

**Health Reimbursement Arrangement for Retired Staff
Of Battelle Memorial Institute
Plan Document and Summary Plan Description**



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Important Information

Plan Documentation

The following is the legal Plan Document and Summary Plan Description (“SPD”) for the Health Reimbursement Arrangement for Retired Staff of Battelle Memorial Institute, commonly known as the HRA for PNNL Retired Staff (the “Plan”) as of July 1, 2013. The purpose of the Plan is to reimburse eligible Participants for certain medical expenses which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Code, as well as a Health Reimbursement Arrangement (“Health Reimbursement Account” or “HRA”) as defined in Internal Revenue Service Notice 2002-45.

Battelle Memorial Institute (“Battelle”) is the Plan Sponsor and Plan Administrator of the Plan. As Plan Administrator, Battelle Memorial Institute has the full and exclusive discretionary authority to:

- Interpret the Plan and to resolve all questions arising in the administration, interpretation, and application of the Plan
- Interpret the other terms, conditions, limitations, and exclusions of the Plan; and
- Make factual determinations related to the Plan and its benefits.

This Plan Document and SPD, prepared by the Plan Administrator, is a written statement to inform you about the coverage and any limitations, exclusions, and requirements that apply within the Plan.

This document and any Amendments and attachments are intended to constitute the Plan Document as required by Section 402 of ERISA and the SPD as required by Section 102 of ERISA. Please refer to this document for information regarding benefits provided under the Plan. This Plan Document and SPD is effective July 1, 2013.

Many words used in this document have special meanings. These words appear in capital letters and are defined for you the first time they are used or in the “Definitions” section of this document. Please note that “you” and “your” when used in this document refer to you, the retiree.

HRA Claims Administration

Battelle has delegated much of the day-to-day administration of the Plan to the Plan’s third party administrator, Extend Health, Inc. (“Extend Health.”) Extend Health has discretionary authority to make benefit determinations under the Plan. Benefit determinations include processing claims, and interpreting and enforcing the provisions of the Plan according to the terms of the Plan.

Staff may contact **Extend Health, Inc.** via:

Phone

Extend Health is available Monday through Friday, 5:00 A.M. – 6:00 P.M. PST at (888) 724-5579. Extend Health also provides a TTY service to its hard-of-hearing and deaf customers. If you have

equipment for TTY calls, you can call (866) 508-5123 Monday through Friday, 5:00 A.M. – 6:00 P.M. PST.

Internet

The Extend Health, Inc. web address is www.extendhealth.com/pnnl. This website may be used to create your “personal profile” online and schedule an enrollment appointment at a time that is convenient for you. Creating an account will allow you to search for and save medical plans that you may wish to enroll for during the enrollment season. You may also track the status of your applications after your enrollment call. In addition, the website provides you with your Health Reimbursement Account balance and allows you to file a claim for reimbursement, enroll for direct deposit, or check the status of your claims.

Mail

Extend Health, Inc.
10975 South Sterling View Drive
Suite A-1 South
Jordan, UT 84095

Claims Submission Agent

All reimbursement claim forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should **not** be mailed to Extend Health.

PayFlex Systems USA, Inc.
Extend Health HRA
P.O. Box 3039
Omaha, NE 68103-3039
Fax: (402) 231-4310

Funding

An HRA is a bookkeeping account on Battelle’s records. The HRA Accounts do not bear interest or accrue earnings of any kind. The HRA Accounts may be fully or partially funded by employer contributions held in the Battelle Employee Medical Benefits Trust. The Battelle Employee Medical Benefits Trust is a “voluntary employee beneficiary association” under Section 501(c)(9) of the Code. Any funds that do not come from the Battelle Employee Medical Benefits Trust will be paid from the general assets of Battelle. In no event may any benefits under the Plan be funded with Participant contributions.

Purpose of the Plan

The primary purpose of the Plan is to provide an opportunity for eligible staff to receive favorable tax treatment for certain expenses. If an Eligible Person (as defined in the “Eligible Groups” section of this document) enrolls in the Plan, Battelle will allocate funds to a tax-free Health Reimbursement

Account for the Participant and any Enrolled Spouse. The Health Reimbursement Account may be used to reimburse Eligible Expenses (see the “Eligible Expenses” section of this document) which are not otherwise reimbursed by any other plan or program.

Reimbursements for Eligible Expenses paid by the Plan generally are excludable from the Participant’s taxable income. However, Battelle cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Plan Effective Date

July 1, 2013

Eligibility

Eligible Groups

An “Eligible Employer” is the Pacific Northwest Division of Battelle Memorial Institute.

An “Eligible Person” is a former staff member who meets all of the eligibility requirements in the Plan and immediately before terminating their employment or becoming disabled was classified as a salaried employee of an Eligible Employer for payroll purposes.

When an Eligible Person actually enrolls, that person is called a “Participant.”

An “Eligible Spouse” is the Spouse of an enrolled Participant in this Plan or another Battelle-sponsored retiree medical plan who meets all of the eligibility requirements in the Plan.

A “Surviving Spouse” is the Spouse of a deceased Participant who met the eligibility requirements to participate in a Battelle-sponsored retiree medical plan at the time of death. A Surviving Spouse will lose eligibility if he or she remarries.

When an Eligible Spouse or Surviving Spouse actually enrolls, that person is called an “Enrolled Spouse.”

The Plan Administrator determines who is eligible to enroll under the Plan.

Bargaining Active Staff who Retire on or after April 1, 2013

You and your Spouse are not eligible to participate in the Plan if you are classified as a Bargaining Active Staff Member who retired or became disabled on or after April 1, 2013. Any Bargaining Active Staff Member who retired or became disabled on or before to March 31, 2013 is an Eligible Person if they meet all of the eligibility requirements in the Plan.

Eligibility Requirements for Active Staff who Retired prior to July 1, 2013

You are eligible for this plan if you are participating in the Medical Plan for BMI Retirees (commonly known as The Medicare Complement Plan for Retirees and Dependents eligible for Medicare) on June 30, 2013 and enroll in this Plan through Extend Health by the enrollment deadline. See the “Enrollment Deadline” section of this document for additional information.

