Long Term Care Plan	518	Welfare	Calendar
The Group Welfare Benefit Plan for Retirees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee provides for the following health benefits:			
Medical	520	Welfare	July
Dental & Vision	520	Welfare	July

Insurer, Claims Administrator, or Trustee	Source of contributions	Source of benefits
Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
State Street Bank and Trust (serves as Trustee) State Street Bank and Trust P.O. Box 1389 Boston, MA 02104-1389	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust
Metropolitan Life Insurance Company	Employee/Retiree and Company	Benefits are paid from an insurance contract
For under age 65 retiree or spouse of retiree Medical: Administered by Connecticut General Insurance Company (CIGNA) Dental: Administered by MetLife Dental: Administered by Delta Dental of Tennessee Vision: Administered by Vision Service Plan (VSSP)	Retiree and Company	Benefits are paid (through claims administrator) from retiree contributions and general assets of the Company
Prescription Drug Plan Medco	Retiree and Company	Benefits are paid through claims administrator and paid from retiree contributions and general assets of the Company.
Long term Care Plan MetLife	Retiree	Benefits are paid from an insurance contract
For over age 65 retiree or spouse of retiree Medical: Administered by UnitedHealthcare Company	Retiree and Company	Benefits are paid through claims administrator and paid from retiree contributions and general assets of the Company.
Dental & Vision: UnitedHealthcare Company	Retiree	Company benefits are paid from an insurance contract.

Your Rights Under COBRA

You and your Eligible Dependents covered under a group health plan (i.e., one of the medical plans or one of the dental plans) have the option to purchase a temporary continuation of health care coverages at full group rates, plus a 2% administrative charge in certain instances when your coverage would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Participation

If one of the events (such events are referred to as “Qualifying Events”) listed in the following chart causes you or an Eligible Dependent to lose coverage under one of the group health plans, you and/or the Eligible Dependent, as the case may be, are a “Qualified Beneficiary” with respect to such group health plan. Each Qualified Beneficiary independently may elect to continue coverage under such group plan. Covered employees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of the eligible Dependents.

If you adopt or have a Child while covered by COBRA, that Child is also a Qualified Beneficiary entitled to COBRA coverage.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the Qualifying Event outlined in the chart on the following page. You may only continue to participate in the health care spending account through the end of the year in which the Qualifying Event occurs.

When the Qualifying Event is the death of an employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child’s losing eligibility as an Eligible Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are 2 ways in which the 18-month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under a group health plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator within 60 days of the disability determination and before the close of the initial 18-month period of continuation coverage, each Qualified Beneficiary is entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time

before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of continuation coverage.

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and other Eligible Dependents in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the plan administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the group health plan had the first Qualifying Event not occurred.

COBRA Continuation Period			
Qualifying Event (if accompanied by a loss of coverage)	Maximum Continuation Period		
	You	Spouse	Child
Your hours of employment are reduced	18 months	18 months	18 months
You terminate for any reason (except gross misconduct)	18 months	18 months	18 months
You or any of your Eligible Dependents who is a Qualified Beneficiary is determined to be disabled at any time during the first 60 days of COBRA coverage.	29 months	29 months	29 months
You die	n/a	36 months*	36 months*
You and your spouse legally separate or divorce	n/a	36 months	36 months
You become entitled to Medicare (Part A or B, or both)	n/a	36 months	36 months
Your Child no longer qualifies as an Eligible Dependent	n/a	n/a	36 months

* If your dependent is eligible for extended coverage under the medical plan, as described in the "Medical Plan" section, then the maximum COBRA period will be reduced by the length of that extended coverage.

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to a plan sponsor, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and other Eligible Dependents will also become Qualified Beneficiaries if bankruptcy results in their loss of coverage under the group health plan.

Choosing COBRA

Here are some things to keep in mind about COBRA continuation:

You and your eligible dependents have 60 days after your COBRA notice to elect continued participation. You will have an additional 45-day period to pay any make up contributions you missed from the first day of the COBRA coverage.

- If COBRA is elected, the coverage previously in effect will generally be continued.
- Coverage will be effective as of the date of the Qualifying Event, unless you waive COBRA coverage and subsequently revoke your waiver within the 60-day election period. In that case, your election coverage begins on the date you revoke your waiver.

- You may change coverage if you experience a Qualifying Event as described in the “About Your Benefits” section.

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

- For medical and dental coverage, premiums are based on the full group rate per covered person set at the beginning of the year, plus 2% to cover administrative costs.
- Health care spending account contributions can be continued on an after-tax basis, plus the 2% administrative charge.
- If you are disabled under the Social Security definition of disability, COBRA premiums for months 19–29 reflect the full group cost per person, plus 2%.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance including continuation coverage.

If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

Notification

The Benefit Plans Office will notify you by mail of your COBRA election rights when the Qualifying Event is a reduction in hours or termination of employment. You will receive instructions on how to continue your health care benefits under COBRA.

If your dependents lose coverage due to divorce, legal separation, or loss of dependent status, you (or a family member) must notify the Benefit Plans Office within 60 days of the event so that COBRA can be offered and your election rights can be mailed to you. Also, to extend coverage beyond 18 months because of disability, notice of the Social Security Administration’s determination must be provided within 60 days after you receive that determination and before the end of the initial 18-month period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

- a person who was covered under COBRA becomes covered under another group health plan not offered by the Company after you elect COBRA (providing the other plan does not have pre-existing condition limitations affecting the covered person; if the other plan has such limitations, COBRA coverage will end when those limitations expire);
- you or your Eligible Dependent becomes entitled to Medicare after you elect COBRA;

- the first required premium is not paid within 45 days, or any subsequent premium is not paid within 30 days of the due date;
- the Company's group health plans are terminated; and/or
- questions concerning your COBRA continuation coverage rights should be addressed to the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Social Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa>.

Grandfathered Plan Status

The Group Welfare Benefit Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee believes that each coverage under the plan is a "grandfathered health plan" to the extent applicable to retiree plans, under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act.

The post-65 retiree coverages (The Group Welfare Plan for Retirees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee) are not subject to the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Your Rights Under ERISA

As a participant in any of the Company's benefit plans described in this book, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- receive information about your plan and benefits.
- examine, without charge, at the plan administrator's office, and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- obtain copies of all plan documents and other plan information, including insurance contracts

and collective bargaining agreements, and copies of the latest annual report, and updated summary plan description, by writing to the plan administrator. The plan administrator may make a reasonable charge for copies.

- receive a summary annual report of the plan's financial activities. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition, once every 12 months, you may request information concerning the total value of your Savings Plan accounts and a statement as to what amount (if any) of the Company contributions to your Savings Plan account is then vested (or the earliest date on which it will become vested).

Similarly, once each year, you may request information concerning your vested rights under the Pension Plan (or, if you are not vested, the earliest date on which you become vested), and what your benefit would be at normal retirement age if you stopped working under the plan now. This information is free of charge, but you must address a written request for it to the plan administrator or, for Savings Plan information, call the Information line.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or eligible dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation of coverage, and when your COBRA continuation of coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

In order to file suit in a state or federal court concerning:

- (i) a claim for a benefit;
- (ii) the qualified status of a domestic relations order or medical child support order, or
- (iii) your service credit, you must file the suit within one year (180 days for the Savings Plan and Pension Plan) of the date of the final determination by the plan administrator which is the basis of your suit.

If you do not file the suit within this time period, the plan administrator's final determination will be binding and cannot be challenged by you in court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory, or the following address:

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue
N.W. Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.



CONTACT INFORMATION

For all your benefit questions:
Benefits Service Center
P.O. Box 2115
602 Scarboro Road, MS-8258
Oak Ridge, TN 37831-2115

Call: 574-1500 or
toll-free 1-877-861-2255
Fax: 1-865-241-0531

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



YOUR BOOK OF BENEFITS — ALL RETIREES

Contact Information

For all of your benefits questions:

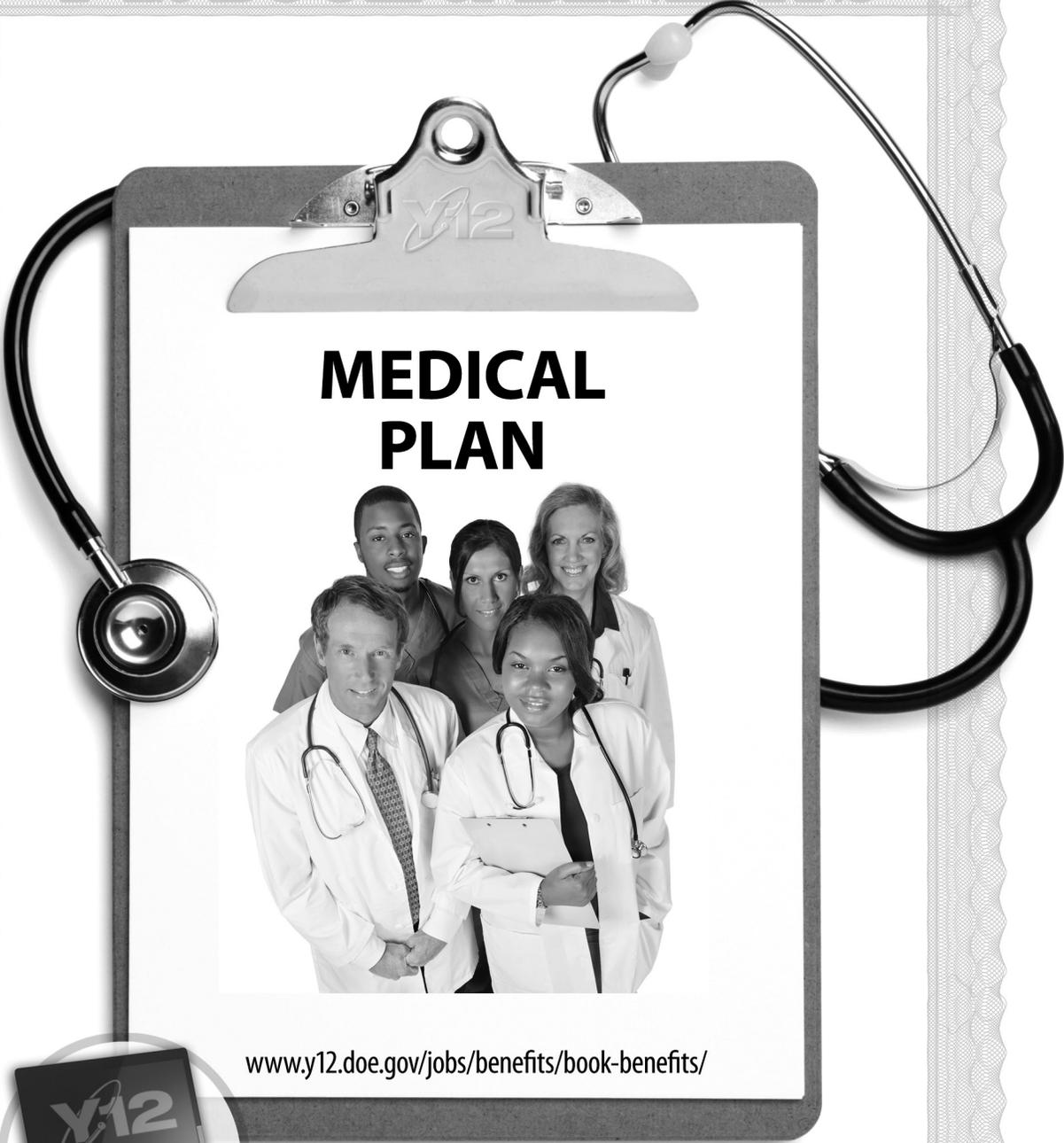
Benefits Service Center
P.O. Box 2115
602 Scarboro Road, MS-8258
Oak Ridge, TN 37831-2115
Call: 865-574-1500 or toll-free 1-877-861-2255
Fax: 1-865-241-0531

