2018
OPEN ENROLLMENT GUIDE

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

IGUA Security Police Officers

BENEFITS

One Team | Better Together

Between **October 23 and November 3, 2017**, you may make changes to your current benefit plan elections.

What Happens If You Do Nothing?

If you take no action, coverage in your existing plans will remain the same for 2018. Review the material in this guide to be sure you enroll in the benefit plans that are right for you and your family.

You will not be able to enroll in or change your benefits during the year unless you have a qualified change in status. (See "Making Changes During the Year" on page 3.)

Note: If you are currently participating in one or both flexible spending accounts (FSAs), your 2017 elections will not roll over and you must re-enroll in one or both accounts during Open Enrollment.

Inside this Guide

Read this Guide

Take the time to read the information in this guide. It is designed to give you an overview and help you prepare to enroll in your 2018 benefits.

Need Help?
Call 1-865-574-1500 or 1-877-861-2255

Starting October 23, you can call CNS Benefit Plans Monday–Friday, 8 a.m.–5 p.m. ET, to get your questions answered and get help in making changes to your 2018 benefits.

Your 2018 Benefit Choices

During Open Enrollment you can choose the coverage that is right for you and your family. The following chart highlights the 2018 options.

IMPORTANT: You have access to the same benefit options with no plan design changes.

Coverage	Options
Medical: Cigna – (includes prescription drugs through Express Scripts and vision through VSP)	• Open Access Plus coverage • No medical coverage
Dental: Delta Dental	• Dental coverage • No dental coverage
FSAs: Cigna	• Contribute up to $2,600 to a Health Care FSA • No Health Care FSA • Contribute up to $5,000 to a Dependent Care FSA • No Dependent Care FSA

FSA – flexible spending account
VSP – Vision Service Plan

Who Is Eligible

You and your eligible dependents may enroll in the CNS benefit plans described in this guide. You can enroll your eligible dependents in any plan that offers dependent coverage, provided you enroll yourself as well. Your eligible dependents include:

- Your legal spouse
- Your eligible dependent child(ren):

  For medical, dental, and vision, you may enroll a dependent child up to the end of the month of his or her 26th birthday. You may enroll a dependent child older than age 26 in CNS health plans if the child is incapable of self-sustaining employment by reason of a mental or physical handicap and is chiefly dependent on you for support and maintenance.

  Child eligibility for other plans varies. If you have questions about eligibility, contact CNS Benefit Plans at 1-865-574-1500 or 1-877-861-2255.

  Dependent children include:
  - Your or your spouse's biological children
  - Stepchildren
  - Legally adopted children (or children proposed for adoption)
  - Foster children

Do Not Enroll Ineligible Dependents

CNS has a strict policy against enrolling ineligible dependents. Enrolling ineligible dependents or failing to notify CNS Benefit Plans in a timely manner to remove a dependent who no longer meets eligibility rules can result in fines and/or disciplinary action up to and including possible termination.

CNS reserves the right to audit your enrolled dependents and request verification documents at any time.

Rather than subjecting yourself to these actions, it's better to pay attention up front and make sure all your covered dependents are eligible.

How to Enroll

Beginning Monday, October 23, you may access the open enrollment application from the internal Benefits homepage to make any desired changes. If you do not have computer access at work, forms are included in your open enrollment packet or you can request them from the Benefit Plans Office. Please remember that you only need to take enrollment action if you wish to make a change. Otherwise, medical, dental, and vision coverage will automatically continue in 2018. Enrollment in FSAs is required annually. **All enrollment changes or elections must be received by the CNS Benefit Plans Office by 4 p.m. ET on Friday, November 3.**

Check your Provider

When you log onto the Cigna website at www.myCigna.com, you will be able to ensure your health care providers are in the network. You do not have to be enrolled in a plan to use the tool.

Making Changes During the Year

Typically, the elections you make during Open Enrollment will stay in effect until December 31, 2018. However, in certain circumstances you may be able to make changes to your benefits during the year. If you experience a qualified life event, such as marriage, divorce, or birth or adoption of a child, you can make benefit changes directly related to that life event. You must initiate your qualified life event change within 31 days of the qualifying event by calling CNS Benefit Plans at 1-865-574-1500 or 1-877-861-2255.

Medical, Dental, and Vision Rates

Below are the monthly employee rates for the CNS health plans (medical, dental, and vision).

Cigna Medical (includes Express Scripts prescription drug coverage)	
	Open Access Plus
Employee Only	$119.00
Employee + 1	$239.00
Employee + Family	$368.00
Delta Dental Preferred Provider Organization	
Employee Only	$6.04
Employee + 1	$11.96
Employee + Family	$21.00
VSP Vision Care	
Employee Only	$1.96
Employee + 1	$2.88
Employee + Family	$5.20

Benefits Overview

The information on the following pages provides an overview of your CNS benefit options. Use this information and the plan summaries to make your benefits decisions.