Eligibility Requirements for Active Staff who Retire on or after July 1, 2013

You are also eligible to participate in the Plan upon your termination from Active Service, if as of the date of such termination you meet all of the following requirements:

- You were hired by a Battelle Group Member (as defined in the section “Certain Transfers Within Battelle Controlled Group”) prior to July 1, 2005.
- You are covered under a Battelle-sponsored medical care plan.
- You are eligible for Medicare and you have enrolled in Medicare Part A and Medicare Part B.*
- You enroll and maintain coverage in a Commercial Medicare plan with Extend Health.
- You are age 55 with 10 or more Years of Credited Service after June 30, 1976.
- You earned at least three consecutive Years of Credited Service in a continuous period of employment ending on your retirement date.
- You immediately commence pension benefits from a Battelle-sponsored qualified retirement plan.
- You reside within the United States. You cannot reside outside of the U.S. permanently (including Guam and Puerto Rico) and still qualify for coverage under the Plan.

If you meet the eligibility requirements listed above, and you do not elect coverage under the Plan at the time of retirement from Active Service, you will not be eligible to elect coverage under the Plan at a later date except as provided for Spouses in Active Service (not retired). Additional information can be found in the “Deferral of Enrollment in the Plan where Spouse is a Staff Member in Active Service” section of this document.

*Please note that if you are not eligible for Medicare upon retirement and therefore enroll in another Battelle-sponsored retiree medical plan, and later become eligible for Medicare you will receive enrollment materials for this Plan at that time. See the “Retirees and Spouses Enrolled in Another Battelle-Sponsored Retiree Medical Plan” section of this document for more details.

Eligibility Requirements for the Spouse of a Retiree

Eligible Persons (as defined in the “Eligible Groups” section of this document) have the opportunity to elect coverage for their Eligible Spouse when they enroll in the Plan. An Eligible Spouse is eligible to participate in the Plan upon your retirement from Active Service, if as of the date of such retirement, your Eligible Spouse:

- Is covered under a Battelle-sponsored medical care plan as your dependent
- Is eligible for Medicare and has enrolled in Medicare Part A and Medicare Part B

- Enrolls and maintains coverage in a Commercial Medicare plan with Extend Health; and
- Resides within the United States. You cannot reside outside of the U.S. permanently (including Guam and Puerto Rico) and still qualify for coverage under the Plan.

If your Eligible Spouse meets the eligibility requirements listed above, and you do not elect coverage for your Eligible Spouse under the Plan at the time of your retirement from Active Service, you will not be eligible to elect coverage for your Eligible Spouse under the Plan at a later date except as provided for Spouses in Active Service (not retired). Additional information can be found in the “Deferral of Enrollment in the Plan where Spouse is a Staff Member in Active Service” section of this document.

If you meet all of the eligibility requirements as an Eligible Person, but your Spouse does not meet the eligibility requirements as an Eligible Spouse, your Spouse can enroll in another Battelle-sponsored retiree medical plan as long as you enroll in this Plan and your Spouse otherwise meets the requirements for participation in another Battelle-sponsored retiree medical plan. Please note that if your Spouse is not eligible for Medicare upon your retirement and therefore enrolls in another Battelle-sponsored retiree medical plan, and later becomes eligible for Medicare he or she will receive enrollment materials for this Plan at that time. See the “Retirees and Spouses Enrolled in Another Battelle-Sponsored Retiree Medical Plan” section of this document for more details.

Eligibility Requirements for Disabled Participants

You are eligible to continue coverage after termination of employment for disability, regardless of age or Years of Credited Service, if you meet all of the following requirements:

- You incur a disability as an Active staff member from an Eligible Employer
- That same disability qualifies you for benefits from the Battelle-sponsored disability plan (the “PNNL LTD Plan”)
- You are covered by a Battelle-sponsored medical plan as of the day prior to beginning benefits under the PNNL LTD Plan
- You have received at least 24 months of benefits (including retroactive payments, if applicable) from the PNNL LTD Plan
- You are eligible for Medicare and you have enrolled in Medicare Part A and Medicare Part B
- You enroll and maintain coverage in a Commercial Medicare plan with Extend Health; and
- You reside within the United States. You cannot reside outside of the U.S. permanently (including Guam and Puerto Rico) and still qualify for coverage under the Plan.

After 24 months of benefits from the PNNL LTD Plan, your status will change from Long-Term Disability Leave-Without-Pay status to Long-Term Disability Retirement Status. You must complete a Battelle Retirees’ Medical and Medical Plan Enrollment and Change Form and return it to your

Benefits Office no later than the end of the month in which your employment status is changed to LTD retirement.

Your Spouse will be eligible for the Plan if he or she:

- Is covered under a Battelle-sponsored medical plan at the time of your employment change in status to LTD Retirement
- Is eligible for Medicare and has enrolled in Medicare Part A and Medicare Part B; and
- You reside within the United States. You cannot reside outside of the U.S. permanently (including Guam and Puerto Rico) and still qualify for coverage under the Plan.

Please note that if you or your Spouse are not eligible for Medicare and therefore enroll in another Battelle-sponsored retiree medical plan and you or your Spouse later become eligible for Medicare, you will receive enrollment materials for this Plan at that time. See the “Retirees and Spouses Enrolled in Another Battelle-Sponsored Retiree Medical Plan” section of this document for more details.

Retirees and Spouses Enrolled in Another Battelle-Sponsored Retiree Medical Plan

If you are not eligible for Medicare upon retirement or disability and therefore enroll in another Battelle-sponsored retiree medical plan and then later become Medicare-eligible due to becoming age 65, you will receive information about enrolling in this Plan from Extend Health.

If you are enrolled in another Battelle-sponsored retiree medical plan, and then later become Medicare-eligible due to a disability prior to age 65, you must notify your Benefits Office to ensure you receive this information from Extend Health.

If you are entitled to Medicare benefits, you must elect to enroll and maintain coverage in Medicare Part A and Medicare Part B to become eligible for the Plan.