<p>Medical For retiree or retiree's dependents under age 65: Open Access Point-of-Service Indemnity</p>	<p>CIGNA</p>	<p>Member Services: 1-800-244-6224</p> <p>To file a claim, mail your completed claim form to the address shown on your ID card</p> <p><i>Website: www.cigna.com</i></p>
<p>For retiree or retiree's dependents under age 65: Mental Health/Substance Abuse (MH/SA)</p>	<p>CIGNA Behavioral Health</p>	<p>Member Services: phone number is found on your CIGNA ID card (MH/SA)</p> <p><i>Website: www.cigna.com</i></p>
<p>Prescription Drugs</p>	<p>Medco</p>	<p>Member Services: 1-800-685-8869</p> <p>To mail new prescriptions:</p> <p>Medco P.O. Box 650322 Dallas, TX 75265-0322</p> <p>To order online: www.medco.com</p> <p>For the automated refill system:</p> <p>1-800-473-3455</p> <p>For instructions on how to fax your prescription, have your doctor call:</p> <p>1-888-327-9791</p>
<p>For retiree or retiree's dependents under age 65: Vision</p>	<p>Vision Service Plan</p>	<p>Member Services: 1-800-877-7195</p> <p>To file a claim, mail your claim to:</p> <p>Vision Service Plan Attn: Out-of-Network Provider Claims P.O. Box 997100 Sacramento, CA 95899-7100</p> <p><i>Website: www.vsp.com</i></p>
<p>For retiree or retiree's dependents under age 65: Disease Management</p> <p>Clinical support for specific health conditions; asthma, cardiac arterial disease, chronic obstructive pulmonary disease, congestive heart failure, diabetes, low back pain</p>	<p>Optimal Health</p>	<p>1-866-225-2980</p>

For retiree or retiree's dependents under age 65: Dental	MetLife	Member Services: 1-800-942-0854 To file a claim, mail your claim to: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 <i>Website: www.metlife.com</i>
	Delta Dental	Member Services: 1-800-223-3104 To file a claim, mail your claim to: Delta Dental Plan of Tennessee 240 Venture Circle Nashville, TN 37228 <i>Website: www.deltadentaltn.com</i>
Long Term Care	MetLife	Member Services: 1-800-438-6388 Mailing address: Metropolitan Life Insurance Company P.O. Box 937 Westport, CT 06881-0937
Life Insurance: Basic Life, Supplemental Life	MetLife	Statement of Health Unit: 1-800-638-6420 prompt 1 For Life Insurance conversions information: 1-877-275-6387
Savings Program	Retirement Savings Plan Committee	Mailing address: Y-12 National Security Complex c/o Plan Administrator's Office 602 Scarboro Road, MS-8258 Oak Ridge, TN 37830-8258
	Schwab Retirement Plan Services Company	United States: 1-800-777-4015 TDD: 1-877-852-4289 <i>Website: http://www.401kaccess.com/oakridge</i>
COBRA	Ceridian Benefits Services	Member Services: 1-800-877-7994 Mailing address: Ceridian COBRA Services COBRA Administration Center 3201 34th Street South St. Petersburg, FL 33711

<p>Direct Billing for Insurance Continuation</p> <p>For Retirees under age 65, Displaced Defense Workers and Long Term Disability participants who directly pay medical, dental, and life premiums.</p>	<p>Ceridian Services</p>	<p>Member Services: 1-800-898-0217</p> <p>Billing address</p> <p>If an invoice is included with the payment, mail invoice and check to:</p> <p>Ceridian Benefits Services, Inc. 7738 Collection Center Drive Chicago, IL 60693</p> <p>If no invoice will be mailed, please be sure to include the social security number of the member on the check. Mail the check to:</p> <p>Ceridian Benefits Services Attn: Y-12 Insurance Continuation P.O. Box 7482 Princeton, NJ 08543-7482</p>
<p>Where to Get Social Security and Medicare Questions Answered</p>	<p>Social Security and Medicare</p>	<p>Social Security</p> <p>Main Telephone: 1-800-772-1213 Oak Ridge Office: 1-865-482-6908 <i>Website: www.socialsecurity.gov</i></p> <p>Medicare</p> <p>Main Telephone: 1-800-633-4227 <i>Website: www.medicare.gov</i></p>
<p>For Retiree or Retiree's Spouse over age 65: Dental/Vision</p>	<p>United Healthcare</p>	<p>Member Services 1-866-605-2540 (Dental) 1-800-638-3120 (Vision)</p> <p>UnitedHealthcare Dental Attn: Claims Division P. O. Box 30567 Salt Lake City, UT 84130</p> <p>UnitedHealthcare Vision Attn: Claims Division P. O. Box 30978 Salt Lake City, UT 84130 Fax: 1-248-733-6060</p>
<p>For retiree or retiree's spouse over age 65: Major Medical Medicare Supplement Plan</p>	<p>United Healthcare</p>	<p>Member Services: 1-800-436-7295</p> <p>To file a medical claim, mail your claim to:</p> <p>UnitedHealthcare Company P. O. Box 740800 Atlanta, GA 30374-0800</p>

Y-12 BOOK OF BENEFITS



MEDICAL PLAN



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



YOUR BOOK OF BENEFITS—PRE-65 RETIREES

Y-12 BOOK OF BENEFITS

Depending on where you live, you may continue enrollment at early retirement until age 65 for medical coverage under one of the two medical plans – the Point-of Service Plan (POS) or the Open Access Plan. If there is no CIGNA contracted network available, coverage may be available under the Indemnity Plan. The medical plans have different plan designs. CIGNA administers these plans. CIGNA also administers and manages the network of health care providers for the medical plans. You are automatically covered for prescription drug benefits and vision benefits when you enroll in a medical plan.

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

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

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

Your Medical Benefits

- Offer coverage under one of the Point-of-Service plans for most eligible retirees or retirees' dependents – who are under age 65. After age 65, a retiree and spouse may be eligible to enroll in the post 65 retiree benefit plans.

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

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

You may also choose to waive continuation of coverage. If you waive coverage continuation, you will not be able to enroll at a later date.

Eligible Dependents may be eligible for coverage under the same plan in which you are enrolled. However, dependents cannot have coverage unless you are covered.

What happens to your benefits when?

For more information about what happens to your medical benefits when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” section. Also, see “Your Rights Under COBRA” in the “Administrative Information” section. Point-of-Service Medical Plans

How the Point-of-Service Plans Work

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

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

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

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

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

Under the Point-of-Service Plan:

- You must select a primary care physician for each covered family member. You or your family may designate any licensed/certified participating primary care provider who is available to accept you or your family member. For any participant or beneficiary that is a child, you have the right to designate a licensed/certified participating pediatrician as a primary care provider.
- Your primary care physician must refer you to a specialist physician in order for you to receive in-network benefits (even in-network physicians). Otherwise, your benefits will be considered at the out-of-network rate. If the specialist refers you to another specialist, that referral must be made by the primary care physician. If you need more visits with the specialist than is approved, the primary care physician must get approval for more visits or the additional charges will be denied and you will have to pay them. Make sure you know how many visits are approved.
- A woman may “self-refer” to a network OB/GYN (Obstetrical/Gynecological). OB/GYN care from a licensed/certified OB/GYN physician does not require prior authorization or referral.

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

Under the Open Access Plan:

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

Deductibles, Copayments and Coinsurance

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

Coinsurance means the percentage of charges for covered expenses that you are required to pay under the plan.

Copayments and Deductibles are those expenses to be paid by you or your Eligible Dependents for the services received.

Deductible amounts are separate from, and not reduced by, copayments.

Copayments and deductibles are in addition to any coinsurance.

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

If You Have an Emergency

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

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

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

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

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

The Network Credentialing Process

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

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

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

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

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

Special Circumstances

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

If you need care while traveling outside your network area

You are covered for Emergency care or Urgent Care on an in-network basis, as long as you call your primary care physician or CIGNA Member Services within 48 hours of receiving the emergency or

urgent treatment. (If you are traveling outside the U.S. you may wait until you return home to contact your primary care physician. You must file a claim for reimbursement as soon as possible when you return.) For other types of care, call your primary care physician to determine your best options.

Residing in another location

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

Out-of-Network Benefits

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

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

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

Reasonable and Customary Charges

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

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

The Family Deductible

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

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

The Out-of-Pocket Expenses and Your Maximum Expenses

The out-of-pocket expenses are covered expenses incurred for in-network and out-of-network charges for which no payment is provided because of any applicable coinsurance. The out-of-pocket maximum

limits the amount you pay for medical expenses in one year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses.

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

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

Precertification

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

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

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

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

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

Mental Health/Alcohol and Substance Abuse Treatment

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

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

CIGNA Member Services

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

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

In addition to Member Services:

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

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

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

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

Contacting CIGNA Member Services

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

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

Summary of Benefits: Point-of-Service Plan

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

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

Point-of-Service: Hospital Care

Services Covered	In-Network	Out-of-Network*
Inpatient Services		
Semi-private room, Operating room, X-ray, and laboratory services. Includes stand-alone facilities such as Birthing Center	Covered 100%, no copayment	Covered 80% of R&C* after deductible
Outpatient Services		
• Outpatient surgery. Operating, Recovery, Procedure and Treatment room	Covered 100%	Covered 80% of R&C* after deductible
• Physician's Office	Covered 100% after \$10 office visit copayment per visit	Covered 80% of R&C* after deductible
Organ Transplant Coverage		
• Inpatient Facility	Covered 100% at approved facilities	Not covered
• Travel Benefit	\$10,000 per transplant per lifetime available when using an approved facility	Not covered
Emergency Room Services (not covered if not true Emergency)	Covered 100% after \$50 copayment (waived if admitted)	Covered 100% after \$50 copayment (waived if admitted)
Ambulance Services (not covered if not true Emergency)	Covered 100%*	Covered 100%
Urgent Care Facility (not covered if not true Emergency)	Covered 100% after \$25 copayment	Covered 100% after \$25 copayment
Inpatient Mental Health	Covered 100%*	Covered 80% of R&C* after deductible
Inpatient Substance Abuse	Covered 100%*	Covered 80% of R&C* after deductible

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

Point-of-Service: Physician Care

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

Point-of-Service: Physician Care Cont.

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

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

Point-of-Service: Prescription Drugs

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

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

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

For Vision Benefit Summary - see Vision section.