Medical Summary	
Services	**Cigna Open Access Plus In-Network***
	You Pay
Annual Deductible (how much you pay before the plan pays coinsurance)	$75 Individual/$150 Family
Medical Out-of-Pocket Annual Limit (the most you pay for covered services including deductibles, coinsurance, and copays, including Rx)	$500 Individual/$2,000 Family
Maximum Lifetime Benefit	Unlimited
Physician Office Visits	
Primary Care Office Visit (including labs and X ray)	$20
Specialist Office Visit (including labs and X ray)	$20
Surgery Performed in Physician's Office	$20
Allergy Treatment/Injections	$20
Allergy Serum (dispensed by the physician in the office)	$0
Maternity Office Visit	$20
Maternity Delivery (physician charges)	$0
Preventive Health Services	
Well-Baby Care	$20 (Immunizations covered at 100%)
Routine Physical Exams, Gynecological Exams, Mammograms, PSA Tests	$20 (Mammograms covered at 100%)
Hospital Services	
Inpatient (Semi-private room, operating room, X ray, and laboratory services. Includes maternity inpatient and stand-alone facilities such as birthing centers.)	$0 (after the deductible is met)
Outpatient (Operating Room, Recovery Room, Procedure Room, and Treatment)	$0 (after the deductible is met)
Inpatient Physician and Surgeon Visits and Services	$0 (after the deductible is met)
Emergency Room Services	$50 copay/visit
Urgent Care Facility	$35 copay/visit
Emergency Ambulance Services	$0 (after the deductible is met)
Other Services	
Outpatient Facility Services (including Lab and X ray)	$0 (after the deductible is met)
Chiropractic Care (when medically appropriate – 20-day max)	$20
Mental Health/Substance Abuse – Inpatient	$0 (after the deductible is met)

Medical Summary	
Services	**Cigna Open Access Plus In-Network***
	You Pay
Mental Health/Substance Abuse – Outpatient	$20 copay for office visits; 0% for facility
Hearing Aid Benefits	$0 (one pair per 36 months; $750 maximum)
Durable Medical Equipment – Reasonable and Customary (R&C) applies	$0 (after the deductible is met)
External Prosthetic Devices – requires approval by the health plan	$0 (after the deductible is met)
Home Health Care	$0 (after the deductible is met)
Skilled Nursing Facility (60-day max)	$0 (after the deductible is met)
Hospice Care – Inpatient	$0 (after the deductible is met)
Hospice Care – Outpatient	$0 (after the deductible is met)
Outpatient rehabilitation (short-term and includes speech, occupational, physical, and cardiac rehabilitation) (120-day max combined)	$0

**Cigna Open Access Plus offers out-of-network benefits; however, you will pay more when you go out of the network for care, including a deductible and higher coinsurance. Additionally, your coinsurance for out-of-network services is based on the reasonable customary charges as defined in the plan, and if your out-of-network provider charges more than what the plan considers reasonable and customary, the provider can bill you for the difference.*

1) In-network copays will not apply toward the in- or out-of-network annual deductibles.
2) All out-of-network inpatient hospitalizations and outpatient surgeries must be pre-certified. Failure to do so will result in a 20% reduction of covered expenses incurred for services.
3) Hospital stays not deemed medically necessary will be disapproved.
4) Certain procedures require prior health plan approval. Please check with your health plan provider for additional information.

Prescription Drugs – Provided by Express Scripts	
	Cigna Open Access Plus
	You Pay
Annual Prescription Drug Deductible	None
Retail – 30-Day Supply	
Generic	$5
Preferred Brand	$10
Non-preferred Brand	$25
Mail Order – 90-Day Supply	
Generic	$10
Preferred Brand	$20
Non-preferred Brand	$50

1. Pharmacy benefits for the Cigna Open Access Plus are through Express Scripts.
2. Certain drugs may require a prior authorization to receive the prescription or the full quantity your doctor prescribes.
3. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts at **1-800-685-8869**.

Procurement restrictions in contracts effective 2015 between the drug manufacturers and Express Scripts may require Express Scripts to substitute an equivalent drug within certain drug categories. While the CNS prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be. For any questions, you may contact Express Scripts at 1-800-685-8869.

Need Help Understanding Your Options? Call CNS Benefit Plans

A trained customer service representative can answer your questions and help you understand your benefit options. Call CNS Benefit Plans at 1-865-574-1500 or 1-877-861-2255 Monday–Friday, 8 a.m.–5 p.m. ET.