If your Spouse is under age 65, your Spouse will be covered under another Battelle-sponsored retiree medical plan as long as your Spouse meets the eligibility requirements of the other plan and you remain enrolled in a Medicare plan through Extend Health.

Deferral of Enrollment in the Plan where Spouse is a Staff Member in Active Service

If, at the time you first become an Eligible Person under this Plan, you are covered (or eligible for coverage) as a dependent of your Spouse in a Battelle-sponsored medical plan for Active (not retired) staff, you may defer enrollment for so long as you remain continuously covered as a dependent of your Spouse under a Battelle-sponsored medical plan. However, you must enroll in this Plan as of the first of the month after such coverage as a dependent ends in order to maintain your eligibility for this Plan. If you do not timely elect coverage under the Plan at the time your coverage ends as a dependent of an Active (not retired) staff member, you will not be eligible to enroll in the Plan at a later date.

You do not have to elect coverage under the Plan. Alternatively, if at the time your Spouse retires, he or she is an Eligible Person and enrolls therefore becoming a Participant in the Plan, you may

elect coverage as an Eligible Spouse. Once you are an Enrolled Spouse under the retiree medical Plan, you will not maintain eligibility for enrollment as a Participant. Please review the provisions regarding Spouse coverage carefully prior to making your decision.

For example:

Bob and Sue are married and are both employees of an Eligible Employer. Bob decides to retire on February 1, 2014 with 30 years of service. Sue plans to retire later on December 1, 2014. She will have 20 years of service as of December. Both Bob and Sue are Medicare eligible. At Bob's retirement he has two choices; elect coverage as a Participant under this Plan or elect coverage as Sue's dependent in a Battelle-sponsored active medical plan.

If Bob decides to enroll in this Plan immediately upon his retirement, Sue has the following options:

- Sue may enroll as Bob's Enrolled Spouse and her HRA Allocation will be based on Bob's Years of Credited Service (30 years). Sue must drop her coverage in the Battelle-sponsored active medical plan. Sue may not maintain coverage in both plans.
- Sue may remain enrolled in the Battelle-sponsored active medical plan. However, upon Sue's retirement in December, she will not be eligible to enroll as Bob's Enrolled Spouse. Sue will become a Participant in her own HRA and receive an HRA Allocation based on her 20 Years of Credited Service at the time of her retirement

If Bob decides to enroll as Sue's dependent in the active plan, upon Sue's retirement Bob and Sue have the following options:

- Bob may enroll as a Participant in the Plan and Sue may enroll as Bob's Enrolled Spouse
- Sue may enroll as a Participant in the Plan and Bob may enroll as Sue's Enrolled Spouse
- Bob and Sue may enroll separately, each as a Participant

The chart below shows the impact to the HRA Allocation based on the decision made at the time of Sue's retirement.

Options Upon Sue's Retirement	Total HRA Allocation
Bob enrolls as a Participant & Sue enrolls as Bob's Enrolled Spouse (Plan uses Bob's 30 Years of Credited Service)	$\$1,200 + \$1,200 = \$2,400$
Sue enrolls as a Participant & Bob enrolls as Sue's Enrolled Spouse (Plan uses Sue's 20 Years of Credited Service)	$\$924 + \$924 = \$1,848$
Bob enrolls as a Participant Only	\$1,200
Sue enrolls as a Participant Only	\$ 924

Certain Transfers within Battelle's Controlled Group

If you transfer from employment with Battelle to employment with a member of Battelle's controlled group or a subsidiary that is at least 51%-owned by Battelle or Battelle's controlled group (a "Battelle Group Member"), you maintain your eligibility for this Plan until your termination of employment with the Battelle Group Member (even if subsequently less than 51%-owned by Battelle or Battelle's controlled group.) In addition, if you return directly to employment with Battelle from the Battelle Group Member (even if Battelle's or its controlled group ownership is reduced to less than 51%), you maintain your eligibility for the Plan provided that the service with Battelle and the Battelle Group Member is continuous and uninterrupted. (However, only certain salaried/regular service with Battelle and/or participating employers can count as Years of Credited Service.) In order to maintain eligibility under this provision, you must enroll in the Plan immediately upon your termination of continuous employment with Battelle and the Battelle Group Member, and coincident with your commencement of pension benefits under a Battelle-sponsored pension plan.

Participants in the Battelle Medicare Complement Plan as of June 30, 2013 who are not enrolled in Part B prior to July 1, 2013

If you are a participant in the Battelle Memorial Institute Medical Plan for BMI Retirees (commonly known as the Battelle Blue Cross Blue Shield Medicare Complement Plan for BMI Retirees Eligible for Medicare) as of June 30, 2013 who has not enrolled in Medicare Part B prior to July 1, 2013, the Plan Administrator may allow you to enroll in this Plan effective July 1, 2014 if you are enrolled in Medicare Part B as of July 1, 2014.

In order for the Plan Administrator to approve this exception, you must provide documentation acceptable to the Plan Administrator of your Medicare Part B enrollment on or before April 30, 2014.

This exception can also apply to an Eligible Spouse or a Surviving Spouse.

Enrollment

Upon enrollment in the Plan and as a condition to participating in and receiving benefits from the Plan, you and your Enrolled Spouse are subject to the Plan's terms as set forth in this document, and also as provided from time to time by the Plan Administrator or its delegates.

Enrollment Deadlines

If you meet the eligibility requirements of the Plan, elections in a Medicare Advantage Plan or Medigap Plan should be made by you and your Eligible Spouse no later than the end of the month prior to your Medicare Part A and Part B effective date to ensure no lapse in coverage. However, as an Eligible Person or Eligible Spouse you have two months from the Coverage Effective Date to make an election. Your first HRA Allocation will be based on the Coverage Effective Date.

The Plan Administrator has the full and exclusive discretionary authority to determine eligibility under the Plan.

If you do not elect a medical plan through Extend Health when you first become eligible, you will not be eligible to elect coverage under the Plan at a later date except as provided to Spouses in Active Service (not retired). Additional information can be found in the “Deferral of Enrollment in the Plan where Spouse is a Staff Member in Active Service” section of this document.