Summary of Benefits: Open Access Plan

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

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

Open Access: Hospital Care

Services Covered	In-Network	Out-of-Network*
Inpatient Services: semi-private room, operating room, X-ray, and laboratory services. Includes stand-alone facilities such as Birthing Center.	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Outpatient Services: Outpatient surgery, Operating, Recovery, Procedure, and Treatment Room.	Covered 90% after deductible and \$150 copayment per visit	Covered 60% of R&C* after deductible and \$300 copayment per visit
Organ Transplant Coverage		
• Inpatient Facility	Covered 90% after deductible and \$250 copayment at approved facilities	Covered 60% of R&C* after deductible and \$500 copayment per admission
• Travel Benefit	\$10,000 per transplant per lifetime available when using an approved facility	Not covered
Emergency Room Services	Covered 100% after \$100 copayment (waived if admitted)	Covered 100% after \$100 copayment (waived if admitted)
Ambulance Services (not covered if not true emergency)	Covered 100%*	Covered 100%
Urgent Care Facility	Covered 100% after \$50 copayment	Covered 100% after \$50 copayment
Inpatient Mental Health	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Inpatient Alcohol and Drug Abuse	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Maternity – Inpatient	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
Inpatient Services at other healthcare facilities: • Includes Skilled Nursing Facility, Rehabilitation Hospital and Subacute facility • 60 days per calendar year for in-network and out-of-network combined	Covered 90% after deductible	Covered 60% of R&C* after deductible
Hospice Care		
• Inpatient	Covered 90% after deductible and \$250 copayment per admission	Covered 60% of R&C* after deductible and \$500 copayment per admission
• Outpatient	Covered 100%, no copayment	Covered 60% of R&C* after deductible

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

Open Access: Physician Care

Services Covered	In-Network	Out-of-Network*
Primary Care office visit	Covered 100% after \$15 copayment	Covered 60% of R&C after deductible
Specialist office visit	Covered 100% after \$30 copayment	Covered 60% of R&C after deductible
Physician and Surgeon services in hospital	Covered 90% after plan deductible	Covered 60% of R&C* after deductible
Maternity office visits	Covered 100% after one-time office visit copayment	Covered 60% of R&C* after deductible
Maternity Delivery (physician charges)	Covered 90% after plan deductible	Covered 60% of R&C* after deductible
Preventive Health Services		
• Well-baby Care	Covered 100% after \$15 copayment (includes immunizations)	Not covered
• Routine Physical exam	Covered 100% after \$15 primary care office copayment.	Not covered
• Routine Gynecological exams	Depends on how doctor is contracted: If Primary Care: \$15 copayment If Specialist: \$30 copayment	Not covered
• Routine Mammogram	Covered at 100% (no referral needed)	Covered 60% of R&C* after deductible
• Hearing Aid benefits	\$750 maximum every 36 months	Not covered
Hearing Exam	\$30 copayment per visit	Not covered
Chiropractic Care when medically appropriate 25 visits per year	Covered 100% after \$30 copayment	Not covered
Substance Abuse — Outpatient	\$30 copayment per visit	Covered 60% R&C* after deductible
Mental Health — Outpatient	\$30 copayment per visit	Covered 60% of R&C* after deductible
Physician Services in Emergency Room	Covered 100%	Covered 100%

Open Access: Physician Care Cont.

Services Covered	In-Network	Out-of-Network*
<p>Infertility Treatment</p> <p>Coverage will be provided for:</p> <ul style="list-style-type: none"> • Testing and treatment in connection with an underlying medical condition. • Testing specifically to determine the cause of infertility. • Treatment specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial insemination, In-vitro, GIFT, ZIFT, etc. <p>If any infertility procedures result in a successful birth, no further benefits are available.</p> <p>\$20,000 lifetime maximum.</p>	<ul style="list-style-type: none"> • \$30 copay per office visit • Inpatient facility: 90% after \$250 per admission copay and deductible • Inpatient physician: 90% after plan deductible • Outpatient facility: 90% after \$150 per visit copay and deductible 	<ul style="list-style-type: none"> • 60% of R&C* after deductible • 60% after \$500 per admission and plan deductible • 60% after deductible • 60% after \$300 per visit and plan deductible

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

Prescription Drugs Benefit Summary for Open Access Plan

Pharmacy benefits for: Open Access Plan administered by Medco.

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

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

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

Vision Benefit Summary - see Vision section.

Contacting CIGNA Member Services

For medical precertification, questions, or concerns:
1-800-CIGNA24 (1-800-244-6224)

This telephone number is also listed on your ID card.

CIGNA Indemnity Plan

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

How the Indemnity Plan Works

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

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

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

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

Reasonable and Customary Charges

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

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

The Family Deductible

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

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

The Out-of-Pocket Maximum

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

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

- expenses for substance abuse treatment
- non-compliance penalties for not following precertification requirements

- charges above Reasonable and Customary Charges
- care that is received but not covered by the plan.

Second Surgical Opinion

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

Preadmission and Post-Confinement Testing

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

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

Mental Health/Alcohol and Substance Abuse Treatment

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

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

Summary of Benefits: CIGNA Indemnity Plan

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

Indemnity Plan: Hospital Care

Inpatient Services: semi-private room, operating room, X-ray, laboratory services, and Physician visits/consultations	Covered 80% of R&C* after deductible
<p>Outpatient Services:</p> <ul style="list-style-type: none"> • Physician's office • Outpatient surgery, Operating, Recovery, Procedure, and Treatment room • Outpatient professional services – Surgeon, Radiologist, Pathologist, Anesthesiologist • X-ray and Laboratory services 	Covered 80% of R&C* after deductible
<p>Organ Transplant Coverage:</p> <ul style="list-style-type: none"> • Medically appropriate • Non-experimental • Inpatient and physician services 	<p>Covered 80% of R&C* after deductible</p> <p>Travel services maximum only at a LifeSource Facility: \$10,000 per lifetime</p>
Multiple Surgical Reductions	Multiple surgeries performed during one operating session will result in payment reduction of 50% of charges to the surgery of lesser charges. The most expensive procedure is paid as any other surgery.
Emergency Room	Covered 80% of R&C* after deductible
Inpatient Mental Health	Covered 80% of R&C* after deductible
Inpatient Substance Abuse	Covered 80% of R&C* after deductible
Maternity – Inpatient	Covered 80% of R&C after deductible
<p>Inpatient services at other health care facilities:</p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p>	<p>Covered 100% of R&C*</p> <p>Up to 60 days confinement per calendar year maximum</p>
Ambulance Services	Covered 80% of R&C* after deductible
<p>Outpatient short-term rehabilitation.</p> <p>Includes Cardiac, Physical, Speech, Occupational, Pulmonary, and Cognitive Therapy</p> <p>Contract year maximum is unlimited</p>	<p>Covered 80% of R&C* after deductible</p> <p>Therapy days, provided as part of an approved Home Health Care Plan, accumulate to the Outpatient Short Term Rehab maximum. If multiple outpatient services are provided on the same day, they constitute one day, but a separate copy will apply to the services provided by each participating provider.</p>

Indemnity Plan: Physician Care

<p>Physician Office Visit:</p> <ul style="list-style-type: none"> • Primary Care and Specialist • Surgery performed in the physician's office • Allergy Treatment/Injections • Maternity office visits 	Covered 80% of R&C* after deductible
Chiropractic Care	Covered 80% of R&C* after deductible 25 visit limit per year
Emergency or Urgent Care at doctor's office	Covered 100% of R&C*
Urgent Care Facility	Covered 80% of R&C* after deductible
Physician and Surgeon Services in hospital	Covered 80% of R&C* after deductible
Allergy Serum (dispensed by the physician in the office)	Covered 80%* no deductible
Maternity Delivery (physician charges)	Covered 80% of R&C* after deductible
<p>Preventive Health Services:</p> <ul style="list-style-type: none"> • Well-Child Care for children to age 3 (including immunizations) • Annual routine physicals, adult immunizations, Well Woman Care • Mammogram, Pap test, or Prostate Specific Antigen Test (PSA) 	100% of R&C*
Hearing Aid Benefits	Not Covered
Laboratory, X-ray, Radiology (MRIs, MRAs, CAT Scans and PET scans)	Covered 80% of R&C* after deductible if billed by a separate outpatient diagnostic or independent facility (such as a hospital)
<p>Home Health Care: (skilled care only) Maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. Maximum of 8 visits per day).</p>	<p>Covered 100% of R&C*, no deductible Up to 60 days per calendar year maximum</p>
<p>Hospice Care:</p> <ul style="list-style-type: none"> • Diagnosed as having up to 6 months to live • Inpatient Services • Outpatient Services • Bereavement Counseling (excludes services by Mental Health Professional) 	Covered 80% of R&C* after deductible, maximum 60 days per lifetime.
<p>Substance Abuse:</p> <ul style="list-style-type: none"> • Outpatient • Inpatient • Physician Office • Outpatient Facility 	Covered 80% of R&C* after deductible

<p>Mental Health Service:</p> <ul style="list-style-type: none"> • Outpatient • Inpatient • Physician Office • Outpatient Facility 	Covered 80% of R&C* after deductible,
Physician Services in Emergency Room	Covered 80% of R&C* after deductible
Durable Medical Equipment	Covered 80% of R&C* after deductible
<p>Infertility Treatment:</p> <ul style="list-style-type: none"> • Artificial insemination is subject to 3 attempts per menstrual cycle with a maximum of 8 cycles per lifetime. Total attempts is 24 per lifetime. Includes tests and counseling. • In Vitro fertilization, GIFT and ZIFT is subject to a separate lifetime maximum of 4 attempts. Includes tests and counseling. 	<p>Covered 80% of R&C* after deductible</p> <p>If any infertility procedures result in a successful birth, no further benefits are available.</p>
<p>External Prosthetic Devices - Requires approval by Health Plan</p> <p>(External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints).</p> <p>Excludes orthotics.</p>	Covered 80% of R&C* after deductible
<p>Dental Care – Limited to charges for a continuous course of dental treatment started within six months of an injury to sound, natural teeth</p> <ul style="list-style-type: none"> • Physician’s Office/Services • Inpatient Facility • Outpatient Surgical Facility 	Covered 80% after the deductible
<p>Temporomandibular Joint Disorder (surgical & non-surgical treatment):</p> <ul style="list-style-type: none"> • Physician’s Office/Services • Inpatient Facility • Outpatient Surgical Facility 	Covered 80% of R&C* after deductible
Chemotherapy & Radiotherapy	<ul style="list-style-type: none"> • Inpatient services covered 80% of R&C* after deductible • Outpatient services covered 100% of R&C*

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

Prescription Drug Benefit Summary for Indemnity Plan

Pharmacy benefit for: Indemnity Plan administered by Medco.

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

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

For Vision Benefit Summary - see Vision section.

Important Telephone Numbers

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

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

These telephone numbers are also listed on your ID card.

Information for All Medical Plans

Certification Requirements

For all medical plans, all inpatient hospital admissions, outpatient diagnostic tests and outpatient procedures must be reviewed to certify the medical necessity of the admission, test or procedure.

OB/GYN does not require precertification or referral.

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

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

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

Preadmission Certification/Continued Stay Review for Hospital Confinement

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

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

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

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

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

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

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

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

Outpatient Certification Requirements

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

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

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

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

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

Diagnostic Testing and Outpatient Procedures

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

Prior Authorization/Pre-Authorized/Precertification

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

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

- inpatient hospital services
- inpatient services at any participating other health care facility
- residential treatment
- outpatient facility services
- advanced radiological imaging
- nonemergency ambulance
- transplant services.