Dental Coverage

You can enroll in the Delta Dental Preferred Provider Organization. Note that you do **not** have to be enrolled in medical coverage to enroll in dental coverage. The plan uses Delta Dental's network of providers and allows you to go in- or out-of-network for dental care.

You pay less when you stay in-network because your share of the cost will be based on the lower in-network negotiated rates. When you receive services (including diagnostic and preventive) from a non-participating (out-of-network) dentist, the percentages paid by the plan are based on Delta Dental's Non-participating Dentist Fee for those services. The Non-participating Dentist Fee may be less than what your dentist charges, and you are responsible for that difference.

Dental Plan Highlights	Delta Dental (In-Network)
Annual Deductible (In-Network/Out-of-Network) Applies to basic and major services	You pay $50 per person
Annual Benefit Maximum	Plan pays $1,500 per person
Lifetime Maximum	$10,000 per person
Diagnostic and Preventive Services* (No deductible)	
Oral exams	Plan pays 100%
Cleanings	Plan pays 100%
X rays	Plan pays 100%
Fluoride treatment (under age 19)	Plan pays 100%
Space Maintainers	Plan pays 100%
Sealants	You pay 20% after deductible
Basic Services*	
Restorative (fillings)	You pay 20% after deductible
Extractions	You pay 20% after deductible
Oral surgery	You pay 20% after deductible
Periodontics	You pay 20% after deductible
Endodontics (root canal therapy)	You pay 20% after deductible
Major Services*	
Crowns	You pay 50% after deductible
Bridges	You pay 50% after deductible
Partial, full dentures and implants	You pay 50% after deductible
Orthodontia for Child(ren) to age 24	50%
Lifetime Orthodontia Maximum	$1,500

*Plan limits apply to certain services.

Vision Plan

The plan provides comprehensive coverage through a network of providers. Services received outside the network are still covered but will cost you more money out of your pocket.

Vision Plan Summary (In Network)	
Services Covered	**You Pay**
Exam – once every calendar year	$0
Lenses – once every calendar year Single Bifocal Trifocal	$0
Frames – once every other calendar year (once every calendar year for children up to 19 years old)	Plan covers: $110 allowance; 20% discount for amounts over $110 or $60 allowance at Costco Optical
Contact Lenses – once every calendar year (instead of glasses)	Plan covers: Medically necessary lenses: covered in full; Elective lenses: $100 allowance for contacts and contact lens exam (fitting and evaluation); 15% off contact lens exam
Lens Enhancements and Additional Discounts	Plan covers: 20–25% on lens enhancements; 20% on additional glasses and sunglasses at any VSP provider within 12 months of your last exam; 15% off laser vision correction or 5% off the promotional price; discounts only available from contracted facilities

Note: Retail chains treated as out-of-network.

Flexible Spending Accounts

Looking to save money on your out-of-pocket health care and dependent care costs? CNS offers two FSAs—Health Care and Dependent Care. The FSAs allow you to pay eligible health care and dependent day care expenses with money that is not taxed, saving you 20 to 30% on your out-of-pocket expenses. You may choose to enroll in one or both of these accounts or waive coverage.

The **Health Care FSA** is used for health-related expenses, like copays for visits to the doctor and out-of-pocket expenses for prescriptions and other health care services. Health care expenses for you and your eligible dependents can be reimbursed from your Health Care FSA.

Cigna Will Continue to Administer the FSAs

If you are currently participating in one or both FSAs, your 2017 elections will not roll over and you must re-enroll in one or both accounts during Open Enrollment. If you wish to elect or change your FSAs for 2018, please enroll online or complete the enrollment form included in your packet.

- **You can contribute to the Health Care FSA** if you are enrolled in the Open Access Plus plan, a non-high-deductible medical plan outside of the CNS plan (e.g., you are enrolled in a plan through your spouse's employer), or you are not enrolled in a medical plan.
- **You cannot contribute to a Health Care FSA** if you are enrolled in a high-deductible medical plan outside the CNS plan.

The **Dependent Care FSA** is only used for child care or elder care expenses that allow you to work. It is not used for dependents' health care expenses. You don't need to be enrolled in a health plan to participate in the Dependent Care FSA. To qualify for a Dependent Care FSA:

- You and your spouse must work or attend school full-time.
- Your child must be under age 13 or qualify as a federal income tax-eligible dependent who can't care for him or herself.