If your employment status is changed to LTD Retirement, you are required to notify Battelle of your eligibility status for Medicare. If you are Medicare eligible and do not inform your Benefits Office and if you do not enroll in a Medicare Advantage Plan or Medigap Plan through Extend Health, you will lose your eligibility to enroll in the Plan at a later time.

If you cancel coverage or lose coverage for any reason, there is no future opportunity to enroll in this Plan. If you marry after your initial enrollment date, you cannot add your newly acquired Spouse to this Plan.

How to Establish your Health Reimbursement Account

You must be enrolled and maintain coverage in Medicare Part A and Medicare Part B before you can select a supplemental Commercial Medicare plan through Extend Health. ***To establish your Health Reimbursement Account (HRA) under the Plan you must enroll in a commercial Medicare Advantage plan or Medigap plan through Extend Health by the enrollment deadline.*** The annual HRA Allocation that Battelle makes to your HRA is automatic upon enrollment in the Plan.

After you and your Eligible Spouse (if any) enroll in a Commercial Medicare plan your HRA will be established and you will receive the annual HRA Allocation. See the “Health Reimbursement Account Allocation” section of this document for more details.

Waiver of Participation

Participation in the Plan is voluntary. Participation is subject to the conditions specified in the Plan and such other conditions determined by the Plan Administrator to be necessary or desirable for the administration of the Plan.

Any person who has waived participation in the Plan is not eligible to participate in the Plan. A person is considered to have “waived participation” in the Plan as of the earlier of receipt of a written waiver of participation acceptable to the Plan Administrator, or by not enrolling in a Medicare Part A, Medicare Part B, and a Commercial Medicare plan when you first become eligible.

Staff Who Enrolled in a Medicare Advantage Plan prior to July 1, 2013

Prior to July 1, 2013, staff members and their eligible dependents were permitted to enroll in a Medicare Advantage plan upon retirement and still retain eligibility for the Battelle Blue Cross Battelle Medicare Complement Plan for BMI Retirees Eligible for Medicare (the “Medicare

Complement Plan.”) This action was described as “opting out” of the Medicare Complement Plan. Effective January 1, 2014, staff members who opted out of the Medicare Complement Plan must enroll in a Commercial Medicare plan through Extend Health in order to receive the HRA Allocation under this Plan. The enrollment deadline for staff members who opted out is December 7, 2013. If you opted out of the Medicare Complement Plan and do not enroll during this initial enrollment period, you will forfeit eligibility and will not have the option to participate in the Plan in the future.

Individuals who opted out of the Medicare Complement Plan are not guaranteed acceptance into a Commercial Medicare plan. If you are currently enrolled in a Medicare Advantage plan and you wish to enroll in a Medigap plan you may be required to show evidence of insurability, even during the initial enrollment.

If Extend Health determines your current insurance company will not permit you to drop your current Commercial Medicare plan and re-enroll through Extend Health, please contact your Benefits Office by December 7, 2013. Upon written documentation of the facts from Extend Health, the Plan Administrator may determine that you are eligible for the HRA Allocation.

Benefits

Health Reimbursement Account

A Health Reimbursement Account (“HRA”) is a special, tax-free account which allows you and your Enrolled Spouse to pay for individual health care Premiums and other Eligible Expenses. Each year, Battelle will provide Participants and Enrolled Spouses with financial support by contributing funds via a Health Reimbursement Allocation on their behalf. This Health Reimbursement Allocation will be made to the Participant’s HRA which is maintained by Extend Health.

Eligible Expenses may be reimbursed from your HRA balance by submitting claims through the Extend Health website or directly to the Claims Submission Agent. At any time, the Participant may receive reimbursement for Eligible Expenses up to the amount in his or her HRA Account. The Eligible Expenses must be incurred on behalf of yourself, your Spouse or any dependent children. Expenses are eligible for reimbursement only if they are not reimbursable by insurance, another Health Reimbursement Account, public healthcare reimbursement, or a flexible reimbursement plan. See the “Eligible Expenses” and “Claims Procedures” sections of this document for more details.

Note that the law does not permit Participants to make any contributions to their HRA Accounts.

Health Reimbursement Account Allocation

Battelle currently determines the amount it expects to contribute towards the cost of Participant health care under the Plan. This contribution is referred to as an “HRA Allocation.”

The HRA Allocation will be credited to your account at the beginning of each Plan Year that you are a Participant. If your Spouse is also enrolled, you will receive an additional HRA Allocation each Plan Year your Spouse is an Enrolled Spouse.

The amount of your HRA Allocation will be based on Years of Credited Service at the time you become an Eligible Person.

Years of Credited Service	Designated HRA Annual Amounts for Each Retiree and Each Spouse or Surviving Spouse	2013 Prorated Amount for Each Retiree and Each Spouse or Surviving Spouse
Disabled	\$1,200	\$ 600
Retired before January 1, 2005 with 10+ Years of Credited Service	\$1,200	\$ 600
Retired on or after January 1, 2005, attained at least age 50, and actively employed by an Eligible Employer on December 31, 1998 with 10+ Years of Credited Service	\$1,200	\$ 600
Retired on or after January 1, 2005 with		
30+ Years of Credited Service	\$1,200	\$ 600
25 to 29 Years of Credited Service	\$1,092	\$ 546
20 to 24 Years of Credited Service	\$ 924	\$ 462
15 to 19 Years of Credited Service	\$ 708	\$ 354
10 to 14 Years of Credited Service	\$ 504	\$ 252

Staff members who began employment on or after January 1, 2012 with an Eligible Employer will still be able to contact Extend Health for assistance in enrolling with a Commercial Medicare plan when they become Medicare eligible; however, they will not receive an HRA Allocation.

If you become eligible to participate and enroll in the Plan after the beginning of the Plan Year, the HRA Allocation amount allocated by Battelle will be pro-rated based on the number of months remaining in that Plan Year. The Prorated HRA Allocation calculation is based on the Coverage Effective Date. The formula is:

$$(\text{Annual HRA Allocation amount}) / 12 \times (\text{remaining months in the calendar year})$$

Equals

Prorated HRA Allocation

At the beginning of the next Plan Year, the Participant and Enrolled Spouse will be eligible to receive the full annual HRA Allocation.