Emergency Hospitalization

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

For precertification call:

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

Expenses Not Covered and General Limitations

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

- expenses for supplies, care, treatment, or surgery that are not medically necessary
- to the extent that you or any one of your Eligible Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- to the extent that payment is unlawful where the person resides when the expenses are incurred
- charges made by a hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected injury or sickness
- for or in connection with an injury or sickness which is due to war, declared or undeclared
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care
- for or in connection with experimental, investigational or unproven services (as defined and determined by CIGNA and/or the Institutional Review Board, the Food and Drug Administration)
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance
- macromastia or gynecomastia surgeries; surgical treatment of varicose veins
- Regardless of clinical indication for: abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:
 - charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth
 - charges made by a hospital for bed and board or necessary services and supplies
 - charges made by a free-standing surgical facility or the outpatient department of a hospital in connection with surgery
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management

of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision

- excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to restrict food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejuna bypass
- unless otherwise covered by the plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this plan
- infertility services except as provided by the plan including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage
- reversal of male or female voluntary sterilization procedures
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation – except as provided by the plan
- medical and hospital care and costs for the infant child of an Eligible Dependent, unless this infant child is otherwise eligible under this plan
- nonmedical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected
- consumable medical supplies other than ostomy supplies and urinary catheters, except as provided by the plan
- private hospital rooms and/or private duty nursing unless determined by the utilization review physician to be medically necessary
- personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an injury or sickness

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs
- hearing aids, except as provided by the plan, including but not limited to semi-implantable hearing devices, audiant bone conductors and bone anchored hearing aids (BAHAs). A hearing aid is any device that amplifies sound
- aids or devices that assist with nonverbal communications
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that covered expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- treatment by acupuncture
- all non-injectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the plan
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease
- dental implants for any condition
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- blood administration for the purpose of general improvement in physical condition
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
- cosmetics, dietary supplements and health and beauty aids
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism and professional medical services under the supervision of a physician and special dietary formulas medically necessary for therapeutic treatment of PKU
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider

- medical treatment when payment is denied by a primary plan because treatment was received from a nonparticipating provider
- for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit (including workers compensation).
- telephone, e-mail, and Internet consultations, and telemedicine
- massage therapy
- for charges which would not have been made if the person had no insurance
- to the extent that charges are more than Reasonable and Customary Charges
- expenses incurred outside the United States, unless you or your Eligible Dependent is a U.S resident and the charges are incurred while traveling on business or for pleasure
- charges made by any covered provider who is a member of your family or your Eligible Dependent's family
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Filing Claims

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

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

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

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

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

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

Coordination of Benefits

If you or any of your Eligible Dependents are covered under another medical plan, CIGNA determines how benefits from all such plans will be coordinated, as described in the plan document that governs

the company plan under which you are covered (refer to the “Administrative Information” section in this book on how to obtain a plan document).

Medicare Eligible

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

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

Company Right to Reimbursement (Subrogation)

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

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

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

Newborns’ and Mothers’ Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

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

Medical Insurance After Age 65 – During Active Service

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

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

Continuation of Medical Coverage (COBRA)

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

Proof of Prior Coverage

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

Certificate of Creditable Coverage

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

Health Insurance Portability and Accountability Act

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

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

Coverage for Reconstructive Surgery Following Mastectomy

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

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

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

Genetic Non-Discrimination Act (GINA)

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

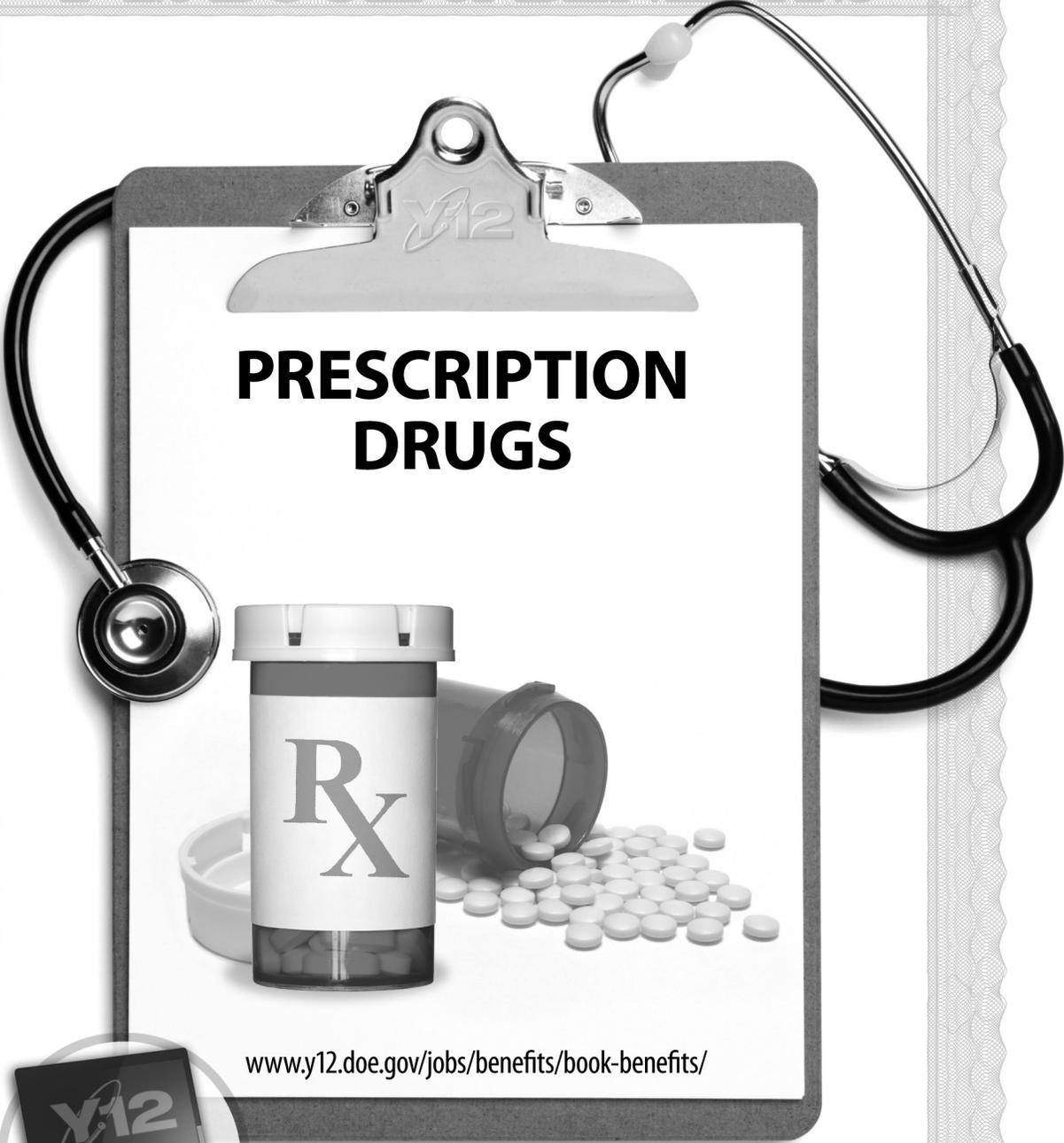
Conversion Privileges

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

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

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

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



**PRESCRIPTION
DRUGS**

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



YOUR BOOK OF BENEFITS—PRE-65 RETIREES

PRESCRIPTION DRUGS

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

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

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

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

Refills: www.medco.com or call 1-800-473-3455.

Have your ID card and your refill bottle with the prescription information ready.

Your Prescription Drug Benefits:

There are two prescription drug benefit designs. The design available to retirees or retiree's dependents under age 65 is based on the medical plan in which you are enrolled (i.e., the **Point-of-Service**, the **Open Access**, or the **Indemnity Plan**). The prescription design with the Point-of-Service Plan has a 3-tier design structure, and is the same for the retail network or mail pharmacy. The design with the Open Access Plan or the Indemnity Plan is different at retail versus mail order. Regardless of the benefit design that is applicable to your coverage, you can get up to a 30-day supply at a retail network pharmacy, and a 90-day supply at the mail order pharmacy.

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

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

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

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

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

Summary of Benefits: Prescription Drugs

Prescription Drug Benefit Summary for Point-of-Service Plan

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

Prescription Drug Benefit Summary for Open Access and Indemnity Plans

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

Medco Pharmacy Features

Consultation with a Pharmacist

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

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

Disease Management

Clinical support and counseling is available for specific health conditions:

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

Mail Order for 90-Day Supply

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

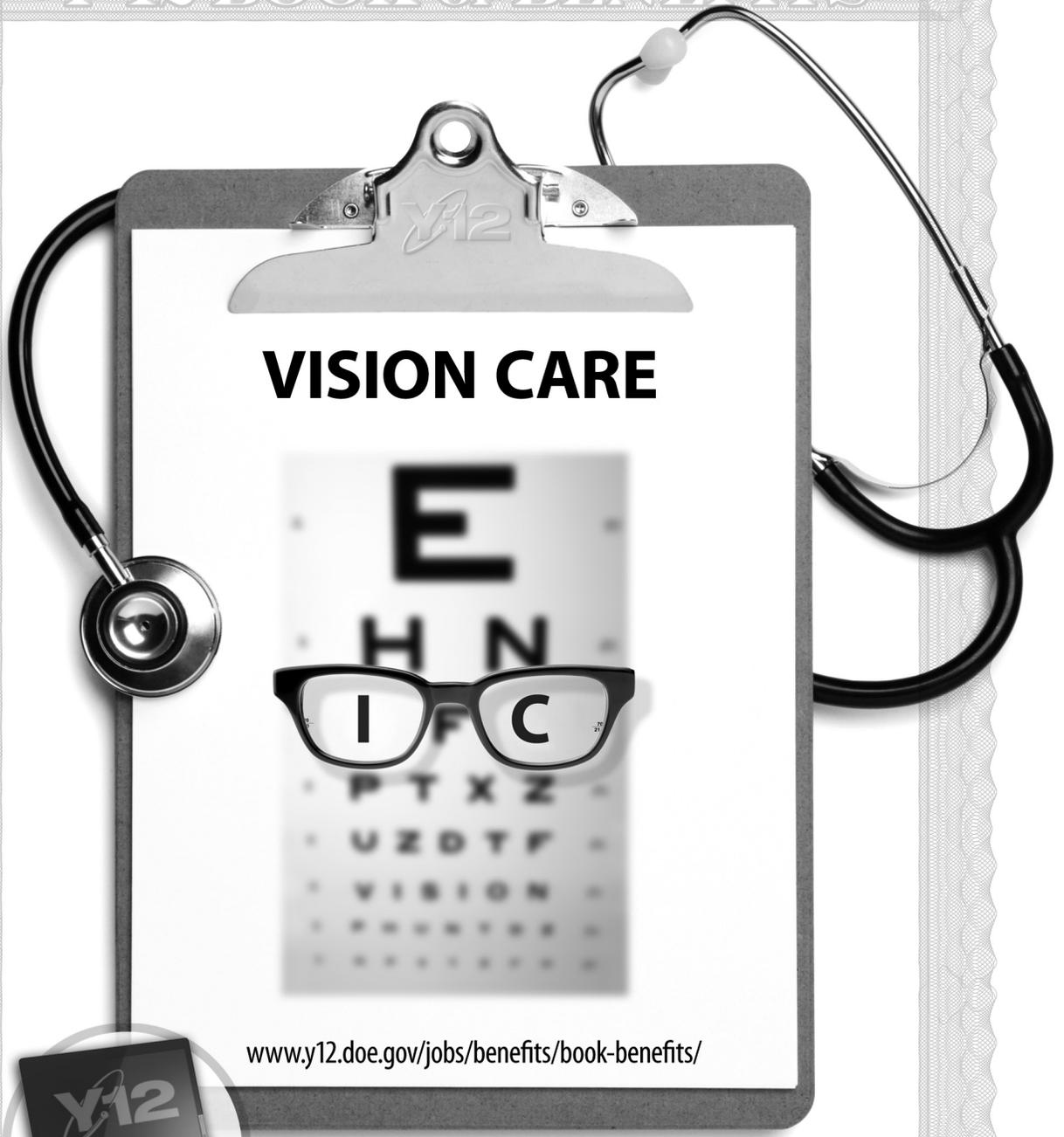
Fax: Have your doctor call 888-327-9791

Web: www.medco.com

Telephone: 1-800-473-3455

Customer Service

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



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



YOUR BOOK OF BENEFITS—PRE-65 RETIREES

The Vision Plan

Retirees or retiree's dependents under age 65 are automatically enrolled in the Vision Plan when you enroll for retiree medical coverage. Vision benefits are the same when enrolled in any medical plan: **Point-of-Service, Open Access, or Indemnity.**

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

Your Vision Benefits

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

Web: www.vsp.com

Customer Service: 1-800-877-7195

To file a claim:

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

Exclusion for Surgery or Disease

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

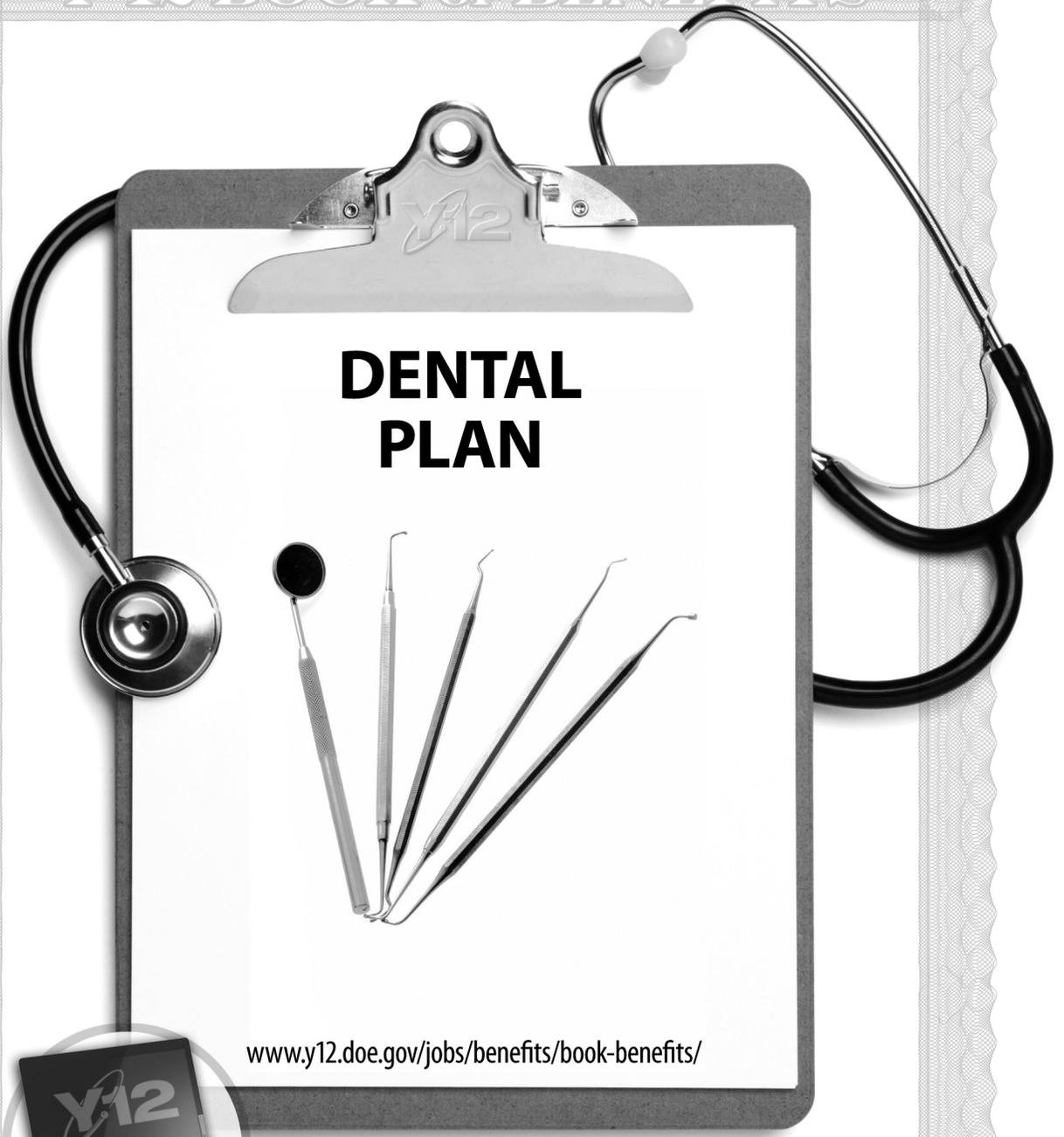
VSP Customer Service: 1-800-877-7195

VSP Vision Features

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

Summary of Benefits: Vision Plan

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



**DENTAL
PLAN**

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



YOUR BOOK OF BENEFITS—PRE-65 RETIREES

There are two retiree dental plans to choose from – the Metropolitan Life Plan (MetLife) and the Delta Dental Plan of Tennessee (Delta Dental). You may elect either plan, but not both.

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

The Dental Plans:

- Encourage preventive care

The dental plans promote regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings and X-rays, at 100% of Reasonable and Customary Charges with no deductible.

- Offer protection for more extensive treatment

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

- Provide orthodontic benefits for your children

Coverage for orthodontic treatment is available for your Eligible Dependent Children under age 24.

What happens to your benefits when?

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

For more information about coverage you and your Eligible Dependents may be eligible to continue in certain cases when coverage would otherwise end, refer to COBRA within the “Administrative Information” section. Also, see “Your Rights Under COBRA” in the “Administrative Information” section.

Some facts to remember about your dental plans:

- Dependents in military service are not eligible for dental coverage.
- A predetermination of benefits is recommended for costs that are expected to exceed \$100.
- Individuals who waive retiree coverage when first eligible, or drop after retirement, will not be eligible to enroll at a later date.
- Open enrollment will allow retiree to switch between the MetLife and Delta Dental plans or delete dependents.
- Retirees or surviving spouses may continue retiree coverage at retirement, but a newly acquired spouse cannot be added.

MetLife Dental Plan—How the MetLife Plan Works

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

Network Provider

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

Non-Network Provider

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

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

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

Briefly, the plan covers four types of dental services:

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

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

Annual Deductible

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

Maximum Benefits

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

MetLife Dental Plan

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

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

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

Covered Expenses

Type A – Preventive and Diagnostic Services

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

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

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

Type B – Oral Surgery and Restorative Services

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

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

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

Type C – Prosthodontic Services

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

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

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

Type D – Orthodontic Services

No deductible applies to Type D covered expenses.

All covered Children through age 23 are eligible to receive benefits for orthodontic services. At age 24, all coverage under the plan ends, even if a course of orthodontic treatment is ongoing.

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

Covered expenses for orthodontic services include charges for:

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

Exclusions

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

- services provided before plan coverage becomes effective
- services other than those specifically covered by the plan
- services and supplies that are not provided by a legally licensed dentist or physician (or a licensed hygienist for the scaling or cleaning of teeth and topical application of fluoride under the dentist's supervision)

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

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

Extended Dental Care Benefits

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

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

Exceptions to this 30-day extension include treatment involving:

- prosthetic devices – impressions and tooth preparation must be completed before coverage ends and the device must be installed or delivered within two calendar months following the end of coverage
- crowns – tooth preparation must be completed before the coverage ends and the crowns installed within two calendar months following the end of coverage

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

Predetermination of Benefits

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

Here is how it works:

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

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

Alternative Course of Treatment

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

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

Treatment in Progress

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

Claiming Benefits

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

Completed forms should be mailed to MetLife at the address listed on the claim form.

MetLife will send an explanation of payment with the benefit check. If you have authorized MetLife to pay your dentist directly, the dentist will receive an explanation of payment with the check. You will receive a copy of the explanation if you have a balance due. Detailed claim information is available on the MyBenefits website at www.metlife.com/mybenefits.

Coordination of Benefits

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

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

Other Company Benefits

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

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

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

Delta Dental Plan—How the Delta Plan Works

Eligibility and Enrollment

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

Choosing a Dentist

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

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

Participating vs. Non-Participating

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

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

Annual Deductible

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

Maximum Benefits

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

Emergency Dental Care

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

Four Types of Dental Services

Type A: Preventive and diagnostic benefits

Type B: Basic Benefits

Type C: Major Benefits

Type D: Orthodontic services

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

Delta Dental Plan

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

Services covered	Amount of coverage
Calendar year maximum	\$1,500
Lifetime orthodontic maximum	\$1,500
Lifetime maximum	N/A
Annual deductible (applies to Type B and Type C services only)	\$50 per member
Type A: Preventive and diagnostic services	
Oral examinations	Covered 100% twice every 12 months
Prophylaxis (cleanings)	Covered 100% twice every 12 months
Full mouth X-rays	Covered 100% once every 36 months
Bite-wing X-rays	Covered 100% two sets every 12 months
Fluoride	Covered 100% under age 19
Space maintainers	Covered 100% under age 15
Type B: Basic services	
Fillings (other than gold), general anesthesia, occlusal guards, extractions and oral surgery, periodontics, endodontics (root canal therapy)	Covered 80% after deductible
Sealants	Covered 80% under age 16, one benefit per tooth. Chewing surfaces for permanent first and second molars only.
Type C: Major services (no age limit for bridges, partial dentures, or full dentures)	
Crowns	Covered 50% after deductible, excluding porcelain, gold or veneer crowns for children under age 12
Bridges	Covered 50% after deductible, excluding fixed bridges or cast partials for children under age 16
Partial dentures/full dentures	Covered 50% after deductible
Type D: Orthodontic services	
Orthodontic services: braces, surgical repositioning to correct malocclusion, surgical extractions, X-rays, retention checking	Covered 50% for dependents up to age 24 Lifetime maximum: \$1,500

Delta Dental Schedule of Benefits

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

Type A – Preventive and Diagnostic Services

- Preventive – prophylaxis (cleaning), topical application of fluoride, and space maintainers.
- Diagnostic – oral examination and X-rays to aid the dentist in planning required dental treatment.

Limitations and Exclusions on Preventive and Diagnostic Benefits:

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

Type B – Basic Benefits Services

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

Limitations and Exclusions on Basic Benefits:

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

- Payment for root canal treatment includes charges for X-rays and temporary restorations. Root canal treatment is limited to once in a 24-month period by the same dentist or dental office.
- Payment for periodontal surgery shall include charges for three months postoperative care and any surgical re-entry for a three-year period. Root planning, curettage and osseous surgery are not benefits for members under 14 years of age.
- The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not a benefit.
- The replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within a 24-month period of the initial placement is not a benefit.
- The replacement of a stainless steel crown on a permanent tooth by the same dentist or dental office within a 60-month period of the initial placement is not a benefit.
- Gold foil restorations are an Optional Service.
- Porcelain, composite, and metal inlays are Optional Services.
- A sealant is a benefit only on the unrestored, decay free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars. Sealants are only a benefit on members under 16 years of age. Only one benefit will be allowed for each tooth within a lifetime.

Type C – Major Benefits

- Cast Restorations – Crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.
- Prosthodontics – Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
- Complete or Partial Denture Reline – Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
- Complete or Partial Denture Rebase – Laboratory replacement of the acrylic base of the appliance.

Limitations and Exclusions on Major Benefits

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

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

Type D – Orthodontic Services

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

Limitations and Exclusions on Orthodontic Benefits

- Orthodontic benefits are limited to Eligible Dependent Children to age 24.
- Delta Dental shall make regular payments for orthodontic benefits.
- If orthodontic treatment began prior to enrolling in this plan, Delta Dental will begin benefits with the first payment due the orthodontist after the subscriber or covered Eligible Dependent becomes eligible.
- Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
- Benefits are not paid to repair or replace any orthodontic appliance received.
- Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under Preventive and Diagnostic or Basic Benefits.

Orthodontic Payment Method

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

Predetermination of Benefits

You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a predetermination. You may have your dentist send Delta Dental a claim form detailing the projected treatment and Delta Dental will give an estimate of the benefits to be paid. This will let you know approximately how much the work will cost and what your share of the costs will be. A predetermination is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums.