FSA Highlights

- You choose how much you want to set aside each year:
  - Health Care FSA: $50 to $2,600 per year
  - Dependent Care FSA: $50 to $5,000 per year (If you're married and file your taxes separately, the limit is $2,500.)
- Your contributions are taken from your paycheck before federal and state taxes are deducted, making these amounts tax free.
- Pay for your eligible expenses using:
  - The FSA debit card or
  - Your regular funds and submit a claim for reimbursement.
  - Save your receipts, even if you use the debit card.
- IRS rules say that you must forfeit any money left in your accounts at the end of the year, so estimate your expenses carefully. Any account balances remaining at the end of the year cannot be returned.
- Although it's a good idea to submit your claims as you incur expenses during the year, you have until June 30 of the next year to submit eligible expenses for reimbursement from the current plan year.
- Both accounts are administered by Cigna. Go to **myCigna.com** for account details, including up-to-date balance information, claim status, claim forms, and answers to general questions. Call Cigna at **1-855-247-0884** to speak with a customer service representative 24/7/365.

Important Legal Notices

Grandfathered Health Plan

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act (ACA), a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

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 at **1-865-574-1500 or 1-877-861-2255**. 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.

Patient Protection and Affordable Care Act (PPACA, or Health Care Reform)

The Affordable Care Act (ACA) has brought sweeping changes to the U.S. health insurance system. Its goal is to make health insurance available to everyone, regardless of medical history or ability to pay. Many of the ACA changes have already affected our medical plans, such as covering children through age 26, free preventive care, and reducing or removing annual or lifetime limits on essential health benefits.

Health Care Reform and You—the "Individual Mandate"

The ACA requires most Americans to purchase health insurance or pay a penalty. This is called the "individual mandate." The medical plans offered by CNS meet or exceed the affordability and coverage requirements. Therefore, being enrolled in the company-sponsored medical plan satisfies the individual mandate.

HIPAA Privacy Notice Reminder

The health plans offered by the company are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to maintain the privacy of your health information. The Notices of Privacy Practices for our health plans are available from the benefits administrator and vendors. Be assured the company and our benefits administrator and vendors fully comply with this requirement.

Note: Because this reminder is required by law, you will receive separate reminders from each of the insurance plans in which you enroll as well as other providers describing the availability of their HIPAA notice of privacy practices and how to obtain a copy.

HIPAA Special Enrollment Rights

If you (or an eligible dependent) declined coverage in a CNS health insurance plan because you had coverage under another plan, and that coverage ended, you may be eligible to enroll in a CNS health plan. Normally, you would have to wait until the next Annual Enrollment period to enroll, but you may be eligible for a special enrollment period if your other coverage ends because:

- Your employment ended, you had a change in work status, or you became ineligible for coverage.
- The other health insurance plan was terminated.
- The other employer stopped paying a required contribution for coverage.
- COBRA continuation coverage was exhausted.

If your Children's Health Insurance Program (CHIP) or Medicaid coverage is terminated because you lose eligibility or you become eligible for group health plan premium assistance under a state CHIP or Medicaid program, you are eligible for a special enrollment period in a CNS health insurance plan.

In addition, if you acquire new dependent(s) through marriage, birth, adoption, or placement for adoption, you [or your eligible dependent(s)] may be eligible to enroll in a CNS health insurance plan as long as you apply within 60 days following the day after your other coverage ends or the date you acquire a new dependent(s).

COBRA

If you, your spouse, or eligible dependent loses coverage under any CNS group medical or dental plan because of a COBRA-qualifying event, you may have the right to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For details about qualifying events, refer to the Initial COBRA Notice.

If your coverage ends due to a COBRA-qualifying event, you will receive a notice of your continuation rights. At that time, you will have up to 60 days—from the date of your event or the date you received your notice—to decide whether you want to continue your health coverage. If you, your spouse, and/or dependent have a COBRA-qualifying event, you must notify CNS Benefit Plans at **1-865-574-1500 or 1-877-861-2255** immediately.

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.

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).

Women's Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call Cigna at **1-855-247-0884** for more information.

Contact Information

Coverage	Website	Phone Number
CNS Benefit Plans	http://home1.y12.doe.gov/benefits	1-865-574-1500 or 1-877-861-2255 Monday–Friday 8 a.m.–5 p.m. ET
Medical – Cigna	www.myCigna.com	1-855-247-0884
Prescription Drugs – Express Scripts	www.express-scripts.com	1-800-685-8869
Dental – Delta Dental	www.deltadentaltn.com	1-800-223-3104
Vision – VSP	www.vsp.com	1-800-877-7195
FSAs – Cigna	www.myCigna.com	1-855-247-0884

This guide is not a guarantee of benefits and is only intended to provide you with an overview of your benefit options. Complete descriptions of the plans and their provisions are available to you. If any information in this guide conflicts with the detailed plan documents and insurance contracts, the plan documents and contracts are the authority. Although Consolidated Nuclear Security intends to continue providing a variety of plan options, we reserve the right to make changes in whole or in part, or terminate any of the options at any time. This guide is not to be construed to create a contract of employment between Consolidated Nuclear Security or its subsidiaries and you.