Although dependent children are not eligible to receive an HRA Allocation, claims for children may be reimbursed if they are your tax dependents.

Battelle reserves the right to change the HRA Allocation under the Plan at any time, or to cease coverage under the Plan entirely.

Joint Health Reimbursement Account

If you and your Spouse are both enrolled you will receive an HRA Allocation in the form of one sum from Battelle into a Joint HRA. You will be the account holder of the HRA, but because it is a joint account, you and your Enrolled Spouse can determine how you wish to apply the account proceeds against claims for reimbursement for Eligible Expenses.

Eligible Expenses

The Plan will reimburse Participants for Eligible Expenses, up to the unused amount in the Participant's Health Reimbursement Account. A Participant shall be entitled to reimbursement under this Plan only for Eligible Expenses incurred on or after the Coverage Effective Date and before his or her participation terminates. Eligible Expenses are "incurred" when the medical care is provided, not when you or your Spouse are billed, charged, or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the service or treatment giving rise to the expense has been provided. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Expenses.

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Expenses (to the extent all other conditions for Eligible Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to the HRA Plan for reimbursement.

Your HRA will reimburse the following Eligible Expenses:

- Medical and prescription drug Premiums paid to a carrier on an after-tax basis
- Medical and prescription drug copayments, deductibles and coinsurance; and
- All other Eligible Expenses as described below.

213(d) Eligible Expenses

The following are examples of 213(d) expenses that are eligible for reimbursement:

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (in narrow circumstances)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports

- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Birth Control Pills (by prescription)
- Blood tests
- Blood transfusions
- Braces (durable medical equipment)
- Cardiographs
- Chiropractor
- Christian Science Practitioner
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Guide dog
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal (in narrow circumstances)
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Oral surgery (not cosmetic)
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician

- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (in narrow circumstances and only if prescribed)
- Wheelchair
- X-rays

Over-the-counter Eligible Expenses

The following over-the-counter drugs are eligible for reimbursement (with a prescription):

- Antacids
- Allergy Medications
- Pain Relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Antacids
- Allergy Medications
- Pain Relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Wart removal medication

- Antibiotic ointments
- Suppositories and creams for hemorrhoids
- Sleep aids
- Motion sickness pills

Ineligible Expenses

The Plan will not reimburse Participants for Ineligible Expenses. Your HRA will not reimburse the following Ineligible Expenses:

- Dental and Vision Premiums
- Dental and Vision copayments, deductibles and coinsurance; and
- All other Ineligible Expenses as described below.

213(d) Ineligible Expenses

The following are examples of 213(d) expenses that are ineligible for reimbursement:

- Advancement payment for services to be rendered next year
- Athletic Club membership
- Automobile insurance Premium allocable to medical coverage
- Boarding school fees
- Bottled Water
- Braces (orthodontia)
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Contact Lenses
- Dental Treatment
- Dental X-Rays
- Dentures
- Eye Glasses
- Fluoridation Unit
- Funeral, cremation, or burial expenses
- Gum Treatment
- Health programs offered by resort hotels, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Maternity clothes
- Medicare Part B Premiums
- Non-prescription medication
- Ophthalmologist
- Optician
- Optometrist

- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Social activities
- Special foods and beverages
- Specially designed car for the handicapped other than an autoette or special equipment
- Stop-smoking programs
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses to send a child with special needs to a particular school
- Weight loss programs.

Over-the-counter Ineligible Expenses

The following are examples of over-the-counter drugs and supplies that are ineligible for reimbursement:

- Toiletries (including toothpaste)
- Acne treatments
- Lip balm (including Chapstick or Carmex)
- Cosmetics (including face cream and moisturizer)
- Suntan lotion
- Medicated shampoos and soaps
- Vitamins (daily)
- Fiber supplements
- Dietary supplements
- Weight loss drugs for general well being
- Herbs

Rollover

If your Premiums and Eligible Expenses are less than the amount allocated to your HRA, therefore you do not use all of your HRA Allocation during a Plan Year, the remaining HRA Allocations will be carried over to be used in future years.

Payments for Insurance

You will pay your Premiums directly to the insurance company for the coverage you choose. You will then request and receive reimbursement from your HRA, either by a check mailed to you or by direct deposit to the account designated by you.

Termination of Coverage

Your entitlement to the HRA Allocation automatically ends on the date that coverage ends. Once a Participant or an Enrolled Spouse has lost coverage, he or she will not be permitted to re-enroll into the Plan and will not receive any future HRA Allocations, unless a timely COBRA election has been made.

After you are no longer covered by the Plan, you may be reimbursed for Eligible Expenses incurred during the Plan Year after your enrollment date, but before the date your coverage ends. Claims may be submitted to Extend Health for 180 days following your termination of coverage date. After 180 days, any unused HRA Allocations in your account will be forfeited.

Retired Participants

Except as provided otherwise in the Plan or law, your coverage under the Plan automatically terminates at 11:59 PM on the earliest of the following dates:

- The date in which the Participant ceases to be an Eligible Person
- The date you are rehired by an Eligible Employer as an Active employee and are eligible for coverage under the Battelle Memorial Institute Medical Plan for BMI Active Staff
- The date you cease to be eligible for Medicare
- The date that you cease to be enrolled in an individual insurance policy through Extend Health
- The date on which, in the opinion of the Plan Administrator, the Participant and/or the Enrolled Spouse/Surviving Spouse of the Participant intentionally furnished incomplete or incorrect information to Battelle, the Plan Administrator or Extend Health for the purpose of effecting coverage under the Plan. Such a determination by the Plan Administrator will prohibit future participation in any self-insured medical plan sponsored by Battelle
- The date that the Plan is discontinued or amended to terminate applicable eligibility of coverage; or
- Your date of death.