Optional Services

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

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

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

General Provisions

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

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

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

General Limitations and Exclusions

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

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

- Treatment to restore tooth structure loss from wear.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- Diagnosis or treatment for any disturbance of the temporomandibular joints (i.e., 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 any subscriber or Eligible Dependent terminates when they are no longer eligible for benefits as a member of the group.

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

Y-12 BOOK OF BENEFITS

**MEDICARE
SUPPLEMENT PLAN**



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



YOUR BOOK OF BENEFITS—AGES 65 AND OLDER RETIREES

Y-12 BOOK OF BENEFITS

If you are a retiree or retiree's spouse over age 65 and have Medicare Part A and Part B coverage and you do not have Medicare Part D prescription drug coverage, the Major Medical Medicare Supplement Plan is available to you. You are automatically covered for prescription drug benefits when you enroll in this medical plan. This self-funded retiree medical plan is administered by UnitedHealthcare Insurance Company (UnitedHealthcare). UnitedHealthcare has the responsibility for determining eligible expenses for covered services that are incurred while the medical plan is in effect. As the Claims Administrator, UnitedHealthcare has the discretion and authority to determine whether a treatment or supply is a covered health service, and how the eligible expense will be determined. You are responsible for paying directly to the provider any deductible or co-payment amounts in excess of any Plan maximum; and the difference between the amount the provider bills you and the amount the plan considers as eligible expenses. You should call UnitedHealthcare's Customer Service if you have questions about the limits of the medical coverage available to you.

Customer Service

As shown on your ID card

Telephone: 1-800-436-7295

Internet: www.myuhc.com

Claims submittal address: UnitedHealthcare Insurance Company
Attn: Claims
P.O. Box 740800
Atlanta, GA 30374

Review of denied claims and notice of complaints:

UnitedHealthcare Insurance Company
Attn: Appeals
P.O. Box 30432
Salt Lake City, Utah 84130

If you are over age 65, the available retiree medical plan design is a Major Medical Medicare Supplement Plan. Medicare Part A and Part B benefits are primary to this plan's benefits for Medicare eligible retirees and retiree's eligible Medicare dependent spouse. This means Medicare pays eligible expenses first, as if this plan does not exist. Then, this plan considers eligible expenses which are more than the amount payable for the same medical expenses under Medicare Part A or Part B.

Here are some important steps you must take to be covered under this plan. The list is not comprehensive, however. You should also refer to the "About Your Benefits" section of this book for additional information on eligibility.

- You must enroll when first eligible and maintain coverage, under both Medicare Part A and B to be eligible for coverage in this plan. A copy of your Medicare Part A and Part B enrollment cards should be kept on file at all times at the Benefit Plans office.
- If you enroll in a Medicare Part D prescription drug plan, your medical and prescription drug coverage under this retiree plan will be cancelled, and you cannot re-enroll at a later time. These eligibility rules apply to retirees and to an eligible spouse of a retiree.
- If you or your spouse cancel coverage or lose coverage for any reason (including enrolling in Medicare Part D), there is no future opportunity to re-enroll in this lan.
- In order for a spouse to participate in this plan, the retiree must participate.
- You must elect coverage when you are first eligible. If you do not, or you elect and later cancel coverage, neither you nor your spouse can later enroll.
- The coordination of payment between Medicare and this plan can be setup under the Medicare Crossover arrangement.
- You must enroll in the Medicare Cross-Over Program to have Medicare claims filed automatically with UnitedHealthcare. When you enroll for this program, you no longer have to file a separate claim with the plan to receive secondary benefits for these eligible expenses. Once Medicare reimburses your healthcare provider for eligible expenses, Medicare will electronically submit the necessary information to UnitedHealthcare to process the balance of your claim under the benefit provisions of this plan. Forms for enrolling in this program are available in the Benefit Plans Office. Some expenses must be filed directly with UnitedHealthcare to be considered for payment.
- Any claims that must be filed directly for reimbursement should be submitted within 90 days from the date of service. If this information is not received within one (1) year and 90 days from the date of service, the claim will be denied.
- Claims for prescription drugs must be filed under the prescription plan, including injectibles and non-injectibles given in a physician's office.

Annual Deductible

Each covered person must first pay the Annual Deductible under the Major Medical Medicare Supplement Plan. The Annual Deductible and other charges you pay are summarized in the Summary of Benefits that follows in this medical section.

When Medicare applies the Part A or Part B deductible to a medical claim submitted to Medicare, this plan also applies the same amount toward meeting this plan's Annual Deductible. This plan's Annual Deductible for medical expenses will be met when any eligible credits from Medicare Part A or Part B, plus any eligible out-of-pocket expenses you pay, equal this plan's Annual Deductible.

To help you meet your annual deductible, the plan has the following features:

First Year Credit – When you first become covered under the Major Medical Medicare Supplement Plan, you may receive credit toward your deductible for any deductible expenses you have met under your current Company medical coverage during the same year, providing you furnish copies of Explanation of Benefit (EOB) statements from the current plan that substantiates the credit.

Three Month Carryover – If you do not meet the Major Medical Medicare Supplement Plan annual deductible by the end of the calendar year, any expenses incurred during the last three months of the calendar year may be “carried over” and applied to the following year's plan deductible. You must provide EOBs from the current plan that substantiates the expenses.

Lifetime Maximum Benefits

Once plan coverage begins, the Major Medical Medicare Supplement Plan will pay up to \$75,000 in eligible medical benefits for each covered person during the rest of his or her lifetime. This maximum excludes prescription drugs. The maximum is accumulated from what is paid after Medicare pays for medical expenses.

Filing Medical Claims

The coordination of eligible payments between Medicare and this plan can be set up under the Medicare Crossover arrangement. Then, Medicare will automatically file claims information with UnitedHealthcare. Medicare Crossover forms are available in the Benefit Plans Office. Otherwise, claims for reimbursement of eligible expenses should be submitted within 90 days from the date of service. If the claim information is not received within 1 year and 90 days from the date of service, the claim will be denied.

Coordination of Benefits

The plan pays eligible expenses after Medicare has paid. The Major Medical Medicare Supplement Plan also has a coordination of benefits provision that is designed to prevent duplication of payments when you or your covered spouse can collect benefits from another coverage plan.

Under this provision, when coverage is provided by both the Company and another coverage plan, you or your covered spouse can receive up to a total of 100% of total allowable expenses from both plans — but 100% is the maximum.

Under this provision, there are order of benefit determination rules which determine whether this plan is a “primary coverage plan” or a “secondary coverage plan” when compared to another coverage plan.

In general, the primary coverage plan pays as if the secondary coverage plan did not exist. When the plan is secondary, it pays after those of another coverage plan, and eligible expenses may be reduced because of the allowable expenses paid by the primary coverage plan.

Coordination of benefits under this Plan excludes individual or family insurance, unless permitted by law.

Subrogation and Refund of Expenses

In summary, subrogation under the plan is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided under this plan to you from any or all of the following:

- third parties, including any person alleged to have caused you to suffer injuries or damages;
- your employer;
- any person or entity who is or may be obligated to provide benefits or payments to covered persons, including benefits or payments for underinsured or uninsured motorist protection, no fault, or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), Workers' Compensation coverage, other insurance plans, or third party administrators; or
- any person or entity who is liable for payment to a covered person in any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You shall cooperate and timely comply with every effort in protecting the plan's legal rights to subrogation and reimbursement. You shall do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the plan. The Company is entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you. Other subrogation and recovery rights under the plan may apply.

Refer to the "Administration Information" section for other important information.

The terms "Annual Deductible," "Retiree," "Eligible Dependents," and "Reasonable and Customary Charge" are defined in the Glossary.

Summary of Benefits: Major Medical Supplement Plan

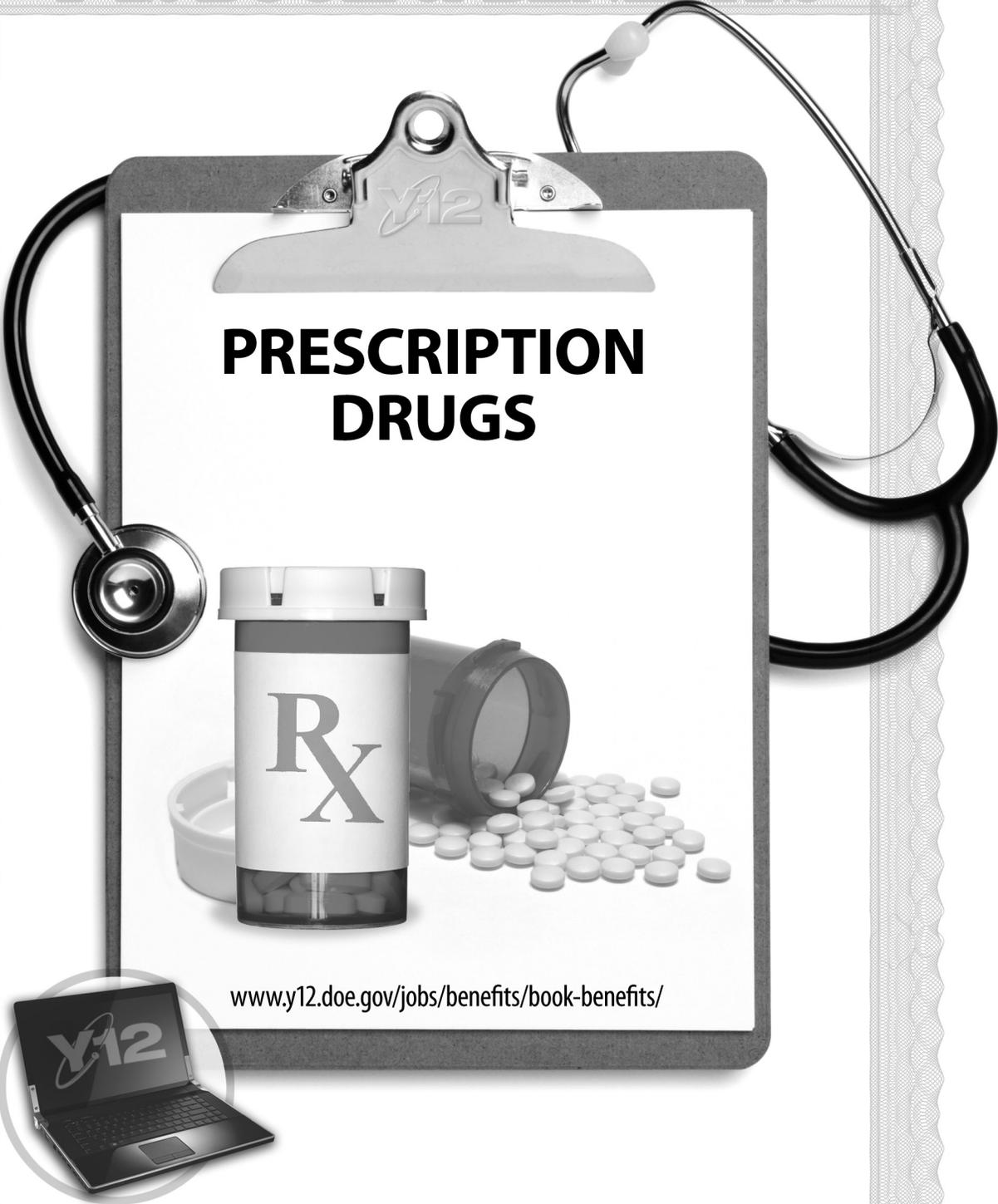
Service	After Medicare Part A or B Pays – You Pay
Annual Deductible	\$100 per person
Maximum Lifetime Benefit	\$75,000
Service	Your Coinsurance After Annual Deductible
Medical Services in a Physician's Office	20% of Eligible Expenses
Allergy Services in a Physician's Office	20% of Eligible Expenses
Professional Fees for Surgical and Medical Services	20% of Eligible Expenses
Inpatient Hospital and Related Health Services	20% of Eligible Expenses
Outpatient Emergency Health Services	20% of Eligible Expenses
Urgent Care Center	20% of Eligible Expenses
Outpatient Surgery, Diagnostic and Therapeutic Services	20% of Eligible Expenses
Mental Health and Substance Abuse Services	
• Inpatient	20% of Eligible Expenses
• Outpatient	50% of Eligible Expenses
Home Health Agency Services	20% of Eligible Expenses
Hospice Care	20% of Eligible Expenses
Ambulance Services (Emergency only to nearest hospital)	20% of Eligible Expenses
Accident-related Dental Services	20% of Eligible Expenses
Prosthetic Devices and Durable Medical Equipment	20% of Eligible Expenses
Rehabilitation Services — Inpatient or Outpatient (Includes physical therapy, occupational therapy, speech therapy, and cardiac/pulmonary rehabilitation)	20% of Eligible Expenses
Reconstructive Surgery	20% of Eligible Expenses
Bone Mass Measurement	20% of Eligible Expenses

General Expenses Not Covered

The Major Medical Medicare Supplement Plan does not cover some expenses. These include, but are not limited to, charges for:

- Routine health checkups
- Treatment in a skilled nursing facility, nursing home, convalescent home, or similar institution
- Dental services, except for treatment by a physician, dentist, or dental surgeon as a result of accidental injury to natural teeth and received within six months of the accident while insured under the plan
- Cosmetic surgery to treatment except as required to correct damage caused by an accident while insured

- Smoking cessation programs and treatment of nicotine addition
- Acupressure, hypnotism, rolfing, massage therapy, acupuncture, and other forms of alternative treatment
- Repair, replacement or duplicate prosthetic or durable medical equipment
- Experimental or investigational services and unproven services are excluded. The fact that an experimental or investigational service or an unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition
- Health services received after the date your coverage under the plan ends, including health services for medical conditionals arising before the date your coverage under the plan ends
- Foot care and foot orthotics
- Prescription drugs, vision, hearing, nutritional care, or travel
- Health services provided in a foreign country, unless required as emergency health services. An emergency medical condition is one that manifests itself by symptoms of sufficient severity and potentially results in serious jeopardy, serious impairment of bodily functions or dysfunction of any bodily organ or part
- Eyeglasses, hearing aids, and related examinations
- Treatment of any injury or sickness caused by an act of war
- Services which do not require payment
- Treatment received before the effective date of coverage under this plan
- Services to the extent they are covered by any government plan
- Services prohibited by law or regulation of any government
- Treatments for which automobile no-fault benefits or third party coverage are payable
- Health services and associated expenses for the surgical treatment and non-surgical medical treatment of obesity, including morbid obesity
- Expenses above Reasonable and Customary Charges.



**PRESCRIPTION
DRUGS**

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

YOUR BOOK OF BENEFITS—AGES 65 AND OLDER RETIREES

PRESCRIPTION DRUGS

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

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

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

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

Refills: www.medco.com or call 1-800-473-3455.

Have your ID card and your refill bottle with the prescription information ready.

Your Prescription Drug Benefits

The prescription drug benefit available to you as a post 65 Medicare eligible participant is designed to provide you with comprehensive drug coverage. If you enroll in the Major Medical Medicare Supplemental Plan, you will automatically be enrolled in the retiree prescription drug plan. The Prescription Drug Plan does not coordinate with Medicare Part D prescription drug benefits. If you already have coverage under a Medicare prescription drug plan, you cannot be covered under the Company sponsored Major Medical Medicare Supplemental Plan for medical coverage or the prescription drug plan. Benefits are different at a retail pharmacy versus mail order. You can get up to a 30-day supply at a retail network pharmacy, and a 90-day supply at the mail order pharmacy.

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

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

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

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

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

Summary of Benefits: Prescription Drugs

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

Medco Pharmacy Features

Consultation with a Pharmacist

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

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

Mail Order for 90-Day Supply

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

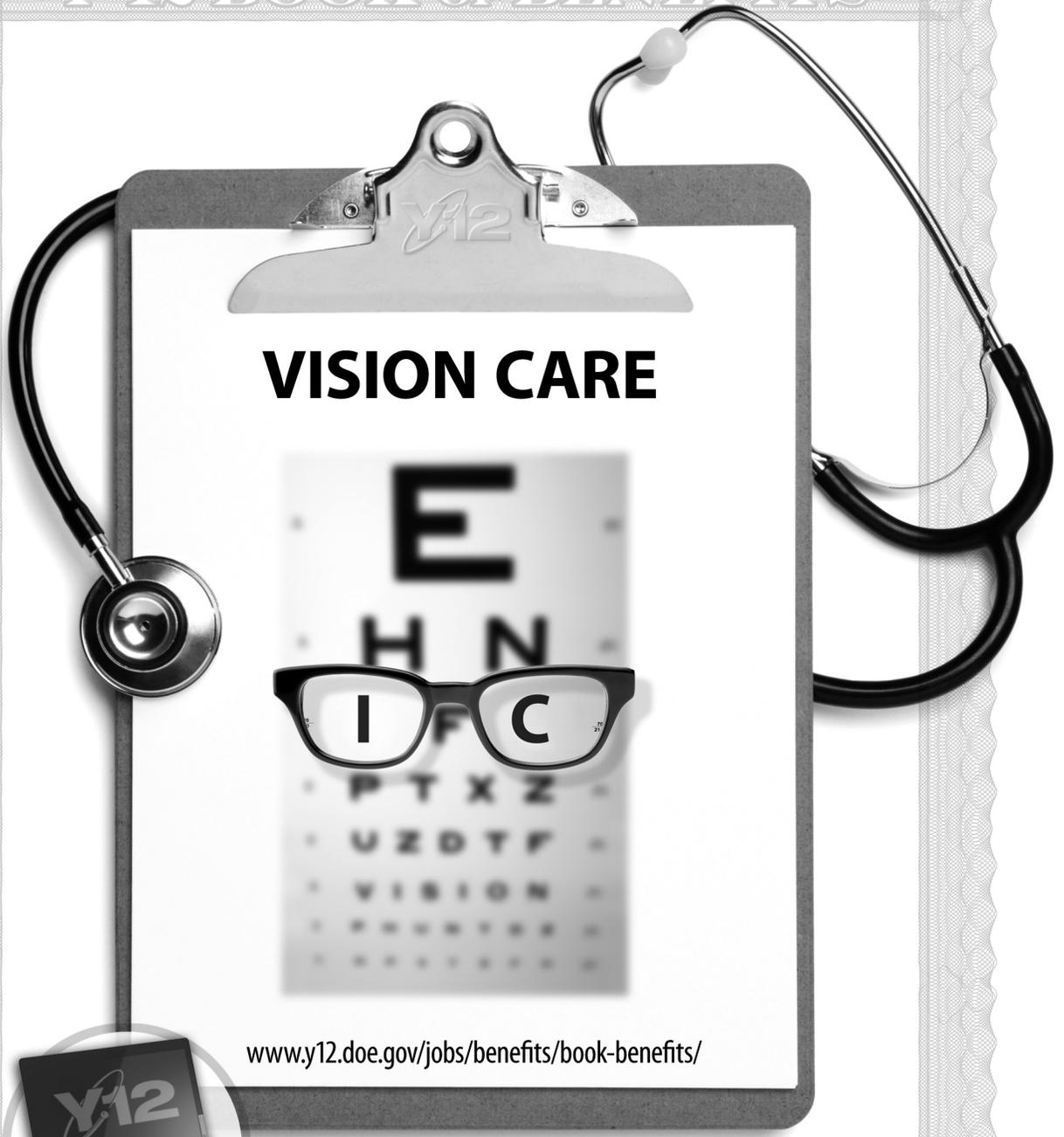
Fax: Have your doctor call 888-327-9791

Web: www.medco.com

Telephone: 1-800-473-3455

Customer Service

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



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



YOUR BOOK OF BENEFITS—AGES 65 AND OLDER RETIREES

UnitedHealthcare – Vision Plan

For retirees and eligible spouses, or surviving spouses age 65 or older, you may enroll in the UnitedHealthcare Vision Plan. When you enroll in the Vision Plan, you are automatically enrolled in the Dental Plan. You must, however, complete enrollment forms for both the Vision and the Dental plans.

When making an appointment, tell your vision provider that you have UnitedHealthcare Spectra Vision benefits so you can obtain a claim authorization prior to your visit. To receive vision benefits, select and schedule an appointment with an in-network provider in order to receive maximum benefit payments. When you use an out-of-network provider, benefit payments are reduced and additional coverage limits may apply. The Vision Plan is administered by UnitedHealthcare. A list of UnitedHealthcare network providers is available at:

Web: www.myuhcvision.com

24-Hour Provider Locator Line: 1-800-839-3242

Customer Service: 1-800-638-3120

In-Network Claims: Automatically filed for you

Mail Out-of-Network Claims: UnitedHealthcare Visions
Attention: Claims
P. O. Box 30978
Salt Lake City, UT 84130

Important to Remember

- Always identify yourself as a UnitedHealthcare participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
- Benefits are available every 12 to 24 months, depending on the benefit frequency, based on the last date of service.
- Contact Customer Service prior to obtaining out-of-network services to ensure you understand the application of maximum benefits.

Exclusions

The following services and materials are excluded from coverage under the Vision Plan. The following list is not comprehensive:

- post-cataract lenses;
- non-prescription items;
- medical or surgical treatment for eye disease that requires the services of a medical physician;
- Workers' Compensation services or materials;
- services or materials that are not specifically covered under the plan;

- replacement or repair of lenses and/or frames that have been lost or broken;
- cosmetic extras, except as listed in the Summary of Benefits table;
- services or materials that the patient, without cost, obtains from any governmental organization;
and
- services or materials that are not specifically covered under the policy.

Summary of Benefits: Vision Plan

Services Covered	In-Network	Out-of-Network Maximum Benefit
Exam every 12 months	Covered in full after \$15 copay	Covered up to \$40
Materials	\$30 copay The materials copay is a single payment that applies to the entire purchase of eyeglasses (i.e., lenses and frames), or contacts in lieu of eyeglasses.	
Lenses for eyeglasses once every 12 months		
Standard single vision Non-standard lenses (polycarbonate lenses and non-reflective coating may be available at a discount)	Covered in full after \$30 copay	Covered up to \$40
Standard bifocal	Covered in full after \$30 copay	Covered up to \$60
Standard trifocal	Covered in full after \$30 copay	Covered up to \$80
Lenticular	Covered in full after \$30 copay	Covered up to \$80
Frames every 24 months	Most are covered in full. Receive a \$50 wholesale allowance at private practice providers (approximate retail value of \$120 to \$150) or a minimum \$130 frame allowance at retail chain providers.	Covered up to \$45
OR		
Contact lenses every 12 months in lieu of eyeglasses In order to receive the full allowance, you must receive your exam, fitting, and evaluation at the same provider.	In lieu of lenses and frames, you may select fitting/evaluation, two follow-up visits, and contact lenses after applicable copayment. You will receive either one box of standard lenses or up to four boxes of in-network covered disposables. Covered in full contacts may vary by provider for some contact lenses such as tone, gas permeable, bifocal—a \$105 allowance is applied to fitting/evaluation as well as contact lenses. Necessary contacts* are covered in full.	Elective contacts up to \$105 Necessary contacts* up to \$210 Maximum benefit paid includes fitting/evaluation, and lenses cost. Prior authorization is necessary.
Refractive eye surgery discount	Laser vision correction services are provided at a reduced cost through network doctors and contracted laser surgery centers. To find a participating laser eye surgeon, visit the web at: www.myuhcvision.com .	