Participants on Long-Term Disability

Except as provided otherwise in the Plan or law, your coverage under the Plan due to disability automatically terminates at 11:59 PM on the earliest of the following dates:

- The date in which the Participant ceases to be an Eligible Person
- The date as of which the long-term disability benefits from the PNNL LTD Plan terminate*
- The date you are rehired by an Eligible Employer as an Active employee
- The date you cease to be eligible for Medicare
- The date that you cease to be enrolled in a Commercial Medicare plan through Extend Health
- The date on which, in the opinion of the Plan Administrator, the Participant and/or the Enrolled Spouse of the Participant intentionally furnished incomplete or incorrect information to Battelle, the Plan Administrator or Extend Health for the purpose of effecting

coverage under the Plan. Such a determination by the Plan Administrator will prohibit future participation in any self-insured medical plan sponsored by Battelle

- The date that the Plan is discontinued or amended to terminate applicable eligibility of coverage; or
- Your date of death.

*If your PNNL LTD Plan benefits end and you are eligible as a retiree, other than the requirement from Active Service, and you elect to commence pension benefits from a Battelle-sponsored pension plan, you may continue to participate in the Plan only to the extent that you have met the requirements for participation as a retiree.

Enrolled Spouses

Except as provided otherwise in the Plan or law, as an Enrolled Spouse your coverage under the Plan automatically terminates at 11:59 PM on the earliest of the following dates:

- The date the Eligible Retiree ceases to be a Participant for any reason (except in the event of the Eligible Retiree's death)
- The date you cease to be eligible for Medicare
- The date that you cease to be enrolled in an individual insurance policy through Extend Health
- The date on which, in the opinion of the Plan Administrator, the Participant and/or the Enrolled Spouse of the Participant intentionally furnished incomplete or incorrect information to Battelle, the Plan Administrator or Extend Health for the purpose of effecting coverage under the Plan. Such a determination by the Plan Administrator will prohibit future participation in any self-insured medical plan sponsored by Battelle
- The date that the Plan is discontinued or amended to terminate applicable eligibility of coverage
- The date of your remarriage
- Your date of death; or
- The date you cease to be an Eligible Spouse under the Plan.

A former Spouse is not eligible for coverage under the Plan, except as provided under COBRA. Eligibility for a Participant's former Spouse ends as of the last day of the month in which the divorce between the Participant and Spouse is final.

If you or your Enrolled Spouse loses eligibility as described above, you must notify the Benefits Office within 31 days of the loss of eligibility. If you do not notify the Benefits Office within 31 days of the loss of eligibility, coverage will retroactively terminate once notification has been received. However, no right to continue coverage after the loss of eligibility is obtained because of failure to notify the Benefits Office. Continuation of coverage after loss of eligibility is permitted only as required by COBRA.

If your coverage is retroactively terminated, you will be liable for all claims after the date coverage ends.

Other Events Ending Your Coverage

When any of the following happens, the Plan will provide written notice to the Participant or to the Enrolled Spouse that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant or Dependent knowingly gave the Plan, the Plan Administrator or Extend Health false material information. Examples include false information relating to another person's eligibility or status as a dependent as well as permitting an unauthorized person to use your Identification Card or using another person's identification card. Your coverage may be retroactively terminated for fraud or any intentional misrepresentation of a material fact.
Failure to Pay	You failed to pay a required contribution for your Commercial Medicare plan or Medicare Part B Premiums. Your coverage may be terminated retroactively for a failure to make a required contribution.

Death of a Participant or an Enrolled Spouse

If your Spouse dies and you were receiving HRA Allocations for your Enrolled Spouse, this will end on the Enrolled Spouse's date of death. Claims for expenses incurred by your Enrolled Spouse must be submitted within 180 days of his or her death.

If you die with no Spouse, your Health Reimbursement Account is forfeited upon death, but your personal representative or the executor of your estate may submit claims for Eligible Expenses incurred by you before your death. Claims must be submitted within 180 days of your death.

If you die with a Spouse who is an Enrolled Spouse, your HRA Allocations will end on your date of death, but your Enrolled Spouse who is your Surviving Spouse may continue to receive his or her HRA Allocations. The Surviving Spouse will become the account holder of the HRA and may use the entire account balance. The Surviving Spouse may submit his or her Eligible Expenses for reimbursement after your death until earliest of:

- Your Enrolled Spouse's Death
- Your Enrolled Spouse's Remarriage
- Your Enrolled Spouse becoming employed by Battelle or a controlled group member as a salaried staff member; or
- The Plan being discontinued or amended to terminate applicable eligibility or coverage.

At the later of the Participant or Enrolled Spouse's death, the HRA Account is forfeited, but the deceased Eligible Retiree's or Spouse's estate or representatives may submit claims for Eligible Expenses incurred by the Participant or Enrolled Spouse before his or her death. Claims must be submitted within 180 days of the date of death.

Federal Continuation of Coverage (COBRA)

Under a federal law called "COBRA," your Spouse may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce from the Participant. This is called a "qualifying event."

Your Spouse is required to notify the Plan Administrator in writing of a divorce or legal separation within 60 days of the event or they will lose the right to continue coverage under the Plan.

If your Spouse elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of active Participants (subject to any restrictions applicable to active Participants) so long as he or she continues to pay the applicable COBRA premium.

In order to continue coverage, your Spouse must pay a monthly COBRA premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable COBRA premium at the time of a qualifying event. Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA Account is exhausted
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage
- Any required monthly COBRA premium is not paid when due or during the applicable grace period
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Company ceases to provide any group health plan.

Relationship of Parties (Battelle and Extend Health)

The relationships between Extend Health and Battelle as the Plan Sponsor and the Plan Administrator are solely contractual relationships between independent parties. Extend Health is not Battelle's agent or an Employee of Battelle.

Neither Battelle, as Plan Sponsor and Plan Administrator, nor Extend Health, provide medical services.

Extend Health is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Plan Administrator is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of benefits.
- Notifying you of the termination of or modification to the Plan.

Overpayments

If the Plan pays benefits for expenses incurred, and it later determines that all or some of the payment received was made in error, you or your Enrolled Spouse will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment, the Plan reserves the right to offset future reimbursements equal to the overpayment or, if that is not feasible, to withhold such funds from any amounts due to you from the Plan. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Limitation of Action

You cannot bring any legal action against us, the Plan or Extend Health unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us, the Plan or Extend Health you must do so within three years of the date you are notified of the Plan's final decision on your appeal or you lose any rights to bring such an action against us, the Plan or Extend Health.

Protected Health Information under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. A complete description of your rights under HIPAA will be found in the Plan's privacy notice, which will be distributed to you upon enrollment and will be available from the Plan Administrator.

The Plan and the Plan Sponsor will not use or further disclose health information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and Plan administration functions, or as otherwise permitted or required by law. The Plan will not, without authorization, use or disclose protected health information for employment related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor except as permitted between plans that are part of an Organized Health Care Arrangement under HIPAA's privacy rule.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. The Plan's privacy notice will provide a greater description of your rights and the Plan's obligations under the HIPAA privacy rule.

Federally Mandated Health Benefits

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Waiver

No agent or other person, except an authorized officer of the Eligible Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Claims Procedures

It is standard that Health Reimbursement Accounts can be used for reimbursement of claims for the Participant and all of their dependents, regardless of whether the dependents are receiving an HRA Allocation.

Claims Submission

When you pay for Eligible Expenses you are responsible for requesting reimbursement from the Plan through Extend Health by completing and submitting a reimbursement form. The reimbursement form can be found on Extend Health's internet website. Appropriate documentation must be included with your claim for reimbursement. Appropriate documentation includes:

- A copy of your insurance Premium bill; or
- An Explanation of Benefits (EOB).

After you receive medical care, you will generally receive an EOB. The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage; and
- The amount for which you are responsible (if any).

If no EOB is available, you may submit a written statement from the service provider. The written statement from the service provider must contain the following:

- The name of the patient
- The date service or treatment was provided
- A description of the service or treatment; and
- The amount incurred.

You may submit claims for Eligible Expenses along with appropriate documentation to the Claims Submission Agent for reimbursement in one of the following three ways:

- **Online** - You may scan, upload, fax, or mail in your insurance Premium bill and EOBs after completing the online claim form on Extend Health's internet website.
- **Fax** - You will need to print, complete, and sign a reimbursement form available on Extend Health's internet website and then fax the form along with your supporting documentation to the Claims Submission Agent.*
- **Mail** - You will need to print, complete, and sign a reimbursement form available on Extend Health's internet website and then mail the form along with your supporting documentation to the Claims Submission Agent.*

*Please do not mail or fax your reimbursement form to Extend Health as this may result in a delay in processing. Claims are processed by the Claim Submission Agent.

Reimbursements

Your claim is deemed filed when it is received by the Claims Submission Agent. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Claims submitted and approved over the amount currently available can be reimbursed by future HRA Allocations. Claims will be considered back to the original start date for a Participant and paid as HRA Allocations become available.

Payments for reimbursements of approved expenses are made daily. Reimbursements will be paid via check. If direct deposit is desired, register the deposit account information with Extend Health. See the "Important Information" section of this summary for contact information.

Appeals

Denial Notices

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension

of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information
- A description of the Plan's appeal procedures and the time limits applicable to such procedures
- A description of your right to request all documentation relevant to your claim; and
- A statement of your right to bring a civil action under ERISA Section 502(a) following a denied appeal.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided in the "Administrative and Contact Information" section of this document no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law. You must submit a written request for external review to the Plan Administrator within four months of the notice of the internal appeal determination. You may submit additional information that he or she thinks is important for review.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

How To Appeal A Denial Of Eligibility

The Plan provides one level of appeal for eligibility determinations. If you believe you should be covered under the Plan, but your eligibility has been denied, then you may appeal that denial. You must mail a written request for a review (appeal) to the Plan Administrator within 180 days after your receipt of such denial. Your appeal should include an explanation of the reasons you believe you should be eligible to participate in the Plan. Your request will be provided a full and fair review by the Plan Administrator or its Delegate, and you will be notified of the decision in writing within a reasonable period of time, not to exceed 60 days after the Plan Administrator's receipt of your appeal.

Your written request for an **appeal** should be sent to:

Plan Administrator
Battelle Memorial Institute
505 King Avenue
Columbus, OH 43201-2693

How to Appeal a Denial - Extend Health Commercial Medicare Plan Not Available in Your Area

If the Plan Administrator in its sole discretion determines that the Commercial Medicare plans available in your area are not adequate, and you are enrolled in a commercial Medicare plan that is not offered by Extend Health, the Plan Administrator may allow you to enroll in this Plan and receive the HRA Allocation if you meet all of the other eligibility requirements in the Plan.

In order for the Plan Administrator to approve this exception, you must file an appeal as described in the "How to Appeal a Denial of Eligibility" section of this document. Your request for an appeal should include a letter from Extend Health documenting that coverage that is available in your area, proof of enrollment in another commercial Medicare plan, and any other documentation relevant to your request.

This exception can also apply to an Eligible Spouse or a Surviving Spouse.

Definitions

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Active/Active Service: Active and Active Service means you are working for an Eligible Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation on a day that is one of your Eligible Employer's scheduled workdays. You must be working in an eligible employment classification as described under the 'Eligible Groups' section of this document. Your work site must be your usual place of business, an alternative work site (including your home) at the direction of your manager, or a location to which your job requires you to travel. Normal vacation or Family and Medical Leave is considered active employment.

You are considered to be "Active" or in "Active Service" on a day that is not one of your Eligible Employers' scheduled workdays only if you performed in the customary manner all of the regular duties of your salaried/regular employment on the next preceding scheduled workday.

Amendment: Any attached written description of additional or revised provisions or benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Code: The Internal Revenue Code of 1986, as amended from time to time.

Commercial Medicare plan: A Medicare Advantage plan or a Medigap plan offered by Extend Health.

Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”): A federal law that requires employers to offer continued health insurance coverage to certain employees and their Dependents whose group health insurance has been terminated.

Coverage Effective Date: The first of the month after an Eligible Person or Eligible Spouse first enrolls. This is the date that is used when calculating HRA Allocations.