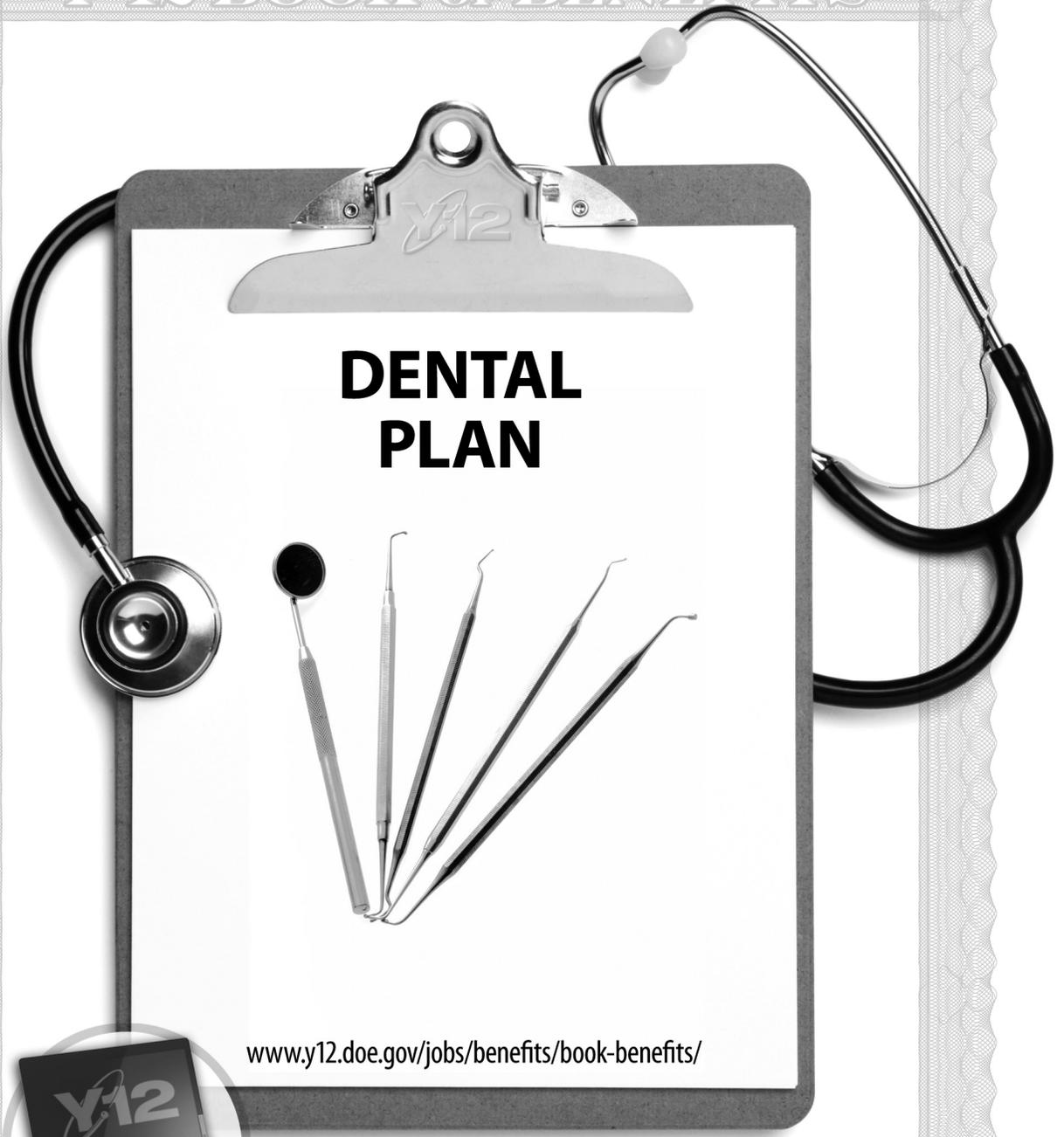
The Network provider copayment will apply once, if frames and lenses are purchased at the same time.

*Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision concerning the reimbursement benefit before you purchase such contacts.

*Necessary contact lenses are covered in full after applicable copayment when services are received in-network, but, are always determined at the provider's discretion for one or more of the following conditions:

- following post-cataract surgery with intraocular lens implant,
- to correct extreme vision problems that cannot be corrected with spectacle lenses, or
- with certain conditions of anisometropia or Keratoconus.

If there are differences in this document and the Group Policy, the Group Policy is the governing document.



**DENTAL
PLAN**

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



YOUR BOOK OF BENEFITS—AGES 65 AND OLDER RETIREES

UnitedHealthcare – Dental Plan

For retirees and eligible spouses, or surviving spouses, age 65 or older, you may enroll in the UnitedHealthcare Dental Plan. When you enroll in the Dental Plan, you are automatically enrolled in the Vision Plan. However, you must complete enrollment forms for both plans.

The UnitedHealthcare Dental Plan is a fully insured Preferred Provider Organization (PPO) product with a national PPO provider network. 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.

A list of network providers can be obtained from the sources below.

Customer Service: 866-605-2540

Web: www.myuhcdental.com

Claims: UnitedHealthcare Dental
Attn: Claims Division
P.O. Box 30567
Salt Lake City, UT 84130

Plan Limitations

In addition to the limitations shown in the Summary of Benefits, the following general limitations apply:

- Oral Examinations – Covered as a separate benefit only if no other service was performed during the visit other than prophylaxis and X-rays. Limited to once every 6 months.
- Complete Series or Panorex Radiographs – Limited to one time per consecutive 36 months. Exception to this limit will be made for Panorex Radiographs if taken for diagnosis of third molars, cysts, or neoplasms.
- Bite-wing Radiographs – Limited to one series of films per calendar year.
- Extraoral Radiographs Limited to two films per calendar year.
- Dental Prophylaxis – Limited to once every 6 months.
- Diagnostic Casts – Limited to one time per consecutive 24 months.
- Fluoride Treatments – Limited to covered persons under the age of 16 years, and limited to once every 6 months. Treatment should be done in conjunction with dental prophylaxis.
- Sealants – Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- Space Maintainers – Limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within 6 months of installation.
- Restorations – Multiple restorations on one surface will be treated as a single filling. Composite restorations limited to anterior teeth only.
- Pin Retention – Limited to two pins per tooth; not covered in addition to Cast Restoration.
- Inlays and Onlays – Limited to one time per 5 calendar years. Covered only when a filling cannot restore the tooth.
- Crowns – Limited to one time per tooth per 5 calendar years. Covered only when a filling cannot restore the tooth.
- Post and Cores – Covered only for teeth that have had root canal therapy.
- Sedative Fillings – Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
- Scaling and Root Planing – Limited to one time per quadrant per consecutive 24 months.
- Periodontal Maintenance – Limited to two times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
- Full Dentures – No additional allowances for overdentures or customized dentures.
- Partial Dentures – No additional allowances for precision or semi-precision attachments.
- Relining and Rebased Dentures – Limited to relining or rebasing performed more than 6 months after the initial insertions. Limited to one time per calendar year.

Summary of Benefits: UnitedHealthcare Dental Plan

Refer to the "Limitations" and "Exclusion" in this dental section, for general limitations.

Services Covered	Amount of Coverage
Annual Deductible (applies to Basic and Major services)	\$50 Individual \$100 Family
Annual Maximum Benefit	\$1,000 per member
Preventive and Diagnostic Services	
• Oral Examinations	Covered 100%, once every 6 months
• Prophylaxis (cleanings)	Covered 100%, once every 6 months
• Full Mouth X-rays	Covered 100%, once every 3 years
• Bite-wing X-rays	Covered 100%, one set every calendar year
• Fluoride	Covered 100% under age 16, once every 6 months
• Sealants	Covered 100% under age 16, once per first or second permanent molar every consecutive 36 months
Basic Services	
• Space Maintainers	Covered 80% under age 16, once per lifetime
• Palliative Treatment (relief of pain)	Covered 80% after deductible Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
• General Anesthesia	Covered 80% after deductible when medically necessary
• Amalgam Restorations (fillings)	Covered 80% after deductible Multiple restorations on one surface will be treated as a single filling.
• Composite Restorations (fillings)	Covered 80% after deductible, for anterior teeth only Multiple restorations on one surface will be treated as a single filling.

UnitedHealthcare Dental Plan – Summary of Benefits (cont.)

Refer to the “Limitations” and “Exclusion” sections, on the following pages, for general limitations.

Services Covered*	Amount of Coverage**
Major Services – 12-month waiting period applies	
• Simple Extraction	Covered 50% after deductible
• Surgical Extraction including Impacted Wisdom Teeth	Covered 50% after deductible
• Root Canal Treatment	Covered 50% after deductible
• Scaling and Root Planing	Covered 50% after deductible, once per quadrant every 24 months
• Periodontal Surgery	Covered 50% after deductible, once every consecutive 36 months per surgical area
• Periodontal Maintenance	Covered 50% after deductible, twice per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement
• Crowns, Inlays and Onlays	Covered 50% after deductible, once every 5 years
• Fixed Bridges	Covered 50% after deductible, once every 5 years Alternative benefits for a partial denture may be applied
• Full or Partial Dentures	Covered 50% after deductible, once every consecutive 60 months from initial or supplement placement
• Recement Bridges, Crowns and Inlays	Covered 50% after deductible, once every consecutive 60 months from initial or supplement placement
• Relining and Rebasings Dentures	Covered 50% after deductible, once per year for relining done more than 6 months after initial insertion
• Repairs to Full Dentures, Partial Dentures and Bridges	Covered 50% after deductible for repairs or adjustment performed more than 12 months after initial insertions

Waiting periods are waived if you were covered under the Company plan when you became effective for this plan.

* Your dental plan provides that, where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$200; please consult your dentist.

**If you visit an in-network provider, the percentage of benefits is based on the discounted fee negotiated with the provider. If you visit a non-network provider, the non-network percentage of benefits is based on the schedule of Reasonable and Customary Charges in the geographic area in which the expenses are incurred.

Plan Exclusions

The UnitedHealthcare dental plan does not cover certain expenses including, but not limited to, charges for:

- Dental Services that are not necessary.
- Hospitalization or other facility charges.
- Any dental procedure performed solely for cosmetic/aesthetic reasons. Cosmetic procedures are those procedures that improve physical appearance.
- Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any dental procedure not directly associated with dental disease.
- Any procedure not performed in a dental setting.
- Repairs to Full Dentures, Partial Dentures, Bridges – Limited to repairs or adjustments performed more than 12 months after the initial insertion.
- Palliative Treatment – Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
- Occlusal Guards – Covered only if prescribed to control habitual grinding, and limited to one guard every consecutive 36 months.
- Full Mouth Debridement – Limited to once every consecutive 36 months.
- General Anesthesia – Covered only where medically necessary.
- Osseous Grafts – With or without resorbable GTR membrane replacement, are limited to once every consecutive 36 months per quadrant or surgical site.
- Periodontal Surgery – Hard tissue and soft tissue periodontal surgery is limited to once every consecutive 36 months, per surgical area. This includes gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, pedicle grafts, and free soft tissue grafts.
- Replacement of Full Dentures, Partial Dentures, Bridges, or Crowns – Replacement of complete or partial dentures, both fixed and removable, or crowns, previously submitted for payment under this Plan is limited to once every consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

- The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
- Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
- Dental services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date individual coverage under the policy terminates.
- Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
- Dental services provided in a foreign country, unless required as an emergency.
- Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
- Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.
- Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
- Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

- Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- Acupuncture, acupressure and other forms of alternative treatment.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

If differences exist between this summary and the Certificate of Coverage, the Certificate will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.