Delegate: Extend Health and/or Plan Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Extend Health's or Plan Administrator's behalf.

Eligibility Date: The date a person terminates employment, retires, or first becomes Medicare eligible. This date is the date when a person is first eligible to participate in the Plan.

ERISA: The Employee Retirement Income Security Act of 1974, as amended from time to time.

HRA Account: The account established for a Participant, Enrolled Spouse, or Surviving Enrolled Spouse to hold his or her HRA Allocation.

HRA Allocation: The amount credited to a Participant's HRA Account. This credited amount can be used to reimburse Eligible Expenses.

Medicare: Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Plan: The Health Reimbursement Arrangement Plan for Retired Staff of Battelle Memorial Institute, commonly known as the HRA for PNNL Retired Staff, provided by the Plan Sponsor and explained in this Summary Plan Description, which also serves as the legal Plan document.

Premium(s): The periodic charges which are required to be paid by you to your insurance carriers and Medicare in order to maintain coverage under the plans.

Spouse: The opposite sex spouse of a Participant as recognized under the laws of the state in which the Participant is domiciled.

Summary Plan Description and Plan Document: This summary of the terms of your medical benefits. This document is also the legal Plan document.

Year of Credited Service: Twelve consecutive months of Active Service in a salaried/regular employment status after June 30, 1976, at Battelle Memorial Institute (including the Pacific Northwest Division). You lose your Years of Credited Service earned before a termination of employment unless you complete at least three consecutive Years of Credited Service in a continuous

period of employment ending on your retirement date. Contact the Benefits Office if you have a question concerning your number of Years of Credited Service.

Years of Credited service include the period during which a Participant is eligible for and receives benefits from the BCO or PNNL LTD Plan.

Administrative and Contact Information

This section provides you with information about the administration of the Health Reimbursement Arrangement for Retired Staff of Battelle Memorial Institute

Plan Name

Health Reimbursement Arrangement for Retired Staff of Battelle Memorial Institute

Plan Type

Self-Insured Medical Reimbursement Plan as well as a Health Reimbursement Arrangement

Employer and Plan Sponsor

Battelle Memorial Institute
505 King Avenue
Columbus, Ohio 43201-2693
(614) 424-6350

Employer Identification Number (EIN)

31-4379427

Plan Number

550

Plan Year

January 1- December 31

Plan Administrator

Battelle Memorial Institute
Attn: Malesa A. Litteral, Esq.
505 King Avenue
Columbus, Ohio 43201-2693
(614) 424-6350

The Plan Administrator may designate other persons to carry out any of these responsibilities under the Plan, and the Plan Administrator and any other person so designated may employ one or more persons to render advice in regard to any responsibility they have under the Plan.

The Plan Administrator has the full and exclusive discretionary authority to:

- Interpret the Plan and to resolve all questions arising in the administration, interpretation and application of the Plan
- Interpret the other terms, conditions, limitations, and exclusions of the Plan; and
- Make factual determinations related to the Plan and its benefits.

Benefits under this Plan will only be allocated if the Plan Administrator or its Delegate decides in its discretion that the applicant is entitled to them.

The Plan Administrator or its Delegate shall establish the Plan's policies, interpretations, practices and procedures. The Plan Administrator or its Delegate has sole discretionary authority to determine eligibility for benefits, to construe and interpret the terms of the Plan, to decide disputes that may arise relative to an Eligible Person's rights and to decide questions of Plan interpretation and those of fact relating to the Plan. The determinations and interpretations of the Plan Administrator or its Delegate shall be conclusive and binding.

Upon challenge by and Enrolled Participant, Enrolled Spouse or other party, interpretations of Plan provisions, applications of the Plan to specific fact patterns and/or discretionary actions by the Plan Administrator and/or any other Plan fiduciaries shall be sustained unless the interpretation, application, or action in question was arbitrary and capricious.

Agent for Service of Legal Process

Battelle Memorial Institute
Attn: Daniel O. Cecil, Esq.
505 King Avenue
Columbus, OH 43201-2693

Service of legal process may also be made upon the Plan Administrator.

Plan Amendment Procedure

Battelle reserves the right at any time to change or terminate the coverage provided under the Plan without prior notice. Any such change or termination adopted by Battelle Memorial Institute shall be on its own behalf and on behalf of each participating Employer. "Participating Employer" is an Employer who has adopted the Plan with the written approval of Battelle Memorial Institute. The benefits to be provided under the Plan and the eligibility of employees members to participate in the Plan are to be determined from time to time under the then-effective provisions of the Plan instrument explaining the Plan.

Battelle has authority to amend or terminate the Plan at any time by its President or designated officer adopting a written instrument of Amendment or termination. In the event of Plan termination,

any remaining assets of the trust funding the Plan will be used to provide benefits due and payable under the terms of the Plan prior to being used for other permissible purposes under law. In no event will the assets be used for the benefit of the Employer. Any provision of the Plan which, on its Effective Date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

The Plan may be amended at any time to change or eliminate any or all benefits under the Plan. The decision to amend or terminate the Plan belongs entirely to Battelle in its sole discretion. Benefits under this Plan do not accrue or vest to Participants or their Dependents regardless of the number of years of service with Battelle.

Statement of ERISA Rights

As a Participant in the Health Reimbursement Arrangement for Retired Staff of Battelle Memorial Institute, 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 locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Medical Plan Coverage

Continue Plan coverage for yourself, Spouse, or 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 Plan Document on rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the 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 Battelle, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits 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.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, which is listed in your telephone directory.

You may also contact:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-275-7922. You may also visit EBSA's website on the Internet at <http://www.dol.gov/ebsa>.

As evidence of its adoption of the Health Reimbursement Arrangement for Retired Staff of Battelle Memorial Institute, commonly known as the HRA for PNNL Retired Staff; Battelle Memorial Institute has caused this instrument to be signed by its President or designated officer this 11th day of April, 2013, but effective as of July 1, 2013.

BATTELLE MEMORIAL INSTITUTE

By: Signature on File
Thomas Snowberger, Sr. V.P.
Human Resources